

AGING AND LONG-TERM SUPPORT ADMINISTRATOR (ALSA)

## Assisted Living Facility Staff Sample / Record Review

ASSISTED LIVING FACILITY NAME			LICENSE NUMBER		INSPECTION DATE		CD ID NUMBER	
LICENSOR NAME			VISIT TYPE <input type="checkbox"/> Initial <input type="checkbox"/> Full <input type="checkbox"/> Follow up <input type="checkbox"/> Complaint: CRU Intake Number _____					
All boxes must be completed. If not applicable, enter N/A. If additional staff entries are needed, use another copy of this form.								
STAFF	ADMINISTRATOR	STAFF (NEW)	STAFF (NEW)	STAFF (NEW)	STAFF (> TWO YEARS)	STAFF (> TWO YEARS)		
NAME								
IDENTIFIER								
DATE OF BIRTH								
POSITION								
DATE OF HIRE*								
FACILITY ORIENTATION								
ORIENTATION AND SAFETY (5 HOURS)								
70 HOUR BASIC								
DOH CREDENTIALS								
DOH EXPIRE DATE								
12 HOURS CE* (NUMBER OF HOURS)								
BGI CHECK DATE*								
FINGERPRINT CHECK DATE	<input type="checkbox"/> N/A <input type="checkbox"/> Pending	<input type="checkbox"/> N/A <input type="checkbox"/> Pending	<input type="checkbox"/> N/A <input type="checkbox"/> Pending	<input type="checkbox"/> N/A <input type="checkbox"/> Pending	<input type="checkbox"/> N/A <input type="checkbox"/> Pending	<input type="checkbox"/> N/A <input type="checkbox"/> Pending	<input type="checkbox"/> N/A <input type="checkbox"/> Pending	
CCS EVALUATION*								
ND* TRAINING								
ND INSULIN*								
* BGI = Background Inquiry; CCS = Character, Competency, and Suitability; CE = Continuing Education; Date of Hire = First date worked for pay								

AGING AND LONG-TERM SUPPORT ADMINISTRATOR (ALTS)

## Assisted Living Facility Staff Sample / Record Review

ASSISTED LIVING FACILITY NAME			LICENSE NUMBER	INSPECTION DATE	CD ID NUMBER	
LICENSOR NAME			VISIT TYPE <input type="checkbox"/> Initial <input type="checkbox"/> Full <input type="checkbox"/> Follow up <input type="checkbox"/> Complaint: CRU Intake Number _____			
STAFF	ADMINISTRATOR	STAFF (NEW)	STAFF (NEW)	STAFF (NEW)	STAFF (> TWO YEARS)	STAFF (> TWO YEARS)
NAME						
DATE OF HIRE						
<b>Specialty Training</b>						
<b>DEMENTIA</b> <input type="checkbox"/> N/A						
<b>MENTAL HEALTH</b> <input type="checkbox"/> N/A						
<b>DDA</b> <input type="checkbox"/> N/A						
FOOD HANDLER EXP.						
1 <sup>ST</sup> AID / CPR EXP.						
<b>TB Testing Review for Staff</b>						
DATE TESTED						
TYPE OF TEST	<input type="checkbox"/> TST* <input type="checkbox"/> IGRA*	<input type="checkbox"/> TST* <input type="checkbox"/> IGRA*	<input type="checkbox"/> TST* <input type="checkbox"/> IGRA*	<input type="checkbox"/> TST* <input type="checkbox"/> IGRA*		
DATE FIRST READ						
RESULT	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		
INDURATION IF TST	MM	MM	MM	MM		
DATE OF SECOND TST TEST	<input type="checkbox"/> N/A, not TST	<input type="checkbox"/> N/A, not TST	<input type="checkbox"/> N/A, not TST	<input type="checkbox"/> N/A, not TST		
DATE SECOND READ						
RESULT	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Positive <input type="checkbox"/> Negative		
INDURATION IF TST	MM	MM	MM	MM		
* ND = Nurse Delegation; TST = Tuberculin Skin Test; IGRA = Interferon Gamma Release Assays						