| 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** | | | | | | | | | | | |
|  | | | | | | | | | | | |