Washington State Department of Social & Health Services
Transforming lives

Follow Up Visit

ASSISTED LIVING FACILITY NAME			LICENSE NUMBER
FACILITY / LICENSEE'S NAME			DATE OF VISIT
LICENSOR'S NAME	DATE OF ORIGINAL VISIT	DATE OF PLAN OF CORRECTION	INTAKE NUMBER

Follow-up Type: ☐ Full inspection ☐ Complaint Investigation ☐ On-Site ☐ Off-site

Issue(s) from Prior Visit	WAC / RCW	Summary of Findings	Corrected
			☐ Yes
			☐ Yes
			☐ Yes
			☐ Yes
			☐ Yes
			☐ Yes
			☐ Yes
			☐ Yes
			☐ Yes
			☐ Yes
			☐ Yes
			☐ Yes
			☐ Yes
			☐ Yes
			☐ Yes

Additional Comments	Attachment R