

WAC 388-78A-2410 Content of resident records. The assisted living facility must organize and maintain resident records in a format that the assisted living facility determines to be useful and functional to enable the effective provision of care and services to each resident. Active resident records must include the following:

- (1) Resident identifying information, including resident's:
 - (a) Name;
 - (b) Birth date;
 - (c) Move-in date; and
 - (d) Sleeping room identification.
- (2) Current name, address, and telephone number of:
 - (a) Resident's primary health care provider;
 - (b) Resident's representative, if the resident has one;
 - (c) Individual(s) to contact in case of emergency, illness or death; and
 - (d) Family members or others, if any, the resident requests to be involved in the development or delivery of services for the resident.
- (3) Resident's written acknowledgment of receipt of:
 - (a) Required disclosure information prior to moving into the assisted living facility; and
 - (b) Information required by long-term care resident rights per RCW 70.129.030.
- (4) The resident's assessment and reassessment information.
- (5) Clinical information such as admission weight, height, blood pressure, temperature, blood sugar and other laboratory tests required by the negotiated service agreement.
- (6) The resident's negotiated service agreement consistent with WAC 388-78A-2140.
- (7) Any orders for medications, treatments, and modified or therapeutic diets, including any directions for addressing a resident's refusal of medications, treatments, and prescribed diets.
- (8) Medical and nursing services provided by the assisted living facility for a resident, including:
 - (a) A record of providing medication assistance and medication administration, which contains:
 - (i) The medication name, dose, and route of administration;
 - (ii) The time and date of any medication assistance or administration;
 - (iii) The signature or initials of the person providing any medication assistance or administration; and
 - (iv) Documentation of a resident choosing to not take his or her medications.
 - (b) A record of any nursing treatments, including the signature or initials of the person providing them.
- (9) Documentation consistent with WAC 388-78A-2120 Monitoring resident well-being.
- (10) Staff interventions or responses to subsection (9) of this section, including any modifications made to the resident's negotiated service agreement.
- (11) Notices of and reasons for relocation as specified in RCW 70.129.110.
- (12) The individuals who were notified of a significant change in the resident's condition and the time and date of the notification.
- (13) When available, a copy of any legal documents in which:
 - (a) The resident has appointed another individual to make his or her health care, financial, or other decisions;

(b) The resident has created an advance directive or other legal document that establishes a surrogate decision maker in the future and/or provides directions to health care providers; and

(c) A court has established guardianship on behalf of the resident.

[Statutory Authority: Chapter 18.20 RCW. WSR 13-13-063, § 388-78A-2410, filed 6/18/13, effective 7/19/13. Statutory Authority: RCW 18.20.090 (2004 c 142 § 19) and chapter 18.20 RCW. WSR 04-16-065, § 388-78A-2410, filed 7/30/04, effective 9/1/04.]