### Assisted Living Facility
#### Resident Record Review

**Assisted Living Facility Name**

**License Number**

**Inspection Date**

**Licensor Name**

**Inspection Type:**
- [ ] Initial
- [ ] Full
- [ ] Follow up
- [ ] Monitoring
- [ ] Complaint: Number

### Resident Information

<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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### Pertinent Medical History/Diagnoses

- Yes
- No
- N/A

### Assessment

- 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.

### Monitoring Resident’s Well-Being

- Documented.
- Action taken as needed.

### Negotiated Service Agreement (NSA)

- Initial on admission and completed within 30 days (for residents admitted in last six months).
- Updated as necessary.
- 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)

### Medication Services

- Independent
- Assistance
- Administration

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

### Intermittent Nursing Services Provided

- Nursing Service System developed.
- Services identified and appropriate.
Assisted Living Facility
Resident Record Review

<table>
<thead>
<tr>
<th>ASSISTED LIVING FACILITY NAME</th>
<th>LICENSE NUMBER</th>
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Inspection Date: ____________________________  License Number: ____________________________

Inspection Type:  
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- [ ] Full  
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- [ ] Monitoring  
- [ ] Complaint: Number ____________________________

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Modified / Therapeutic Diet</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Receiving Food Services as ordered.</td>
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<td></td>
<td>Receiving eating assistance.</td>
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Notes:

Additional Notes

NAME

Attachment J