## Assisted Living Facility
### Resident Record Review

<table>
<thead>
<tr>
<th>ASSISTED LIVING FACILITY NAME</th>
<th>LICENSE NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>INSPECTION DATE</th>
<th>LICENSOR NAME</th>
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**Inspection Type:**
- [ ] Initial
- [ ] Full
- [ ] Follow up
- [ ] Monitoring
- [ ] Complaint: Number __________

<table>
<thead>
<tr>
<th>NAME</th>
<th>ID NO.</th>
<th>DATE OF BIRTH</th>
<th>ROOM NO.</th>
<th>MOVE-IN DATE</th>
<th>PAY STATUS</th>
</tr>
</thead>
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<table>
<thead>
<tr>
<th>FAMILY/MEMBER/RESIDENT’S REPRESENTATIVE/PHONE</th>
<th>PERTINENT MEDICAL HISTORY/DIAGNOSES</th>
</tr>
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### Assessment
- [ ] Yes
- [ ] No
- [ ] N/A

**Pre-admission** (for residents admitted in last six months).
- Annual to meet resident’s needs or semi-annual for EARC – Specialized Dementia Care contract.
- Limited for change of condition as needed.

**NOTES**
- [ ] Yes
- [ ] No
- [ ] N/A

### Monitoring Resident’s Well-Being
- [ ] Yes
- [ ] No
- [ ] N/A

- Documented.
- Action taken as needed.

**NOTES**
- [ ] Yes
- [ ] No
- [ ] N/A

### Negotiated Service Agreement (NSA)
- [ ] Yes
- [ ] No
- [ ] N/A

- Initial on admission and completed within 30 days (for residents admitted in last six months).
- Contents meet resident’s needs and preferences.
  - Defined roles and responsibilities of resident, staff, resident’s representative, outside agency if used, and alternate plan when necessary.
  - Times services will be delivered including frequency and approximate time of day.
  - Resident’s preferences for activities and how supported.
  - Identifies and incorporates Resident Arranged Services (if applicable).
  - Identifies and incorporates External Health Providers (if applicable)

**NOTES**
- [ ] Yes
- [ ] No
- [ ] N/A

### Medication Services:
- [ ] Independent
- [ ] Assistance
- [ ] Administration

- Family / plan.
- Facility.
- Appropriate for resident abilities and needs.
- Review of medication record.
- Documentation of refusal (if applicable)

**NOTES**
- [ ] Yes
- [ ] No
- [ ] N/A

### Intermittent Nursing Services Provided
- [ ] Yes
- [ ] No
- [ ] N/A

- Nursing Service System developed.
- Services identified and appropriate.

**NOTES**
- [ ] Yes
- [ ] No
- [ ] N/A
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- Complaint: Number ____________________________

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<thead>
<tr>
<th>Yes</th>
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<th>N/A</th>
<th>Modified / Therapeutic Diet</th>
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<tr>
<td></td>
<td></td>
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<td>Receiving Food Services as ordered.</td>
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<td></td>
<td></td>
<td></td>
<td>Receiving eating assistance.</td>
</tr>
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### NOTES

**Additional Notes**

Attachment J