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| A picture containing text, clipart  Description automatically generated | Attachment B  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  **Assisted Living Facility Request for Documentation** | | | |
| ASSISTED LIVING FACILITY NAME | | | LICENSE NUMBER | |
| ENTRANCE DATE | | LICENSOR NAME | | |
| 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:** | | | | |
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