Washington State Department of Social & Health Services
Transforming lives

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Attachment D

Assisted Living Facility Resident Characteristic Roster and Sample Selection

TOTAL CENSUS

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER	INSPECTION DATE

LICENSOR NAME	Visit Type: ☐ Initial ☐ Full ☐ Follow up ☐ Complaint: Number _____

RESIDENT ROOM	ADMIT DATE	RESIDENT ID NUMBER	RESIDENT NAME	Nursing Services	Medication: Ind. (I), Assist (A), Adm. (Ad), Fam. (F)	Mobility / Falls / Ambulation Devices	Behavior / Psycho Social Issues	Dementia / Alzheimer's / Cognitive impairment	Exit Seeking / Wandering	Smoking	DD / Mental Health	Language / Communication Issue / Deafness / Hearing issues	Vision Deficit / Blindness	Diabetic: Insulin/Non-Insulin	Assist with ADL's	Wounds / Skin Issue	Incontinent / Appliance (catheter) Dialysis	Special Dietary Needs / Scheduled Snacks	Weight Loss / Weight Gain	Medical Devices	Pay Status: Private = P State = S	Recent Hospitalization	Oxygen / Respiratory Therapy	Home Health / Hospice / Private Caregiver	Other

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Coding: In order to assist in more accurate communication of resident characteristics, the following coding legend has been provided.
If characteristics do not apply, leave box blank.

	MARK THE BOX:
Nursing Services (services only a licensed nurse can provide)	**O** - resident receiving Ostomy care; **T** - resident receiving Tube feeding; **I** – resident receiving Injections; **ND** – resident receiving Nurse Delegation.
Medication: Independent Administration Assistance Family Assistance	**I** – resident assessed as Independent with their medication; **A** – resident assessed as needing medication assistance; **AD** – resident assessed medication administration; **F** – resident receiving Family assistance with medications.
Mobility / Falls / Ambulation Devices	**A** – resident requires Assistance with transfers or cannot ambulate independently without assistance from staff or assistive devices; **F** – resident experienced a Fall within the last 30 days; **D** – resident uses a Device to assist with ambulation.
Behavior / Psycho Social Issues	**X** – resident shows or has behaviors such as those requiring special training or assistance increasing the amount of time staff needs to assist resident.
Dementia / Alzheimer's / Cognitive impairment	**X** – resident shows or has behaviors requiring special training or assistance increasing the amount of time staff needs to assist resident.
Exit Seeking / Wandering	**ES** – resident has shown Exit Seeking behaviors; **W** – resident has shown Wandering behaviors
Smoking	**S** – resident Smokes.
DD / Mental Health	**DD** – resident has a Developmental Disability case manager; **MH** – resident receives Mental Health services and/or has a mental health case manager.
Language / Communication Issues / Deafness / Hearing Issues	**X** – resident has a language or communication issue which requires additional staff support; **HI** – resident is Hearing Impaired; **D** – resident is Deaf.
Vision Deficit / Blindness	**X** – resident if blind or has severe vision deficit which requires additional staff support
Diabetic: Insulin / Non-Insulin	**I** – resident if Insulin dependent; **N** – resident is **N**on-insulin dependent diabetic.
Assist with ADL's	**I** – resident assessed as Independent; **MIN** – resident assessed as needing MINimal assistance with ADL's such as curing reminders, supervision, and/or encouragement; **MOD** – resident assessed as needing MODerate assistance with ADL's such as guiding, standby assistance for transfers, or ambulation, bathing and toileting; **MAX** – resident assessed as needing MAXimum assistance with ADL's such as needing a one person or two person transfer, resident was incontinent of bowel or bladder and required staff to assist with care; resident needed assistance with turning, sitting up or laying down, staff must physically turn the resident every two hours.
Wounds / Skin Issue	**P** – resident has a Pressure ulcer; **S** – resident has a Stasis wound; **W** – resident has a Wound or skin issue other than pressure or stasis ulcer.
Incontinent / Appliance (catheter) / Dialysis	**UI** – resident Incontinent of bladder and/or bowel; **C** – resident has Catheter; **D** – resident requires Dialysis.
Special Dietary Needs / Scheduled Snacks	**X** – resident requires a special prescribed diet.
Weight Loss / Weight Gain	**WL** – resident has had more than a 3 – 5 pound Weight Loss within last 60 days; **WG** – resident has had more than a 3 – 5 pound Weight Gain within the last 60 days.
Medical Devices	**X** – resident receives dialysis treatments; **M** – if part of a residents care is the use of side rails, transfer poles, chair / bed alarms / belt restraints.
Pay Status	**P** – all or part of a resident's care is paid by the resident or their family; **S** – all of part of a resident care is paid for by the state.
Recent Hospitalization	**X** – resident has been hospitalized within the last 60 days.
Oxygen / Respiratory Therapy	**X** – resident receives oxygen and/or respiratory therapy or treatments.
Home Health / Hospice / Private Caregiver	**HH** – resident receives Home Health services; **HOS** – resident receives HOSpice services; **P** – resident receives care from Private caregiver.