| A picture containing text, clipart  Description automatically generated |  Attachment J **Assisted Living Facility Resident Record Review** |
| --- | --- |
| ASSISTED LIVING FACILITY NAME | LICENSE NUMBER |
| ENTRANCE DATE | LICENSOR NAME |
| 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 |
| **Yes** | **No** | **N/A** | **D. Medication Services: [ ]  Independent [ ]  Assistance [ ]  Administration** |
|  [ ]  [ ]  [ ]  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. Intermittent Nursing Services Provided** |
|  [ ]  [ ]  [ ]  Nursing Service System developed. [ ]  [ ]  [ ]  Services identified and appropriate. |
| NOTES |
| **Yes** | **No** | **N/A** | **F. Modified / Therapeutic Diet** |
|  [ ]  [ ]  [ ]  Receiving Food Services as ordered. [ ]  [ ]  [ ]  Receiving eating assistance. |
| NOTES |
| **Additional Notes Attachment J** |
|  |