WAC 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.

(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.

(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.

(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.

(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.

[Statutory Authority: Chapter 74.42 RCW and 42 C.F.R. 483.20. WSR 18-11-001, § 388-97-1000, filed 5/2/18, effective 6/2/18. Statutory Authority: Chapters 18.51 and 74.42 RCW. WSR 13-04-093, § 388-97-1000, filed 2/6/13, effective 3/9/13. Statutory Authority: Chapters 18.51 and 74.42 RCW and 42 C.F.R. 489.52. WSR 08-20-062, § 388-97-1000, filed 9/24/08, effective 11/1/08.]