RCW 18.20.350 Preadmission assessment—Initial resident service plan—Respite care. (1) The assisted living facility licensee shall conduct a preadmission assessment for each resident applicant. The preadmission assessment shall include the following information, unless unavailable despite the best efforts of the licensee:

(a) Medical history;

(b) Necessary and contraindicated medications;

(c) A licensed medical or health professional's diagnosis, unless the individual objects for religious reasons;

(d) Significant known behaviors or symptoms that may cause concern or require special care;

(e) Mental illness diagnosis, except where protected by confidentiality laws;

(f) Level of personal care needs;

(g) Activities and service preferences; and

(h) Preferences regarding other issues important to the resident applicant, such as food and daily routine.

(2) The assisted living facility licensee shall complete the preadmission assessment before admission unless there is an emergency. If there is an emergency admission, the preadmission assessment shall be completed within five days of the date of admission. For purposes of this section, "emergency" includes, but is not limited to: Evening, weekend, or Friday afternoon admissions if the resident applicant would otherwise need to remain in an unsafe setting or be without adequate and safe housing.

(3) The assisted living facility licensee shall complete an initial resident service plan upon move-in to identify the resident's immediate needs and to provide direction to staff and caregivers relating to the resident's immediate needs. The initial resident service plan shall include as much information as can be obtained, under subsection (1) of this section.

(4) When a facility provides respite care, before or at the time of admission, the facility must obtain sufficient information to meet the individual's anticipated needs. At a minimum, such information must include:

(a) The name, address, and telephone number of the individual's attending physician, and alternate physician if any;

(b) Medical and social history, which may be obtained from a respite care assessment and service plan performed by a case manager designated by an area agency on aging under contract with the department, and mental and physical assessment data;

(c) Physician's orders for diet, medication, and routine care consistent with the individual's status on admission;

(d) Ensure the individuals have assessments performed, where needed, and where the assessment of the individual reveals symptoms of tuberculosis, follow required tuberculosis testing requirements; and

(e) With the participation of the individual and, where appropriate, their representative, develop a plan of care to maintain or improve their health and functional status during their stay in the facility. [2012 c 10 § 24; 2008 c 146 § 3; 2004 c 142 § 7.]

Application—2012 c 10: See note following RCW 18.20.010.

Findings—Intent—Severability—2008 c 146: See notes following RCW 74.41.040.

Effective dates—2004 c 142: See note following RCW 18.20.020.