WAC 388-76-10335  Resident assessment topics. The adult family home must ensure that each resident's assessment includes the following minimum information:

1. Recent medical history;
2. Current prescribed medications, and contraindicated medications, including but not limited to, medications known to cause adverse reactions or allergies;
3. Medical diagnosis reported by the resident, the resident representative, family member, or by a licensed medical professional;
4. Medication management:
   a. The ability of the resident to be independent in managing medications;
   b. The amount of medication assistance needed;
   c. If medication administration is required; or
   d. If a combination of the elements in (a) through (c) above is required.
5. Food allergies or sensitivities;
6. Significant known behaviors or symptoms that may cause concern or require special care, including:
   a. The need for and use of medical devices;
   b. The refusal of care or treatment; and
   c. Any mood or behavior symptoms that the resident has had within the last five years.
7. Cognitive status, including an evaluation of disorientation, memory impairment, and impaired judgment;
8. History of depression and anxiety;
9. History of mental illness, if applicable;
10. Social, physical, and emotional strengths and needs;
11. Functional abilities in relationship to activities of daily living including:
   a. Eating;
   b. Toileting;
   c. Walking;
   d. Transferring;
   e. Positioning;
   f. Personal hygiene;
   g. Dressing; and
   h. Bathing.
12. Preferences and choices about daily life that are important to the resident, including but not limited to:
   a. The food that the resident enjoys;
   b. Meal times; and
   c. Sleeping and nap times.
13. Activities.

[Statutory Authority: RCW 70.128.040. WSR 09-03-030, § 388-76-10335, filed 1/12/09, effective 2/12/09. Statutory Authority: RCW 70.128.040 and chapters 70.128 and 74.34 RCW. WSR 07-21-080, § 388-76-10335, filed 10/16/07, effective 1/1/08.]