WAC 388-107-0070 Comprehensive assessment. The enhanced services facility must obtain sufficient information to be able to assess the capabilities, needs, and preferences for each resident, and must complete a comprehensive assessment. The assessment addresses the following, within fourteen days of the resident's move-in date:

(1) Individual's recent medical history, including, but not limited to:

(a) Diagnoses from a licensed medical or health professional, unless the resident objects for religious reasons;

(b) Chronic, current, and potential skin conditions; or

(c) Known allergies to foods or medications; or

(d) Other considerations for providing care or services.

(2) Currently necessary and contraindicated medications and treatments for the individual, including any prescribed medications, over-the-counter medications, and antipsychotic medications.

(3) The individual's nursing needs.

(4) Significant known challenging behaviors or symptoms of the individual causing concern or requiring special care, including:

(a) History of substance abuse;

(b) History of harming self, others, or property;

(c) Other conditions that require behavioral intervention strategies;

(d) Individual's ability to leave the enhanced services facility unsupervised;

(e) Any court order or court stipulation regarding activities, surroundings, behaviors, and treatments; and

(f) Other safety considerations that may pose a danger to the individual or others, such as use of medical devices or the individual's ability to smoke unsupervised, if smoking is permitted outdoors in a specific location on the premises.

(5) Individual's special needs, by evaluating available information, or if available information does not indicate the presence of special needs, selecting and using an appropriate tool to determine the presence of symptoms consistent with, and implications for, care and services of:

(a) Mental illness, or needs for psychological or mental health services;

(b) Developmental disability;

(c) Dementia. While screening a resident for dementia, the enhanced services facility must:

(i) Base any determination that the resident has short-term memory loss upon objective evidence; and

(ii) Document the evidence in the resident's record.

(d) Other conditions affecting cognition, such as traumatic brain injury or other neurological conditions.

(6) Individual's activities, typical daily routines, habits and service preferences.

(7) Individual's personal identity and lifestyle, to the extent the individual is willing to share the information, and the manner in which they are expressed, including preferences regarding food, community contacts, hobbies, spiritual preferences, or other sources of pleasure and comfort.

(8) Who has decision-making authority for the individual, including:

(a) The presence of any advance directive or other legal document that will establish a substitute decision maker in the future;

(b) The presence of any legal document that establishes a current substitute decision maker or court orders for treatment, or documents indicating resident is under the supervision and care of the department of corrections; and

(c) The scope of decision-making authority of any substitute decision maker.

(9) A plan to use antipsychotic medications as prescribed and documented in the clinical record in accordance with chapters 71.05 and 70.97 RCW.

(10) If the resident is a medicaid client the assessment must include elements of the CARE assessment.

[Statutory Authority: Chapter 70.97 RCW. WSR 14-19-071, § 388-107-0070, filed 9/12/14, effective 10/13/14.]