ASSISTED LIVING FACILITY NAME	LICENSE NUMBER
ENTRANCE DATE	LICENSOR NAME

Attachment A

Assisted Living Facility
Pre-Inspection Preparation

Inspection Type: ☐ Full

Preparation activities:

- Print licensee summary and room list from tracking system
- Review compliance history since last inspection, expand up to 36 months if needed
- Review past SOD's, uncorrected deficiencies, and enforcement actions since last full inspection
- Review past and current complaint investigations since last full inspection
- Identify current communicable disease outbreaks and review current IPC guidance
- Review resident and staff list from last licensing inspection

Consult regarding concerns about facility with:

- Nurse, Licensor, Complaint Investigators, FM
- Case Managers: HCS, DDA

Contract(s): ☐ AL ☐ EARC ☐ ARC ☐ EARC-SDC ☐ Adult Day Care ☐ Other: ☐ None

Licensed Beds:

Administrator:

CURRENT EXEMPTIONS (IF APPLICABLE)

FACILITY CHANGES SINCE LAST INSPECTION

OMBUDS QUARTERLY MEETINGS SINCE LAST FULL INSPECTION

☐ No Concerns

STATE FIRE MARSHAL'S OFFICE REPORTS SINCE LAST FULL INSPECTION

☐ No Concerns

CASE MANAGER DDA / HCS	CONTACT DATE (IF APPLICABLE)
COMMENTS / CONCERNS	

OTHER OUTSIDE AGENCY	CONTACT DATE (IF APPLICABLE)
COMMENTS / CONCERNS	

ASSISTED LIVING FACILITY NAME		LICENSE NUMBER
ENTRANCE DATE	LICENSOR NAME	

Notes: Pre-Inspection Preparation

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER

ENTRANCE DATE	LICENSOR NAME

Attachment B

DSHS WASHINGTON STATE Department of Social and Health Services

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Assisted Living Facility Request for Documentation

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint: Number _____

☐ **The field office has contacted the Ombuds.**

Licensee / Administrator: Please provide the following documentation to the licensors per WAC 388-78A-3140.

Documentation due to licensor within two (2) hours of entrance:	**Received**
Resident Information	
Resident Characteristic Roster, DSHS 10-362* or Resident List, DSHS 10-361 or facility list of all licensed rooms (occupied and vacant), and all residents including roommates, room number, and language spoken if not fluent in English. If a nonresident is in a licensed room, indicate nonresident. Provide one copy for each inspection team member.	☐
* Note: Maintaining a Resident Characteristic Roster, DSHS 10-362, expedites onsite inspection time. This form can be located at https://www.dshs.wa.gov/fsa/forms/	
Staff / Administrative Information	
Complete list of staff, position title, shift, hire date (first date worked for pay), and date of birth. Provide one copy for each inspection team member.	☐
Three weeks of staffing schedules as actually worked including nursing, dietary staff, and housekeeping / laundry staff.	☐
System for and access to personnel files and resident records (requests for specific resident and staff records will occur during the inspection).	☐
Name and phone numbers of administrator / designee.	☐
Applicable documentation due to licensor by end of entrance day:	**Received**
Disclosure of services.	☐
Copy of evidence of general and professional liability insurance coverage.	☐
Four weeks of menus as served, activity schedule.	☐
Disaster plan, policies and procedures for: Infection Prevention Control, mandated reporting for abuse / neglect.	☐
Valid Medical Test Site Certificate of Waiver License (MTSW) / Clinical Laboratory Improvement Amendment (CLIA) (☐ Not applicable).	☐
Nurse delegation policy and procedure (☐ Not applicable).	☐
Pet policy and records (☐ Not applicable).	☐
Changes in physical environment and approved Construction Review projects since last full inspection (☐ Not applicable).	☐
Copies of any waivers / exceptions / exemptions to rules (☐ Not applicable).	☐
Resident Register (Discharge Information / Move Out Record) List of residents discharged in last six months and reason for discharge (if deceased write deceased) (☐ Not applicable).	☐
Documentation required:	

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER
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Attachment C

CONFIDENTIAL INFORMATION – DO NOT DISCLOSE
NOT FOR PUBLIC DISCLOSURE

Assisted Living Facility
Resident List

Not required if facility uses its own list or Attachment C.

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint: Number _____

ROOM NUMBER	RESIDENT NAME	NOTES

ASSISTED LIVING FACILITY NAME		LICENSE NUMBER
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ASSISTED LIVING FACILITY NAME	LICENSE NUMBER

ENTRANCE DATE	LICENSOR NAME

DSHS WASHINGTON STATE Department of Social and Health Services

Attachment E

Assisted Living Facility
Resident Group Meeting

Inspection Type: ☐ Full

DATE	TIME	NUMBER OF RESIDENTS PRESENT

RESIDENT GROUP MEETING NOT CONDUCTED (SELECT THE REASON WHY AND SKIP THE REST OF THIS FORM)

☐ No attendees arrived. Length waited:

☐ Current infectious disease outbreak

☐ Other:

RESIDENT COUNCIL?	COUNCIL PRESIDENT	FOOD COMMITTEE
☐ Yes ☐ No		☐ Yes ☐ No

Areas of concerns / issues identified prior to meeting. Refer to resident characteristic roster / sample selection form as needed to identify residents.

Introductions and brief explanation of meeting and inspection process by RCS staff. Use questions modified for population type. Suggested areas for discussion:

We would like to ask you several questions about life in the facility and the interactions of residents and staff.

- **Rules.** Tell me about the rules in this facility. For instance, are there rules about what time residents go to bed at night and get up in the morning?

- **Privacy.** Can you please describe the ways staff makes an effort to make sure that your privacy and the privacy of all residents are respected? Do you meet privately with visitors, and have private telephone calls?

- **Dignity respected (those with and without ability to speak for selves).** How do staff members treat the residents here, not just yourselves, but others who cannot speak for themselves? Do they try to accommodate residents' wishes where possible?

- **Abuse and neglect.** Are you aware of any residents that are abused or neglected here? Are you aware of anytime when a resident had property taken away from them by staff? Is there enough staff here to take care of everyone?

- **Personal belongings / Loss or theft.** Can residents have their own belongings in their rooms if they want to? Does the facility make efforts to prevent loss, theft, or destruction of property?

- **Meals and food service.** Can you please describe what the food is like here? If you do not like some food, do they give you something else to eat? Is the temperature of your hot and cold food appropriate? Are your meats tender enough?

- **Response to concerns.** Do you talk to staff about your concerns? What is their response?

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- **Unmet needs.** Do you (and your family) feel comfortable to talk to staff about needs that are not being met? Are there excessive wait times for care or medications?

- **Activities**. Can you please share your thoughts about the activities offered here? Do the activity programs meet your interests and needs? Do you participate in activities? Are there enough help and supplies available so that everyone who wants to can participate

- **Building.** What do you think about the air and temperature in your room; in the dining and activity rooms? Does the lighting in your room allow you to do whatever you want to do? Is it generally noisy or quiet? How about at night?

- **Other.** Is there anything else about life here in the facility that you would like to discuss?

Thank the group for their time. After the interview, follow up on any concerns that need further investigation.

Notes **Attachment E**

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER
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DSHS WASHINGTON STATE Department of Social and Health Services

Attachment F

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Assisted Living Facility Staff Interview

Inspection Type: ☐ Full ☐ Follow-up ☐ Complaint: Number

SHIFT	NAME	DATE	TIME	
☐ Caregiver			:	☐ AM ☐ PM

This form is **optional** and includes sample questions for individual categories. Expand questions to obtain more data in areas where concerns are identified.

Resident Rights • What do you do to promote resident dignity, quality of life, and privacy? • What do you do if you see or discover resident rights being violated?	
Resident Grievances • What do you do if you have a resident who says they are unhappy about the care in this facility?	
Care and Services • What types of daily choices do the residents make? • How do you help residents feel comfortable here?	
Abuse / Neglect / Exploitation • Please give an example of abuse, neglect, or exploitation. • What do you do if you discover abuse, neglect, or exploitation?	
Resident Behavior / Facility Practice • What do you do if a resident is missing? • Do any residents have challenging behaviors? If yes, what behaviors? How do you manage those behaviors?	
Accident / Injury / Prevention • What do you do if a resident falls? • How do you know what each resident needs? • Who do you notify if a resident is injured?	
Staffing • Do you work alone? • How do you get help? • How do staff contact the administrator?	
Emergency Management • When did you participate in an evacuation drill? • What do you do if there is an emergency or disaster?	

ASSISTED LIVING FACILITY NAME		LICENSE NUMBER
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Notes

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER

ENTRANCE DATE	LICENSOR NAME

DSHS WASHINGTON STATE Department of Social and Health Services

Attachment G

Assisted Living Facility Resident Interview

RESIDENT NAME	RESIDENT IDENTIFIER	ROOM NUMBER	PAY STATUS ☐ Private ☐ State

REPRESENTATIVE NAME	REPRESENTATIVE PHONE NUMBER

Brief Review of Negotiated Service Agreement:

Water Temperature (required for half of sampled residents):
☐ Not reviewed for sample resident: Temperature: Date: Time: ☐ AM / ☐ PM

INTERVIEW TYPE
☐ Resident Interview ☐ Representative Interview Date: Time: ☐ AM / ☐ PM

Instructions: The interview must address each category (A through J) and include a documented response. Check "Y" if the answer is yes; check "N" if the answer is no and document interviewee response; or check "D" if the interviewee declined to answer the question. If the question does not apply to the resident, check N/A.

HCBS questions are denoted with ** before each question. For each HCBS question, that question is **REQUIRED** and **MUST** be asked as **written** during the interview. For categories with required **HCBS questions, the additional example questions are optional.

If there is no ** HCBS question for that category, use one of the example questions or write your own question. **You must ask at least one question in each category.** Check the box next to the question asked and document the response or check no concerns.

If you are concerned about any response, please investigate further.

Y	N	D	N/A	**A. Care and Service Needs (Required **HCBS question in this section)**	
☐	☐	☐	☐	** Can you make choices about the care and services you receive here at the facility?	☐ No Concerns
☐	☐	☐	☐	☐ Who helps you with your medications?	☐ No Concerns
☐	☐	☐	☐	☐ What do staff help you with?	☐ No Concerns
				B. Response to Concerns Support of Personal Relationships (Required **HCBS question in this section)	
☐	☐	☐	☐	** Do they pay attention to what you have to say?	☐ No Concerns
☐	☐	☐	☐	☐ Who would you talk to if you had concerns about your care?	☐ No Concerns
☐	☐	☐	☐	☐ Other:	☐ No Concerns
				C. Support of Personal Relationships (Required **HCBS question in this section)	
☐	☐	☐	☐	** Can you choose who visits you and when?	☐ No Concerns

ASSISTED LIVING FACILITY NAME		LICENSE NUMBER
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Y N D N/A		
☐ ☐ ☐ ☐	☐ Other:	☐ No Concerns
D. Meals / Snacks / Preferences (Required **HCBS question in this section)		
☐ ☐ ☐ ☐	** Do you have access to food anytime?	☐ No Concerns
☐ ☐ ☐ ☐	☐ Other:	☐ No Concerns
E. Respect of Individuality, Independence, Personal Choice, Dignity (Required **HCBS question in this section)		
☐ ☐ ☐ ☐	** If you have a roommate, were you informed you would have a roommate? Could you change roommates if you wanted to?	☐ No Concerns
☐ ☐ ☐ ☐	** Can you choose to lock your door?	☐ No Concerns
☐ ☐ ☐ ☐	☐ Are you allowed to make choices and, if yes, are staff respectful of your choices?	☐ No Concerns
☐ ☐ ☐ ☐	☐ Other:	☐ No Concerns
F. Activities (Required **HCBS question in this section)		
☐ ☐ ☐ ☐	** Do you have an opportunity to participate in community activities?	☐ No Concerns
☐ ☐ ☐ ☐	** Do you receive services in the community?	☐ No Concerns
☐ ☐ ☐ ☐	☐ Do you participate in activities while in the facility? How often?	☐ No Concerns
☐ ☐ ☐ ☐	☐ Other:	☐ No Concerns
G. Homelike Environment (Select the question asked by checking the box next to that question)		
☐ ☐ ☐ ☐	☐ Tell me about your room. Did you help decorate it?	☐ No Concerns
☐ ☐ ☐ ☐	☐ Is the temperature comfortable to you?	☐ No Concerns
☐ ☐ ☐ ☐	☐ Other:	☐ No Concerns

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER

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H. Reasonable Facility Rules (Select the question asked by checking the box next to that question

Y	N	D	N/A		
☐	☐	☐	☐	☐ Are there any rules that prevent you from doing the things you like to do every day?	☐ No Concerns
☐	☐	☐	☐	☐ Other:	☐ No Concerns

I. Sense of Well-Being and Safety (Select the question asked by checking the box next to that question)

Y	N	D	N/A		
☐	☐	☐	☐	☐ Do you feel safe?	☐ No Concerns
☐	☐	☐	☐	☐ Other:	☐ No Concerns

J. Medicaid Policy Notice (Select the question asked by checking the box next to that question)

Y	N	D	N/A		
☐	☐	☐	☐	☐ What were you told about paying for your care here?	☐ No Concerns
☐	☐	☐	☐	☐ Other:	☐ No Concerns

K. Notes

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER

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DSHS WASHINGTON STATE Department of Social and Health Services

Attachment H

Assisted Living Facility
Other Contact Interview

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint: Number _____

RESIDENT NAME	RESIDENT NUMBER	DATE OF INTERVIEW

CONTACT NAME AND NUMBER	RELATIONSHIP TO RESIDENT

NOTES

CONTACT NAME AND NUMBER	DATE OF INTERVIEW	RELATIONSHIP TO RESIDENT

NOTES

ASSISTED LIVING FACILITY NAME		LICENSE NUMBER
ENTRANCE DATE	LICENSOR NAME	

Additional Notes

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER
ENTRANCE DATE	LICENSOR NAME

Attachment I

Assisted Living Facility
Environmental Observations

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint: Number _____

Observations of the environment occur throughout the inspection. Interviews with facility staff and residents are an important source of information to include.

A. Quality of Life / Resident Rights

YES	NO	
☐	☐	Staff to resident interaction(s), responsiveness and meeting resident needs
☐	☐	Staff speaking over residents in another language
☐	☐	Appropriate staff communication with residents
☐	☐	Adaptive equipment available, clean and in good repair
☐	☐	Resident grooming, hygiene, and dress and/or delivery of care completed
☐	☐	Recognition of cultural diversity and preferences
☐	☐	Recognition of dignity, privacy, and resident rights (i.e., shades in room, knocking before entering room)
☐	☐	Presence of restraints
☐	☐	Communication system
☐	☐	Homelike

NOTES

B. Physical Environment – Interior

YES	NO	
☐	☐	Information posted
☐	☐	CRU Hotline posted
☐	☐	Current ALF license posted
☐	☐	Ombudsman Hotline posted
☐	☐	Last full inspection, cover letter and report, posted

NOTES

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER

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C. Maintenance and Housekeeping

YES	NO	
☐	☐	Furnishing, floors, walls, and ceilings
☐	☐	Presence of objectionable odors
☐	☐	Housekeeping supply area
☐	☐	Laundry – separate areas for clean and soiled linen
☐	☐	Infection control practices of staff
☐	☐	Hand washing
☐	☐	Temperature (68°+ wake hours / 60°+ sleep hours)
☐	☐	Adequate ventilation in resident rooms and common areas
☐	☐	Adequate lighting in resident rooms and common areas
☐	☐	Cleanliness and maintenance of resident equipment
☐	☐	Safe water temperature in resident rooms and sinks utilized by residents

Water temperature: °F; (date and time); (location)

Water temperature: °F; (date and time); (location)

Water temperature: °F; (date and time); (location)

NOTES

D. Common Bathrooms

YES ☐ NO ☐ Common bathrooms are:

- Safe / clean / adequate lighting / grab bars (if applicable for resident needs)
- Adequately ventilated
- Accessible for all resident / privacy available

NOTES

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER

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E. Safety

YES NO

☐ ☐ Prevention of resident access to storage of:

- Cleaning supplies
- Cleaning carts
- Storage closet
- Toxic materials
- Medications

☐ ☐ Access to outdoors including dementia care unit

- Safe walking areas
- Walking areas protected from the elements
- Can summon staff in an emergency

☐ ☐ System to inform and permit exit without sounding alarm

☐ ☐ Secure outdoor space

- Accessible to residents without staff
- Surrounded by walls or fences at least 72” high
- Firm, stable walking surfaces and outdoor furniture

☐ ☐ Emergency / disaster preparedness

- Emergency lighting
- First Aid supplies
- Disaster plan
- Staff responsibilities

NOTES

F. Physical Environment - Outdoors

YES NO

☐ ☐ Stairs / steps / ramps in good repair

☐ ☐ Handrails

☐ ☐ Garbage / refuse

☐ ☐ Presence of pests

☐ ☐ General maintenance of sidewalks / walkways

NOTES

Continue with Attachment N for further observations if the facility has a contract for AL, EARC, or EARC – Specialty Dementia Care.

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER
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Attachment J

Assisted Living Facility Resident Record Review

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint: Number _____

NAME	ID NO.	DATE OF BIRTH	ROOM NO.	MOVE-IN DATE	PAY STATUS

FAMILY / MEMBER / RESIDENT'S REPRESENTATIVE	REPRESENTATIVE'S PHONE	REASON FOR SAMPLE SELECTION

PERTINENT MEDICAL HISTORY / DIAGNOSIS

Yes	No	N/A	A. Assessment
☐	☐	☐	Pre-admission (for residents admitted in last six months, expand if needed).
☐	☐	☐	Full assessment completed with 14 days of admission (for residents admitted in last six months, expand if needed).
☐	☐	☐	Annual to meet resident's needs or semi-annual for EARC – Specialized Dementia Care contract.
☐	☐	☐	Updated as needed when there is a change of condition as defined in WAC 388-78A-2120.

NOTES

Yes	No	N/A	B. Monitoring Resident's Well-Being
☐	☐	☐	Documented.
☐	☐	☐	Action taken as needed.

NOTES

Yes	No	N/A	C. Negotiated Service Agreement (NSA)
☐	☐	☐	Initial on admission and completed within 30 days (for residents admitted in last six months).
☐	☐	☐	Updated as necessary.
☐	☐	☐	Contents meet resident's needs and preferences.

- Signed annually by resident / resident representative, facility, and case manager (if applicable).
- Defined roles and responsibilities of resident, staff, resident's representative, outside agency if used, and alternate plan when necessary.
- Times services will be delivered including frequency and approximate time of day.
- Resident's preferences for activities and how supported.
- Identifies and incorporates Resident Arranged Services (if applicable).
- Identifies and incorporates External Health Providers (if applicable).

NOTES

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER

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Yes	No	N/A	D. Negotiated Service Agreement (NSA)
☐	☐	☐	Medication services provided by family (review plan).
☐	☐	☐	Medication services provided by facility (review plan).
☐	☐	☐	Appropriate for resident abilities and needs.
☐	☐	☐	Review of medication record.
☐	☐	☐	Documentation of refusal (if applicable).

NOTES

Yes	No	N/A	E. Negotiated Service Agreement (NSA)
☐	☐	☐	Nursing Service System developed.
☐	☐	☐	Services identified and appropriate.

NOTES

Yes	No	N/A	F. Negotiated Service Agreement (NSA)
☐	☐	☐	Receiving Food Services as ordered.
☐	☐	☐	Receiving eating assistance.

NOTES

Additional Notes **Attachment J**

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER
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DSHS WASHINGTON STATE Department of Social and Health Services

Attachment L

Assisted Living Facility
Notes / Worksheet

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint: Number _____

ASSISTED LIVING FACILITY NAME		LICENSE NUMBER
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ASSISTED LIVING FACILITY NAME	LICENSE NUMBER

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Attachment N

Assisted Living Facility Contract Requirements

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint: Number _____

RCS has the authority to regulate to ALF contract requirements found within WAC 388-110 for all partially or fully funded state pay resident(s). For all contracts, the provider must develop and provide services as agreed upon in a negotiated service agreement developed according to WAC 388-78A including reasonable accommodations as required by RCW 70.129.

Contract requirements pertain to state pay residents only. Select which contract(s) the ALF holds and complete the corresponding sections below. If none, check none and skip the rest of this form.

Contracts: ☐ AL ☐ ARC ☐ EARC ☐ EARC-SDC ☐ None

Assisted Living (AL) (WAC 388-110-140 and 388-110-150)

Yes	No	Standard / Regulation	Notes
☐	☐	Provide the following: 1. Intermittent Nursing services 2. Medication administration 3. Personal care services 4. Supportive services that promote independence and self-sufficiency 5. Provide generic personal care items 6. Access to on-site washing machine and dryer 7. Provide beverages and snacks	
☐	☐	Resident room – meeting the requirements of a type "B" dwelling after 09/01/2004: 1. Single occupancy room (no exemption required if spouse) 2. Private bathroom with sink, toilet, shower or bathtub 3. Kitchen with refrigerator, microwave or stove top, counter or table, kitchen sink 4. Lockable door 5. 220 sq feet (180 sq feet before 09/01/2004)	
☐	☐	Includes storage for utensils / supplies, counter surface with knee space and wired for phone (if new after 09/01/2004)	
☐	☐	Accessible mailbox	
☐	☐	Common areas: 1. Available at any time to residents 2. Smoke-free 3. Homelike 4. Outdoor areas	

Assisted Residential Care (ARC) (WAC 388-110-240 and 388-110-150)

Yes	No	Standard / Regulation	Notes
☐	☐	Providing personal care services	

☐	☐	Ability to lock resident unit door if desired	

Enhanced Assisted Residential Care (EARC) (WAC 388-110-220)			
Yes	No	Standard / Regulation	Notes
☐	☐	No more than two residents per room	
☐	☐	Provide the following: 1. Intermittent nursing services 2. Medication administration 3. Personal care services 4. Supportive services promoting independence and self-sufficiency	

Enhanced Assisted Residential Care – Specialized Dementia Care (EARC-SDC) (WAC 388-110-220)			
Yes	No	Standard / Regulation	Notes
☐	☐	No more than two residents per room	
☐	☐	Rooms: 1. Furnished and/or decorated to resident preference and needs 2. Accessible without staff assistance	
☐	☐	Providing the following: 1. Intermittent nursing services 2. Medication administration 3. Personal care services 4. Supportive services promoting independence and self-sufficiency 5. Provide generic personal care items	
☐	☐	Maintain either an EARC or AL contract in addition to EARC-SDC contract	
☐	☐	Full reassessment semi-annually	
☐	☐	24-hour awake staff responsive to resident's needs	
☐	☐	Additional policies for: 1. Wandering 2. Actions to be taken regarding elopement 3. Consultation resources to address behavioral issues	
☐	☐	Continuing Ed 12 hours / year requirement for staff to include 6 hours related to dementia.	
☐	☐	Routine eating assistance to include: 1. Extensive assistance, oversight, supervision, cuing and encouragement 2. Occasional total assistance when applicable. Note: tube feeding and IV feeding are not required.	

ASSISTED LIVING FACILITY NAME			LICENSE NUMBER
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☐	☐	Daily activities: 1. Opportunities for independent, self-directed activities 2. Individual activities 3. Group activities 4. Activities that accommodate variations in mood, energy and preferences – based upon individual resident schedules and interests	
☐	☐	Common areas: 1. Multiple and vary in size and arrangement 2. Provide opportunities for privacy, socialization and wandering 3. Garden area	
☐	☐	Outdoor area – At least one outdoor area: 1. Accessible without staff assistance. 2. Surrounded by walls or fences at least 72 inches high 3. Protected from direct sunshine and rain throughout the day 4. Firm, stable and slip resistant walking surfaces free of abrupt changes and appropriate for wheelchairs and walkers that encourage exploration and walking 5. Suitable outdoor furniture 6. No poisonous or toxic plants	
☐	☐	Public address system is used only for emergencies.	

Notes

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER
ENTRANCE DATE	LICENSOR NAME

Attachment P

Assisted Living Facility
Food Service Observations and Interviews

Food Service must meet the requirements of WAC Food Code Chapter 246-215 and WAC 388-78A-2300 and WAC 388-78A-2305

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint: Number _____

A. Food Services: General observation of kitchen and staff (wear a hair restraint per regulation and facility policy).

- Overall cleanliness of kitchen area (06505)
- Free from rodents and pests (06550)
- Proper hand hygiene and glove use (02305 and 02310) during food preparation and service
- Staff cleanliness, use of hair restraints and hygienic practices (02325, 02335, 02410)
- Food from approved sources (03200) (for example food from known providers, no home prepared items)
- Chemicals labeled and properly stored (07200)
- Person in charge to provide a copy of the food worker cards for meal preparation staff observed during the meal observed in this inspection. (02120)
- No ill food workers present (02220)
- Person in Charge describes process for staff to report illnesses and procedures used when an ill food worker reports an illness (02205, 02220, 02225)
- Person in Charge or designee describes proper dishwashing procedure that follow manufacture guidelines for temperature or chemical controls (04555, 04560)

Notes:

B. Food Preparation and Service: Observe for proper food preparation, sanitation, and storage.

- Person in Charge or designee describes how food contact surfaces are thoroughly cleaned/rinsed/sanitized (4640 washing, 04645 rinsing, 04700 sanitation)
- Person in Charge or designee describes steps taken to prevent cross-contamination of food items (03306)
- No bare hand contact with ready to eat foods, except during the washing of fruits and vegetables (03300)
- Fruits and vegetables are thoroughly rinsed (washed) (03318)
- Raw meats stored below or away from ready to eat food (03306)
- Stored food is date marked (03526) (resource: Department of Health Date Marking Toolkit)

Notes:

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER

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C. Food Storage: Observe for proper time / temperature controls.

- Food stored with proper temperature controls (for example, no potentially hazardous foods (e.g., beef, chicken, pork) thawing at room temperature) (03510)
- Refrigerator temperature is maintained at ≤41°F (internal temperature of potentially hazardous food must be at ≤41°F) (03525)
- Foods are frozen in freezer (no specific temperature requirement) (03500)
- Potentially hazardous foods are properly cooled (within two hours going from 135°F to 70°F and then to ≤41°F within a total of six hours or follow the rapid cooling procedure of continuous cooling in a shallow layer of 2 inches or less, uncovered, protected from cross contamination; in cooling equipment maintaining an ambient air temperature of ≤41°F; or other methods as described in regulation) (03515)
- Person in Charge or designee identifies proper cooking time and temperatures for potentially hazardous foods (for example, poultry 165°F [instantaneous], ground meat at least 158°F [instantaneous], fish and other meats 145°F [15 seconds])
- Person in Charge describes process to check food temperatures
- Person in Charge or designee describes how food items are properly reheated (03400)
- Licensors may ask the facility to check food temperature, or licensor may check temperature of food with a sanitized thermometer
  - Hot foods held at ≥135°F prior to serving (03525)
  - Cold foods held at ≤41°F prior to serving (03525)

Food Temperature: _____°F; _____(Date and time); _____(location)

Food Temperature: _____°F; _____(Date and time); _____(location)

Food Temperature: _____°F; _____(Date and time); _____(location)

Notes:

D. Menus: Meal planning to meet residents; dietary needs.

Menus (2300):

- Provide Variety
- Are nutritious, meets the residents' dietary needs
- Are palatable and served at proper temperature (if issues with food palatability temperature and/or palatability, consider obtaining a meal sample)
- Are attractively served
- Alternate choices for entrees are available
- Diet manual is approved by a dietitian and reviewed at least every five years
- Prescribed diets available per diet manual
- Menus are posted

Notes:

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER
ENTRANCE DATE	LICENSOR NAME

E. Dining Service: Dining service observations.

Dining Observation:

- Residents who need assistance for eating or swallowing concerns receive it timely, appropriately and in a dignified manner
- Meals are distributed in a timely manner
- For each sampled resident being observed, identify any special needs and interventions planned to meet their needs
- Tables adjusted to accommodate wheelchairs
- Residents prepared for meals, dentures, glasses and/or hearing aides are in place
- Adaptive equipment is available per need
- Residents at the same table are served and assisted concurrently
- Sufficient staff are available for the distribution of meals and assistance
- Sufficient time is allowed for residents to eat
- Sufficient dining space available in all dining areas
- Dining atmosphere is pleasant
- Family members are accommodated for dining with their resident
- Meals are provided as written on posted menu
- Meals provided in resident rooms are served promptly to ensure proper temperature

Notes:

Additional Notes **Attachment P**

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER
ENTRANCE DATE	LICENSOR NAME

Attachment S

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)

Assisted Living Facility Medication Observation Worksheet

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint: Number _____

Facility Staff Name: Date Time: ☐ AM ☐ PM

This form is **optional** and includes **sample** cues for observation, interview, and record review.

WAC	Subject
388-78A-2210	Medication Services
• Observe: Medication cart • Ask: What pharmacy is used? Do they do monthly cycle fill? Do you renew and process orders or does the nurse? What information is on the MAR? How is the MAR laid out? • Review: MAR	
388-78A-2220	Prescribed Medication Authorization
• Observe: Medication bottle or bingo cards • Ask: If someone didn't have an order for Tylenol but had a bad headache, what would you do?	
388-78A-2230	Medication Refusal
• Ask: What do you do if someone doesn't want their medications? • Review: Records of sample residents for medication refusal.	
388-78A-2240	Non-Availability of Medications
• Ask: What is your process for new medications or residents returning from the hospital? What happens if the medications don't show up?	
388-78A-2250	Alteration of Medications
• Observe: Medication alterations (such as crushing) • Ask: Tell me more about how you are altering the medications. Are there any residents who have special medication needs?	
388-78A-2260	Storing, Securing, and Accounting for Medications
• Observe: Narcotics storage, spot check the med cart by pulling the drawer to ensure it is locked, look for any unsecured pills • Ask: How do you account for narcotics? What would you do if you arrived on shift and there were narcotics missing? How do you store refrigerated medications? • Review: Narcotics book for any missing signatures.	

ASSISTED LIVING FACILITY NAME		LICENSE NUMBER
ENTRANCE DATE	LICENSOR NAME	

388-78A-2270	Resident Controlled Medications
• Ask: Which residents control their own medications? (Compare answer to Resident Characteristics Roster to ensure it is up to date.) How do you assess residents' ability to manage their own medications? • Ask relevant residents: How are your medications stored and locked? • Review: Resident Characteristics Roster	
388-78A-2280	Medication Organizers
• Observe: Medication cart, proper labels • Ask: Who fills the medication organizer?	
388-78A-2290	Family Assistance with Medications
• Ask: What is your facility policy on family assistance with medications? What happens if a family member no longer wants to be involved? • Review: For relevant residents, ensure there is an assessment (2100) and care plan (2130, 2140, 2290)	
388-78A-2320	Intermittent Nursing Services Systems
• Review: Nurse delegation procedure • Ask: Do you use nurse delegation? Are there residents with nursing care needs? How do you meet their needs?	
388-78A-2610	Infection Control
• Observe: Handwashing or sanitizer use, or proper glove use between residents while delivering medications.	
388-78A-2660	Resident Rights
• Observe: Knocking on the door when delivering medications to resident rooms, staff to resident interactions. • Ask: Do residents have the right to refuse medications?	

Notes

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER
ENTRANCE DATE	LICENSOR NAME

DSHS WASHINGTON STATE Department of Social and Health Services

Attachment Q

Assisted Living Facility
Medication Pass Worksheet

Inspection Type: ☐ Full ☐ Follow up ☐ Complaint: Number _____

This form is required **only** if a problem with medications has been identified.

RESIDENT NAME AND ID NUMBER	DRUG PRESCRIPTION NAME, DOSE AND FORM	OBSERVATION OF ADMINISTRATION	DRUG ORDER WRITTEN AS (WHEN DIFFERENT FROM OBSERVATION
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			
ID NUMBER:			

ASSISTED LIVING FACILITY NAME		LICENSE NUMBER
ENTRANCE DATE	LICENSOR NAME	

Notes **Attachment Q**

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER
ENTRANCE DATE	LICENSOR NAME

Attachment R

AGING AND LONG-TERM SERVICES ADMINISTRATION (ALTSA)
RESIDENTIAL CARE SERVICES (RCS)
ASSISTED LIVING FACILITY (ALF)

ALF Follow Up Visit

DATE OF PLAN OF CORRECTION	CD ID NUMBER	DATE OF VISIT	Follow-up Type: ☐ On-Site ☐ Off-site

Issue(s) from Prior Visit	WAC / RCW	Summary of Findings (steps taken to verify)	Corrected
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

ASSISTED LIVING FACILITY NAME		LICENSE NUMBER
ENTRANCE DATE	LICENSOR NAME	

Notes **Attachment R**

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE	LICENSOR NAME

DSHS WASHINGTON STATE Department of Social and Health Services

CONFIDENTIAL INFORMATION – DO NOT DISCLOSE
NOT FOR PUBLIC DISCLOSURE

Attachment D

Assisted Living Facility Resident Characteristic Roster and Sample Selection

TOTAL CENSUS

Visit Type: ☐ 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

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE	LICENSOR NAME

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

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE	LICENSOR NAME

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 **O**stomy care; **T** - resident receiving **T**ube feeding; **I** – resident receiving **I**njections; **ND** – resident receiving **N**urse **D**elegation.
Medication: Independent Administration Assistance Family Assistance	**I** – resident assessed as **I**ndependent with their medication; **A** – resident assessed as needing medication **A**ssistance; **AD** – resident assessed **M**edication **A**dministration; **F** – resident receiving **F**amily assistance with medications.
Mobility / Falls / Ambulation Devices	**A** – resident requires **A**ssistance with transfers or cannot ambulate independently without assistance from staff or assistive devices; **F** – resident experienced a **F**all within the last 30 days; **D** – resident uses a **D**evice to assist with ambulation.
Behavior / Psychosocial 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 **E**xit **S**eeking behaviors; **W** – resident has shown **W**andering behaviors
Smoking	**S** – resident Smokes.
DD / Mental Health	**DD** – resident has a **D**evelopmental **D**isabilities case manager; **MH** – resident receives **M**ental **H**ealth 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 **H**earing **I**mpaired; **D** – resident is **D**eaf.
Vision Deficit / Blindness	**X** – resident is blind or has severe vision deficit which requires additional staff support
Diabetic: Insulin / Non-Insulin	**I** – resident is **I**nsulin dependent; **N** – resident is **N**on-insulin dependent diabetic.
Assist with ADL's	**I** – resident assessed as **I**ndependent; **MIN** – resident assessed as needing **Min**imal assistance with ADL's such as cueing reminders, supervision, and/or encouragement; **MOD** – resident assessed as needing **Mod**erate assistance with ADL's such as guiding, standby assistance for transfers, or ambulation, bathing and toileting; **MAX** – resident assessed as needing **Max**imum 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 **P**ressure ulcer; **S** – resident has a **S**tasis wound; **W** – resident has a **W**ound or skin issue other than pressure or stasis ulcer.
Incontinent / Appliance (catheter) / Dialysis	**UI** – resident **I**ncontinent of bladder and/or bowel; **C** – resident has **C**atheter; **D** – resident requires **D**ialysis.
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 **W**eight **L**oss within last 60 days; **WG** – resident has had more than a 3 – 5-pound **W**eight **G**ain within the last 60 days.
Medical Devices	**X** – resident receives dialysis treatments; **M** – resident uses **M**edical devices such as 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 (**P**rivate pay); **S** – all or part of a resident care is paid for by the **S**tate.
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.

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE	LICENSOR NAME

DSHS WASHINGTON STATE Department of Social and Health Services

Attachment K

AGING AND LONG-TERM SUPPORT ADMINISTRATIN (ALTSA)

Assisted Living Facility Staff Sample / Record Review

CD ID NUMBER

Visit Type: ☐ Full ☐ Follow up ☐ Complaint: Number _____

Address each box not greyed out. When additional staff require review, use another copy of this form. Please see page four for instructions.

STAFF	ADMINISTRATOR	STAFF (NEW)	STAFF (NEW)	STAFF (NEW)	STAFF (> TWO YEARS)	STAFF (> TWO YEARS)
NAME						
IDENTIFIER						
DATE OF BIRTH						
POSITION						
DATE OF HIRE*						
FACILITY ORIENTATION						
ORIENTATION AND SAFETY (5 HOURS)						
70 HOUR BASIC						
DOH* CREDENTIALS	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A	☐ N/A
DOH EXPIRE DATE						
12 HOURS CE* (NUMBER OF HOURS)						
BGI CHECK DATE*					PREVIOUS: CURRENT: ☐ N/A ☐ PENDING	PREVIOUS: CURRENT: ☐ N/A ☐ PENDING
FINGERPRINT CHECK DATE	☐ N/A ☐ Pending	☐ N/A ☐ Pending	☐ N/A ☐ Pending	☐ N/A ☐ Pending		
CCS* DETERMINATION	☐ N/A, not required	☐ N/A, not required	☐ N/A, not required	☐ N/A, not required	☐ N/A, not required	☐ N/A, not required

* DOH – Department of Health; CE – Continuing Education; BGI – Background Inquiry; CCS – Character, Competency, and Suitability; Date of Hire – First Date worked for pay

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE	LICENSOR NAME

STAFF	ADMINISTRATOR	STAFF (NEW)	STAFF (NEW)	STAFF (NEW)	STAFF (> TWO YEARS)	STAFF (> TWO YEARS)
NAME						
DATE OF HIRE						
NURSE DELEGATION (ND) TRAINING						
ND INSULIN						
Specialty Training						
DEMENTIA ☐ **N/A**						
MENTAL HEALTH ☐ **N/A**						
DEVELOPMENTAL DISABILITIES ☐ **N/A**						
FOOD WORKER CARD EXPIRATION						
1ST AID / CPR EXPIRATION						
TB Testing Review (See optional worksheet on Page 3)						
TB TESTING REQUIREMENT MET	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		
PET RECORDS	☐ **No Pets**					
PET 1						
PET 2						
PET 3						

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE	LICENSOR NAME

Optional Worksheet for TB Testing Review. This section can be used to assist in determining compliance with TB Testing requirements. Once determined, indicate compliance status on Page 2.

STAFF	ADMINISTRATOR	STAFF (NEW)	STAFF (NEW)	STAFF (NEW)	STAFF (> TWO YEARS)	STAFF (> TWO YEARS)
NAME						
DATE OF HIRE						
DATE TESTED						
TYPE OF TEST	☐ TST* ☐ IGRA*	☐ TST* ☐ IGRA*	☐ TST* ☐ IGRA*	☐ TST* ☐ IGRA*		
DATE FIRST READ						
RESULT	☐ Positive ☐ Negative	☐ Positive ☐ Negative	☐ Positive ☐ Negative	☐ Positive ☐ Negative		
INDURATION IF TST	MM	MM	MM	MM		
DATE OF SECOND TST TEST	☐ N/A, not TST	☐ N/A, not TST	☐ N/A, not TST	☐ N/A, not TST		
DATE SECOND READ						
RESULT	☐ Positive ☐ Negative	☐ Positive ☐ Negative	☐ Positive ☐ Negative	☐ Positive ☐ Negative		
INDURATION IF TST	MM	MM	MM	MM		
DATE CHEST X-RAY						
X-RAY RESULT	☐ Positive ☐ Negative	☐ Positive ☐ Negative	☐ Positive ☐ Negative	☐ Positive ☐ Negative		

TST - Tuberculin Skin Test; IGRA - Interferon Gamma Release Assays

Notes

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE	LICENSOR NAME

Item	Instructions – WACs referenced below are intended as a guide and may not be all inclusive of applicable regulations.
General	• Each box not greyed out must have data in it. Check N/A box, write N/A, or strikethrough the box for any areas on this form which are not relevant. If there is no data, the reviewer of the record does not know if it was missed by the licensor or if it was a finding for the facility. • Minimally, review the following facility documents and expand as needed based on areas of concern: Emergency Disaster Plan, Insurance verification, Abuse / Neglect Policy, ND Policy, Disclosure of Services, Menus, and Activity Calendar * For facilities requiring a MTSW / CLIA license, the facility is not required to maintain a copy of their license on-site but must have a current license.
Staff Sample	Review administrator's records if new since the previous inspection. Conduct a full review of three staff hired since the last inspection. If fewer than three were hired, review all new staff. Conduct a targeted review of two staff with a >2 year work history to verify a system is in place for all required renewals (e.g., BGI, CE). When there are not enough current staff with >2 years employment, use former staff. Document the reason for any substitutions.
Facility Orientation	Required before having routine interactions with residents (388-112A-0200). Record date of completion.
Orientation and Safety (5 hours)	Two hours of orientation and three hours of safety training is required before providing care to residents (388-112A-0200 and 0220). Record date of completion.
70-hour basic	All long-term care workers hired after 01/07/2012 must complete within 120 days of hire (WAC 388-78A-2474 and WAC 388-112A-0300). See additional regulations within WAC 388-112A for staff hired before 01/07/2012. Record date of completion. Note: DOH HCA certification requires proof of 70-hour basic completion. If staff have current HCA credentials, licensors do not have to review proof of 70-hour training. Denote with N/A or line.
DOH Credentials	Record type of license, certification, or credential. Examples may include registered nurse (RN), licensed practical nurse (LPN), home care aide certification (HCA). Provider credential search is found on the Department of Health website. Check N/A if not applicable.
DOH Expiration Date	Enter the date of expiration for staff credential.
12 Hours CE	When reviewing CE credits, record the number of hours the person received in the time period between their last two birthdays. For example, a review conducted on December 1, 2024, of a person born on January 1 would need to have all hours between January 1, 2023, and January 1, 2024, reviewed. Registered nurses and licensed practical nurses are exempt from this requirement, unless voluntarily certified as a home care aide. The field staff may use the number of credits found at the last inspection only if less than a year has passed since the last inspection, the staff member was reviewed during that inspection, and the staff member has not had a birthday since the last inspection. For newly credentialed HCA workers, initial CE requirement is due before their birthdate following their first HCA credential renewal date. See Continuing Education Requirements for more information. • DSHS-approved courses must be used to meet the CE requirements. Field staff may verify individual CE courses were DSHS-approved by verification of CE course number. Verification of individual courses may be reviewed by logging into the Instructor and Curriculum Tracking System (ICTS). For EARC – SDC Contract, staff must take at least six (6) hours of continuing education per year related to dementia (may be part of the total twelve hours required). WAC 388-110-220(3)(d)

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE	LICENSOR NAME

Item	Instructions (continuation) – WACs referenced below are intended as a guide and may not be all inclusive of applicable regulations.
BGI Check Date	Enter the date BGI was submitted to the department's background check central unit, or the date found on the background check results letter (WAC 388-78A-2466). The submit date and the results date on the background check letter are the same. BGI must be conducted every two years.
Fingerprint Check Date	Common data for this box includes a date, the N/A box being checked, the pending box being checked, a line drawn through the box, or words that clearly describe the result of the fingerprint check review (such as "not found" if the facility will be cited for lack of fingerprint check documentation).
CCS Determination	Required when BGI returns with criminal convictions or pending charges that are not disqualifying (WAC 388-113). CCS must be completed before working unsupervised. A second CCS review is required when the FP results indicate additional, non-disqualifying criminal convictions or pending charges not already reflected in the BGI. The facility may use RCS CCS Determination form (DSHS 15-456). If an alternative format is used, reviews must include all information found in WAC 388-113-0060. Enter date of review.
ND Training and ND Insulin	ND core training is required by a nursing assistant before commencing any specific nursing care tasks (RCW 18.88B.070). Specialized diabetes nurse delegation is an additional training when administering insulin by injection. Record date(s) of completion.
Specialty Training	Required when caring for residents having a primary special need of a developmental disability, mental illness, or dementia (388-78A-2490-2510). Review the disclosure of services and/or Client Characteristics Roster to help determine required trainings. Mark N/A when not applicable.
Pet Records	If the facility has three or fewer pets, review all pet records. If the facility has more than three pets, identify a random sample of three pets. Expand the sample if issues are identified. The sample may include pets of nonresidents. Verify regular examinations and up to date immunizations, certified by a veterinarian to be free of human transmittable diseases, and that the facility is following their internal pet policies. Check no pets if not applicable.

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE	LICENSOR NAME

Attachment M

DSHS WASHINGTON STATE Department of Social and Health Services

Assisted Living Facility
Exit Preparation Worksheet

Visit Type: ☐Full ☐Follow up ☐Complaint: Number _____

ISSUES	RESIDENT / STAFF NO.	SCOPE / CONCERNS	WAC / RCW, (CONSULTATION, CITATION)

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER	ENTRANCE DATE	LICENSOR NAME

ISSUES	RESIDENT / STAFF NO.	SCOPE / CONCERNS	WAC / RCW, (CONSULTATION, CITATION)