| **Confidential Information – Do not disclose. Not for public disclosure.** | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | | | AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ENHANCED SERVICES FACILTY (ESF)  **ESF Resident Characteristic Roster and Sample Selection** | | | | | | | | | | | | | | | | | | Attachment D | | | | | |
| TOTAL CENSUS | | | | | |
| ENHANCED SERVICES FACILITY NAME | | | | | | | | | | | LICENSE NUMBER | | | | | | | | | | ENTRANCE DATE | | | | | |
| LICENSOR’S NAME | | | | | | | | | | | VISIT TYPE  Full  Follow up  Complaint Number: | | | | | | | | | | | | | | | |
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| RESIDENT ROOM | ADMIT DATE | RESIDENT ID NUMBER | RESIDENT NAME | PAY STATUS: PRIVATE = P STATE = S | NURSING SERVICES | MEDICALLY FRAGILE | MEDICATION: IND. (I), ASSIST (A); ADM. (AD) | MOBILITY / FALLS / AMBULATION DEIVICES | BEHAVIOR / PSYCHOSOCIAL ISSUES | DEMENTIA / COGNITIVE IMPAIRMENT | EXIT SEEKING / WANDERNG | SMOKING | DEVELOPMENTAL DISABILITIES | LANGUAGE / COMMUICATION ISSUE / DEAFNESS / HEARING ISSUES | VISION DEFICIT / BLINDNESS | DIABETIC: INSULIN / NON-INSULIN | ASSIST WITH ADLS | WOUNDS / SKIN ISSUE | INCONTINENT / APPLIANCE (CATHETER) DIALYSIS | SPEICAL DIETARY NEEDS / SCHEDULED SNACKS | WIEIGHT LOSS / WEIGHT GAIN | MEDICAL DEVICES | RECENT HOSPITALIZATIONS | OXYGEN / RESPIRATORY THERAPY | HOME HEALTH / HOSPICE / PRIVATE CAREGIVER | OTHER |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| RESIDENT ROOM | ADMIT DATE | RESIDENT ID NUMBER | RESIDENT NAME | PAY STATUS: PRIVATE = P STATE = S | NURSING SERVICES | MEDICALLY FRAGILE | MEDICATION: IND. (I), ASSIST (A); ADM. (AD) | MOBILITY / FALLS / AMBULATION DEIVICES | BEHAVIOR / PSYCHOSOCIAL ISSUES | DEMENTIA / COGNITIVE IMPAIRMENT | EXIT SEEKING / WANDERNG | SMOKING | DEVELOPMENTAL DISABILITIES | LANGUAGE / COMMUICATION ISSUE / DEAFNESS / HEARING ISSUES | VISION DEFICIT / BLINDNESS | DIABETIC: INSULIN / NON-INSULIN | ASSIST WITH ADLS | WOUNDS / SKIN ISSUE | INCONTINENT / APPLIANCE (CATHETER) DIALYSIS | SPEICAL DIETARY NEEDS / SCHEDULED SNACKS | WIEIGHT LOSS / WEIGHT GAIN | MEDICAL DEVICES | RECENT HOSPITALIZATIONS | OXYGEN / RESPIRATORY THERAPY | HOME HEALTH / HOSPICE / PRIVATE CAREGIVER | OTHER |
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| NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| **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. | |
| Pay Status: Private = **P** State = **S** | Mark the box: |
| **P** – all or part of a resident’s care is paid by the resident or their family; **S** – all or part of a resident care is paid for by the State |
| 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 |
| Medically Fragile | **Y** – **Y**es. Resident assessed as meeting the definition of medically fragile per WAC: A chronic and complex physical condition which results in prolonged dependency on specialized medical care that requires frequent daily skilled nursing interventions. If these medically necessary interventions are interrupted or denied, the resident may experience irreversible damage or death.  **N** – **N**o. Resident not assessed as meeting the definition of medically fragile. |
| Medication: Independent (**I**); Assistance (**A**); Administration (**AD**) | **I** – resident assessed as **I**ndependent with their medication; **A** – resident assessed as needing medication assistance;  **AD** – resident assessed medication administration. |
| 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 / Cognitive Impairment | **X** – resident shows or has behaviors such as those 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 **S**mokes |
| Developmental Disabilities | **DD** – resident has a diagnosis of a **D**evelopmental **D**isability |
| Language / Communication Issue / 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 if **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 curing 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 of 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 had more than a 3-pound to 5-pound **W**eight **L**oss within last 60 days; **WG** - resident had more than a 3-pound to 5-pound **W**eight **G**ain within last 60 days |
| Medical Devices | **X** – resident received dialysis treatments; **M** – if part of a resident’s care is the use of side rails, transfer poles, chair / bed alarms, belt restraints |
| 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 **H**ome **H**ealth services; **HOS** – resident receives **HOS**pice services; **P** – resident received care from **P**rivate caregiver |