

388-97-1000 Resident assessment

(1)

The nursing home must: (a) Provide resident care based on a systematic, comprehensive, interdisciplinary assessment, and care planning process in which the resident participates, to the fullest extent possible; (b) Conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity; (c) At the time each resident is admitted: (i) Have physician's orders for the resident's immediate care; and (ii) Ensure that the resident's immediate care needs are identified in an admission assessment. (d) Ensure that the comprehensive assessment of a resident's needs describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

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Ensure that the comprehensive assessment of a resident's needs describes the resident's capability to perform daily life functions and significant impairments in functional capacity.

(2)

The comprehensive assessment must include at least the following information: (a) Identification and demographic information; (b) Customary routine; (c) Cognitive patterns; (d) Communication; (e) Vision; (f) Mood and behavior patterns; (g) Psychosocial well-being; (h) Physical functioning and structural problems; (i) Continence; (j) Disease diagnosis and health conditions; (k) Dental and nutritional status; (l) Skin conditions; (m) Activity pursuit; (n) Medications; (o) Special treatments and procedures; (p) Discharge potential; (q) Documentation of summary information regarding the assessment performed; and (r) Documentation of participation in assessment.

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Special treatments and procedures;

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Discharge potential;

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Documentation of summary information regarding the assessment performed; and

(r)

Documentation of participation in assessment.

(3)

The nursing home must conduct comprehensive assessments: (a) No later than fourteen days after the date of admission; (b) Promptly after a significant change in the resident's physical or mental condition; and (c) In no case less often than once every twelve months.

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(4)

The nursing home must ensure that: (a) Each resident is assessed no less than once every three months, and as appropriate, the resident's assessment is revised to assure the continued accuracy of the assessment; and (b) The results of the assessment are used to develop, review and revise the resident's comprehensive plan of care under WAC 388-97-1020.

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(5)

The skilled nursing facility and nursing facility must: (a) For the required assessment, complete the state approved resident assessment instrument (RAI) for each resident in accordance with federal requirements; (b) Maintain electronic or paper copies of completed resident assessments in the resident's active medical record for fifteen months; this information must be maintained in a centralized location and be easily and readily accessible; (c) Place the hard copies of the signature pages in the clinical record of each resident if a facility maintains their RAI data electronically and does not use electronic signatures; (d) Assess each resident not less than every three months, using the state approved assessment instrument; and (e) Transmit all state and federally required RAI information for each resident to the department: (i) In a manner approved by the department; (ii) Within fourteen days of completion of any RAI assessment required under this subsection; and (iii) Within fourteen days of discharging or admitting a resident for a tracking record.

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facility maintains their RAI data electronically and does not use electronic signatures;

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