|  | | ADULT FAMILY HOME’S (AFH) NAME | | | | | | | LICENSE NUMBER | | | | | | PROVIDER / LICENSEE’S NAME | | | | | | | | INSPECTION DATE | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| LICENSOR’S NAME | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT D  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Resident List** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **See attached resident List Key.**  **Select two residents for comprehensive reviews. Any residents chosen as expanded sample residents should not be identified as comprehensive residents.** | | | **CHECK HERE IF COMPREHENSIVE** | STATE / PRIVATE PAY | ABLE TO INTERVIEW | OUT OF HOME | TRANSFER STATUS | ASSISTIVE MOBILITY DEVICES NEEDED | | EVACUATION LEVEL | INFECTIOUS ILLNESS IN THE HOME | INJURIES / FALLS IN LAST 30 DAYS | WANDERING | PAIN | | BEHAVIOR AFFECTING SELF OR OTHERS | DIABETES | INCONTINENT | NIGHTTIME ASSISTANCE REQUIRED | SKIN CARE ISSUES | NUTRITION ISSUES | WEIGHT LOSS / GAIN | | MEDICATION LEVEL | NURSE DLEGATION | OUTSIDE AGENCY |
| R1 |  | |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |
| R2 |  | |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |
| R3 |  | |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |
| R4 |  | |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |
| R5 |  | |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |
| R6 |  | |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |
| R7 |  | |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |
| R8 |  | |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |
| ANY PLANNED DISCHARGES IN NEXT 30 DAYS? | | | | | | | | | | | ADMISSIONS IN LAST 60 DAYS | | | | | | | | | | | | | | | |
| HOSPITALIZATIONS IN LAST 30 DAYS AND REASON FOR HOSPITALIZATION | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **NOTE:** This form should be used to document any additional information or data that does not fit in the designated space. | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT D  The Licensor uses this key when selecting the sample for the inspection, typically during the entrance onsite phase of the inspection, with the assistance of the adult family home provider. If an area does not apply to the resident place, put a dash in the space. | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| --- | --- | --- |
| STATE / PRIVATE PAY | “S” = State (when Medicaid is the payment source); “P” = Private | |
| ABLE TO INTERVIEW | “Y” = Yes or “N” = No (you may not be able to interview the resident for a number of reasons ranging from cognitive impairment to overt refusal) |
| OUT OF HOME | “Y” = Yes or “N” = No (identify whether or not the resident is literally in the home) |
| TRANSFER STATUS | “I” = Independent; “A” = Assistance required; “T” = Total assistance (Hoyer included) |
| ASSISTIVE MOBILITY DEVICE NEEDED | WC = Wheelchair; W = Walker; C = Cane; BB = Bed Bound |
| EVACUATION LEVEL | “I” = Independent; “A” = Assistance required (see WAC 388-76-10870 for definitions) |
| INFECTIOUS ILLNESS IN LAST 30 DAYS | “Y” = Yes or “N” = No (i.e., Diarrhea, Flu, UTI) |
| FALLS IN LAST 30 DAYS | “Y” = Yes or “N” = No |
| WANDERING | “Y” = Yes or “N” = No (if Yes, has the resident eloped from the home?) |
| PAIN | “Y” = Yes or “N” = No |
| BEHAVIOR | “Y” = Yes or “N” = No (include care refusal, striking out, yelling, throwing things, intrusive behavior) |
| DIABETES | “N” = Not diabetic; “I” = Insulin dependent diabetic; “O” = Oral medication dependent diabetic; “D” = Diet controlled diabetic |
| INCONTINENT | “Y” = Yes (a person is considered incontinent if they require partial or total assistance including presence of an indwelling catheter) or “N” = No |
| NIGHTTIME CARE REQUIRED? | “Y” = Yes or “N” = No |
| SKIN CARE ISSUES | “P” = Pressure sore; “O” = Other (some examples of other skin care issues are wounds and stasis ulcers) |
| NUTRITION ISSUES | “Y” = Yes (the resident requires a nutrient concentrate, supplements, or modified diet); “N” = No; “TF” = Tube Feeding |
| WEIGHT LOSS / GAIN | “L” = Loss; “G” = Gain; “N” = no |
| MEDICATION LEVEL | “I” = Independent; “A” = Assistance required; “AD” = Administration required |
| NURSE DELEGATION | “Y” = Yes; “N” = No |
| OUTSIDE AGENCY | “H” = Hospice; “HH” = Home Health; “T” = therapy (physical, occupational, or speech); “MH” = mental health; “N” = No |