



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT A

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Pre-Inspection Preparation

**Review and Consult:**

- Provider Summary in STARS
- Resident and staff sample from last inspection
- Last 36 months of citations and consultations, including any uncorrected deficiencies
- Review complaint investigations since last inspection, with the focus on trends
- Map or driving directions

**Copy and Review:**

- Floor plan and AFH floor plan key

**Gather Supplies:**

- Thermometer
- Measuring equipment

OMBUDS' CONCERNS – FROM QUARTERLY MEETING NOTES

See attached

Review of Last Inspection / Citations

Enforcement

Number of licensed beds:

See attached.

Disclosure of Services

SPECIALTY APPROVED

Developmental Disabilities

Mental Health

Dementia

Named resident manager:

See attached.

N/A, no resident manager.

Named comprehensive residents from prior inspection:

NOTES



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ATTACHMENT A

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Pre-Inspection Preparation

NOTES



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ATTACHMENT B

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Inspection Process and Records Request

The inspection process consists of:

- Entrance onsite
- Inspection tour
- Sample selection
- Resident interviews
- Observation of care
- Medication review
- Resident record review
- Provider and staff interviews
- Staff record review
- Exit conference

Field Manager's Contact Information:

LICENSEE / RESIDENT MANAGER

Please make the following available to the Licensor today:

- Resident and staff list (please include all employees since the last inspection, but no further back than 2 years)
- Entire resident records, including the negotiated care plan and nurse delegation records, if applicable
- Personnel files, including orientation, CPR, First Aid training, TB testing, background check information, basic or modified training, continuing education and specialty training (as required)
- Proof of current liability insurance (commercial and professional)
- Succession Plan
- Evacuation drills
- Medical Test Site Waiver, if applicable
- Infection Prevention and Control policy and recommended practices
- Staffing plan and policy
- Pet vaccination records, if applicable

The Licensor may require further records and information during the inspection process. Thank you for your assistance.

NOTES



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ATTACHMENT B

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Inspection Process and Records Request

**NOTE:** This form should be used to document any additional information or data that does not fit in the designated space.

NOTES



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ATTACHMENT C

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Entrance Information and Observation

INITIAL ENVIRONMENT OUTSIDE OBSERVATION

TIME OF ENTRANCE

WHO ANSWERED THE DOOR?

WHO IS IN CHARGE OF THE RESIDENTS?

Inspection process and records request form given to provider / representative

INITIAL RESIDENT OBSERVATIONS

INITIAL ENVIRONMENT INSIDE OBSERVATION

OTHER



|                                |                 |
|--------------------------------|-----------------|
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ATTACHMENT C

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Entrance Information and Observation

NOTES



|                                |                 |
|--------------------------------|-----------------|
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ATTACHMENT E

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

**Staff List**

| NAME (ALL EMPLOYEES WITHIN THE LAST TWO YEARS, UP UNTIL LAST INSPECTION) |  | MARK ONE OPTION BELOW                |                          |                          | LIVE ON SITE?            |                          |
|--|--|--------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|  |  | FT                                   | PT                       | PRN                      | YES                      | NO                       |
| PROVIDER / ER  |  | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CO-PROVIDER  |  | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| RESIDENT MANAGER   |  | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CG   |  | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CG   |  | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CG   |  | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CG   |  | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CG   |  | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CG   |  | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CG   |  | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| CG   |  | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  |  | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  |  | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|  |  | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| OTHERS LIVING IN THE HOME  |  | REQUIRES DIRECT CARE FROM CAREGIVERS |                          | AGE 12 YEARS AND OLDER   |                          |                          |
|  |  | YES                                  | NO                       | YES                      | NO                       |                          |
|  |  | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |
|  |  | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |
|  |  | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |
|  |  | <input type="checkbox"/>             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |



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ATTACHMENT E

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Staff List

**NOTE:** This form should be used to document any additional information or data that does not fit in the designated space.

NOTES





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| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
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ATTACHMENT F

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)

ADULT FAMILY HOME (AFH)

### Environmental Tour

| Physical Environment Outside   |              | YES   | NO                       | Bodies of water present (ponds, hot tubs, etc.)   |      | YES   | NO                       |
|--|--------------|---|--------------------------|---|------|---|--------------------------|
| At least one egress door that opens from the inside without special effort or key?   |              | <input type="checkbox"/>                                | <input type="checkbox"/> | If yes, secured?  |      | <input type="checkbox"/>                                | <input type="checkbox"/> |
| All exit doors have no additional locking devices?   |              | <input type="checkbox"/>                                | <input type="checkbox"/> | Water supply approved by local health authority?  |      | <input type="checkbox"/>                                | <input type="checkbox"/> |
| Well drained and free of safety hazards?   |              | <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/> Public sewer system; or  |      | <input type="checkbox"/>                                | <input type="checkbox"/> |
| Adequate lighting?   |              | <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/> Septic system approved by local health authority?  |      | <input type="checkbox"/>                                | <input type="checkbox"/> |
| Safety   |              | YES   | NO                       |   |      | YES   | NO                       |
| Emergency evacuation plan posted on each level?  |              | <input type="checkbox"/>                                | <input type="checkbox"/> | Toxic substances properly stored?   |      | <input type="checkbox"/>                                | <input type="checkbox"/> |
| Three gallons of water per person stored on site?  |              | <input type="checkbox"/>                                | <input type="checkbox"/> | Firearms in home?   |      | <input type="checkbox"/>                                | <input type="checkbox"/> |
| 72-hour emergency food supplies stored on site?  |              | <input type="checkbox"/>                                | <input type="checkbox"/> | If yes, secured?  |      | <input type="checkbox"/>                                | <input type="checkbox"/> |
| Flashlights?   |              | <input type="checkbox"/>                                | <input type="checkbox"/> | Medication refrigerated / locked?   |      | <input type="checkbox"/>                                | <input type="checkbox"/> |
| Smoke detector on each level of the house?   |              | <input type="checkbox"/>                                | <input type="checkbox"/> | First Aid kit with manual?  |      | <input type="checkbox"/>                                | <input type="checkbox"/> |
| At least one fire extinguisher on each floor?  |              | <input type="checkbox"/>                                | <input type="checkbox"/> |   |      |   |                          |
| SERVICE DATE   | SERVICE DATE | <input type="checkbox"/> N/A                            |                          |   |      |   |                          |
| LOCATION   | LOCATION     |   |                          |   |      |   |                          |
| Bathrooms  |              | YES   | NO                       |   |      | YES   | NO                       |
| Accessible to all residents?   |              | <input type="checkbox"/>                                | <input type="checkbox"/> | Clean and sanitary?   |      | <input type="checkbox"/>                                | <input type="checkbox"/> |
| Grab bars in tubs, showers, and next to toilets?   |              | <input type="checkbox"/>                                | <input type="checkbox"/> | One toilet for every five people?   |      | <input type="checkbox"/>                                | <input type="checkbox"/> |
| Adequate water temperature   |              | <input type="checkbox"/>                                | <input type="checkbox"/> | (OPTIONAL, IF NEEDED)   |      |   |                          |
| LOCATION   |              |   |                          | LOCATION  |      |   |                          |
| TEMP °F  | TIME         | <input type="checkbox"/> AM <input type="checkbox"/> PM |                          | TEMP °F   | TIME | <input type="checkbox"/> AM <input type="checkbox"/> PM |                          |
| Kitchen / Dining Rooms   |              | YES   | NO                       |   |      | YES   | NO                       |
| Clean and sanitary?  |              | <input type="checkbox"/>                                | <input type="checkbox"/> | Adequate space for food handling, preparation, and storage?   |      | <input type="checkbox"/>                                | <input type="checkbox"/> |
| Food preparation observed?   |              | <input type="checkbox"/>                                | <input type="checkbox"/> |   |      |   |                          |
| Resident Right   |              | YES   | NO                       |   |      | YES   | NO                       |
| CRU hotline posted?  |              | <input type="checkbox"/>                                | <input type="checkbox"/> | AFH license (any conditions) posted?  |      | <input type="checkbox"/>                                | <input type="checkbox"/> |
| DRW poster visible?  |              | <input type="checkbox"/>                                | <input type="checkbox"/> | Inspection and complaint investigation reports, related follow-up, and cover letters since the last inspection (but not less than 12 months) placed in a visible location in a common use area? |      | <input type="checkbox"/>                                | <input type="checkbox"/> |
| Owner / operator information placed in a visible location in a common use area, with board meeting information, if applicable? |              | <input type="checkbox"/>                                | <input type="checkbox"/> |   |      |   |                          |
| Quality of Life  |              | YES   | NO                       |   |      | YES   | NO                       |
| Home maintained in a clean, homelike setting?  |              | <input type="checkbox"/>                                | <input type="checkbox"/> | Indoor and outdoor common areas are safe, usable, and accessible to residents?  |      | <input type="checkbox"/>                                | <input type="checkbox"/> |
| Adequate furnishings?  |              | <input type="checkbox"/>                                | <input type="checkbox"/> |   |      |   |                          |
| Enough space for residents?  |              | <input type="checkbox"/>                                | <input type="checkbox"/> |   |      |   |                          |



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ATTACHMENT F

AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALSA)

ADULT FAMILY HOME (AFH)

**Environmental Tour**

NOTES



|                                |                 |
|--------------------------------|-----------------|
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ATTACHMENT G

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)

ADULT FAMILY HOME (AFH)

**Environmental Tour - Bedrooms**

| BEDROOMS  | BEDROOM A                |                          | BEDROOM B                |                          | BEDROOM C                |                          | BEDROOM D                |                          | BEDROOM E                |                          | BEDROOM F                |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Name of residents   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| Number of residents / capacity<br><i>(if vacant, skip Part 1 and proceed to Part 2)</i> | /                        |                          | /                        |                          | /                        |                          | /                        |                          | /                        |                          | /                        |                          |
| <b>Part 1: Rooms with</b>   | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                |
| Side rails or transfer poles?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Privacy protected?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Call system?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Adequate space to allow direct, unrestricted, free access to common use areas?          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Special equipment?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| NOTES   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| <b>Part 2: All Licensed Rooms</b>   | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                |
| Smoke detectors in each room?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Smoke detector in proximity to bedrooms?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Smoke detector heard throughout the house?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Windows open easily?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Window screens?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Windows unobstructed?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Doors open on both sides?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Doors unlocking mechanism available?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Space heaters in use?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, heaters get hot to touch?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Closet, dresser / armoire for each resident?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



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ATTACHMENT G

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)

ADULT FAMILY HOME (AFH)

**Environmental Tour - Bedrooms**

| BEDROOMS  | BEDROOM                  |                          | BEDROOM                  |                          | BEDROOM                  |                          | BEDROOM                  |                          | BEDROOM                  |                          | BEDROOM                  |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Name of residents   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| Number of residents / capacity<br><i>(if vacant, skip Part 1 and proceed to Part 2)</i> | /                        |                          | /                        |                          | /                        |                          | /                        |                          | /                        |                          | /                        |                          |
| <b>Part 1: Rooms with</b>   | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                |
| Side rails or transfer poles?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Privacy protected?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Call system?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Adequate space to allow direct, unrestricted, free access to common use areas?          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Special equipment?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| NOTES   |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| <b>Part 2: All Licensed Rooms</b>   | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                | <b>YES</b>               | <b>NO</b>                |
| Smoke detectors in each room?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Smoke detector in proximity to bedrooms?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Smoke detector heard throughout the house?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Windows open easily?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Window screens?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Windows unobstructed?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Doors open on both sides?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Doors unlocking mechanism available?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Space heaters in use?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, heaters get hot to touch?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Closet, dresser / armoire for each resident?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT G

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

**Environmental Tour - Bedrooms**

NOTES



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT I

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

**Resident Record Review**  
**(Resident:  1  2)**

|                        |                 |                  |
|------------------------|-----------------|------------------|
| RESIDENT'S NUMBER      | RESIDENT'S NAME | DATE OF BIRTH    |
| PRACTITIONER'S NAME    |                 | TELEPHONE NUMBER |
| REPRESENTATIVE'S NAME  |                 | TELEPHONE NUMBER |
| ASSESSOR'S NAME        |                 | TELEPHONE NUMBER |
| NURSE DELEGATOR'S NAME |                 | TELEPHONE NUMBER |
| CASE MANAGER'S NAME    |                 | TELEPHONE NUMBER |

|                |  |  |
|----------------|--|--|
| ADMIT DATE     | <input type="checkbox"/> CLOSED RECORD | <input type="checkbox"/> Medicaid policy                               |
| DISCHARGE DATE | <input type="checkbox"/> N/A           | <input type="checkbox"/> Notice of services every 24 months            |
|                |  | <input type="checkbox"/> Disclosure of charges completed and available |

DIAGNOSIS

| YES                      | NO                       | N/A                      |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Social Security Number included in the record? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Personal Belongings Inventory                  |

**NOTE: "NO" ANSWERS REQUIRE NARRATIVE DOCUMENTATION.**

| YES                      | NO                       | N/A                      | ASSESSMENT  | DATE: | DATE OF PRIOR ASSESSMENT: |
|--------------------------|--------------------------|--------------------------|---|-------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Assessment prior to admission (if admitted since last inspection)?                            |       |                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Initial assessment includes preliminary service plan (if admitted since last inspection)?     |       |                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Assessment reflects the current health status / needs, preferences regarding resident rights? |       |                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Updated after a significant change in condition?  |       |                           |

| YES                      | NO                       | N/A                      | NEGOTIATED CARE PLAN   | DATE: | DATE OF PRIOR CARE PLAN: |
|--------------------------|--------------------------|--------------------------|--|-------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Negotiated care plan developed within 30 days (for admission since last inspection)?   |       |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Accurately addresses current: <ul style="list-style-type: none"> <li>Care / service needs?</li> <li>Hospice plan?</li> <li>Crisis plan (if applicable)?</li> </ul> |       |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Identifies preferences / choices?  |       |                          |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Signed and dated by resident and/or representative?  |       |                          |



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT I

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

**Resident Record Review**  
**(Resident:  1  2)**

NOTES



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT J

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

## Comprehensive Resident / Representative Interview

(Resident:  1  2)

|                   |                 |
|-------------------|-----------------|
| RESIDENT'S NUMBER | RESIDENT'S NAME |
|-------------------|-----------------|

|                       |                              |
|-----------------------|------------------------------|
| REPRESENTATIVE'S NAME | TELEPHONE NUMBER (AREA CODE) |
|-----------------------|------------------------------|

**Introductory Questions:** These questions can be used to determine if the resident is interviewable. Indicate the question asked by checking the corresponding box. If the resident is not interviewable, or declines to participate, the representative must be interviewed using the comprehensive interview.

|  |  |
|--|--|
| <input type="checkbox"/> What is the best part about living here?<br><input type="checkbox"/> How long have you lived here?<br><input type="checkbox"/> Are you from around here?<br><input type="checkbox"/> If you could change one thing about living here, what would it be? | <input type="checkbox"/> Other question (include the question and answer): |
|--|--|

Select one:  Resident Interview  Representative Interview

**Instructions:** The questions identified as **\*\*HCBS** questions are **REQUIRED** questions and **MUST** be asked during the interview as written, with the response noted. Check 'Y' if the answer is yes; check 'N' if the answer is no and document the interviewee's response; or check 'D' if the interviewee declined to answer the question.

The interview must address each category. If there is an identified **\*\*HCBS** question in that category, that is the question that **must** be asked. If there is no HCBS question, you can use one of the example questions. Check the question asked or **write your own question**. If you are concerned about the answers, please investigate further.

### A. Care and Service Needs (Required **\*\*HCBS** question in this section)

|   |  |                                      |
|---|--|--------------------------------------|
| Y N D<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <b>** Can you make choices about the care and services you receive here at the home?</b> | <input type="checkbox"/> No Concerns |
|---|--|--------------------------------------|

### B. Response to Concerns (Required **\*\*HCBS** question in this section)

|   |  |                                      |
|---|--|--------------------------------------|
| Y N D<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <b>** Do they pay attention to what you have to say?</b> | <input type="checkbox"/> No Concerns |
|---|--|--------------------------------------|

### C. Support of Personal Relationships (Required **\*\*HCBS** question in this section)

|   |   |                                      |
|---|---|--------------------------------------|
| Y N D<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <b>** Can you choose who visits you and when?</b> | <input type="checkbox"/> No Concerns |
|---|---|--------------------------------------|

### D. Meals / Snack / Preferences (Required **\*\*HCBS** question in this section)

|   |   |                                      |
|---|---|--------------------------------------|
| Y N D<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <b>** Do you have access to food anytime?</b> | <input type="checkbox"/> No Concerns |
|---|---|--------------------------------------|





|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT J

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

## Comprehensive Resident / Representative Interview (Resident: 1 2)

### E. Respect of Individuality, Independence, Personal Choice, Dignity (Two required \*\*HCBS questions in this section)

|                               |                               |                               |  |                                      |
|-------------------------------|-------------------------------|-------------------------------|--|--------------------------------------|
| Y<br><input type="checkbox"/> | N<br><input type="checkbox"/> | D<br><input type="checkbox"/> | ** Can you choose to lock your door?   | <input type="checkbox"/> No Concerns |
| Y<br><input type="checkbox"/> | N<br><input type="checkbox"/> | D<br><input type="checkbox"/> | ** If you have a roommate, were you informed you would have a roommate? Could you change roommates if you wanted to? | <input type="checkbox"/> No Concerns |

### F. Activities (Two required \*\*HCBS questions in this section)

|                               |                               |                               |   |                                      |
|-------------------------------|-------------------------------|-------------------------------|---|--------------------------------------|
| Y<br><input type="checkbox"/> | N<br><input type="checkbox"/> | D<br><input type="checkbox"/> | ** Do you have an opportunity to participate in community activities? | <input type="checkbox"/> No Concerns |
| Y<br><input type="checkbox"/> | N<br><input type="checkbox"/> | D<br><input type="checkbox"/> | ** Do you receive services in the community?                          | <input type="checkbox"/> No Concerns |

### G. Homelike Environment (Select the question asked by checking the box next to that question)

|                               |                               |                               |  |                                      |
|-------------------------------|-------------------------------|-------------------------------|--|--------------------------------------|
| Y<br><input type="checkbox"/> | N<br><input type="checkbox"/> | D<br><input type="checkbox"/> | <input type="checkbox"/> Are you comfortable here?<br><input type="checkbox"/> Is the temperature comfortable to you?<br><input type="checkbox"/> Other: | <input type="checkbox"/> No Concerns |
|-------------------------------|-------------------------------|-------------------------------|--|--------------------------------------|

### H. Reasonable House Rules (Select the question asked by checking the box next to that question)

|                               |                               |                               |   |                                      |
|-------------------------------|-------------------------------|-------------------------------|---|--------------------------------------|
| Y<br><input type="checkbox"/> | N<br><input type="checkbox"/> | D<br><input type="checkbox"/> | <input type="checkbox"/> Tell me about the house.<br><input type="checkbox"/> What have you been told about watching TV? How long can you stay up at night or how early or late can you stay up?<br><input type="checkbox"/> Other: | <input type="checkbox"/> No Concerns |
|-------------------------------|-------------------------------|-------------------------------|---|--------------------------------------|

### I. Sense of Well-Being and Safety (Select the question asked by checking the box next to that question)

|                               |                               |                               |  |                                      |
|-------------------------------|-------------------------------|-------------------------------|--|--------------------------------------|
| Y<br><input type="checkbox"/> | N<br><input type="checkbox"/> | D<br><input type="checkbox"/> | <input type="checkbox"/> Do you feel safe here?<br><input type="checkbox"/> Other: | <input type="checkbox"/> No Concerns |
|-------------------------------|-------------------------------|-------------------------------|--|--------------------------------------|

### J. Notice (Select the question asked by checking the box next to that question)

|                               |                               |                               |   |                                      |
|-------------------------------|-------------------------------|-------------------------------|---|--------------------------------------|
| Y<br><input type="checkbox"/> | N<br><input type="checkbox"/> | D<br><input type="checkbox"/> | <input type="checkbox"/> Do you handle your own finances or does someone help you with that?<br><input type="checkbox"/> What were you told about paying for your own care here?<br><input type="checkbox"/> Other: | <input type="checkbox"/> No Concerns |
|-------------------------------|-------------------------------|-------------------------------|---|--------------------------------------|



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT J

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

**Comprehensive Resident / Representative Interview**  
**(Resident:  1  2)**

NOTES



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT I

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

## Resident Record Review

(Resident:  1  2)

|                        |   |   |
|------------------------|---|---|
| RESIDENT'S NUMBER      | RESIDENT'S NAME   | DATE OF BIRTH   |
| PRACTITIONER'S NAME    |   | TELEPHONE NUMBER  |
| REPRESENTATIVE'S NAME  |   | TELEPHONE NUMBER  |
| ASSESSOR'S NAME        |   | TELEPHONE NUMBER  |
| NURSE DELEGATOR'S NAME |   | TELEPHONE NUMBER  |
| CASE MANAGER'S NAME    |   | TELEPHONE NUMBER  |
| ADMIT DATE             | <input type="checkbox"/> CLOSED RECORD<br>_____<br>DISCHARGE DATE | <input type="checkbox"/> Medicaid policy<br><input type="checkbox"/> Notice of services every 24 months<br><input type="checkbox"/> Disclosure of charges completed and available |
|                        | <input type="checkbox"/> N/A                                      |   |

DIAGNOSIS

| YES                      | NO                       | N/A                      |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Social Security Number included in the record? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Personal Belongings Inventory                  |

**NOTE: "NO" ANSWERS REQUIRE NARRATIVE DOCUMENTATION.**

| YES                      | NO                       | N/A                      | ASSESSMENT   | DATE: | DATE OF PRIOR ASSESSMENT: |
|--------------------------|--------------------------|--------------------------|--|-------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Assessment prior to admission (if admitted since last inspection)?   |       |                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Initial assessment includes preliminary service plan (if admitted since last inspection)?  |       |                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Assessment reflects the current health status / needs, preferences regarding resident rights?  |       |                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Updated after a significant change in condition?   |       |                           |
| YES                      | NO                       | N/A                      | NEGOTIATED CARE PLAN   | DATE: | DATE OF PRIOR CARE PLAN:  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Negotiated care plan developed within 30 days (for admission since last inspection)?   |       |                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Accurately addresses current: <ul style="list-style-type: none"> <li>• Care / service needs?</li> <li>• Hospice plan?</li> <li>• Crisis plan (if applicable)?</li> </ul> |       |                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Identifies preferences / choices?  |       |                           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Signed and dated by resident and/or representative?  |       |                           |



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT I

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

**Resident Record Review**  
**(Resident:  1  2)**

NOTES



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT J

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

## Comprehensive Resident / Representative Interview

(Resident:  1  2)

|                   |                 |
|-------------------|-----------------|
| RESIDENT'S NUMBER | RESIDENT'S NAME |
|-------------------|-----------------|

|                       |                              |
|-----------------------|------------------------------|
| REPRESENTATIVE'S NAME | TELEPHONE NUMBER (AREA CODE) |
|-----------------------|------------------------------|

**Introductory Questions:** These questions can be used to determine if the resident is interviewable. Indicate the question asked by checking the corresponding box. If the resident is not interviewable, or declines to participate, the representative must be interviewed using the comprehensive interview.

|  |  |
|--|--|
| <input type="checkbox"/> What is the best part about living here?<br><input type="checkbox"/> How long have you lived here?<br><input type="checkbox"/> Are you from around here?<br><input type="checkbox"/> If you could change one thing about living here, what would it be? | <input type="checkbox"/> Other question (include the question and answer): |
|--|--|

Select one:  Resident Interview  Representative Interview

**Instructions:** The questions identified as **\*\*HCBS** questions are **REQUIRED** questions and **MUST** be asked during the interview as written, with the response noted. Check 'Y' if the answer is yes; check 'N' if the answer is no and document the interviewee's response; or check 'D' if the interviewee declined to answer the question.

The interview must address each category. If there is an identified **\*\*HCBS** question in that category, that is the question that **must** be asked. If there is no HCBS question, you can use one of the example questions. Check the question asked or **write your own question**. If you are concerned about the answers, please investigate further.

### K. Care and Service Needs (Required **\*\*HCBS** question in this section)

|   |  |                                      |
|---|--|--------------------------------------|
| Y N D<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <b>** Can you make choices about the care and services you receive here at the home?</b> | <input type="checkbox"/> No Concerns |
|---|--|--------------------------------------|

### L. Response to Concerns (Required **\*\*HCBS** question in this section)

|   |  |                                      |
|---|--|--------------------------------------|
| Y N D<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <b>** Do they pay attention to what you have to say?</b> | <input type="checkbox"/> No Concerns |
|---|--|--------------------------------------|

### M. Support of Personal Relationships (Required **\*\*HCBS** question in this section)

|   |   |                                      |
|---|---|--------------------------------------|
| Y N D<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <b>** Can you choose who visits you and when?</b> | <input type="checkbox"/> No Concerns |
|---|---|--------------------------------------|

### N. Meals / Snack / Preferences (Required **\*\*HCBS** question in this section)

|   |   |                                      |
|---|---|--------------------------------------|
| Y N D<br><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <b>** Do you have access to food anytime?</b> | <input type="checkbox"/> No Concerns |
|---|---|--------------------------------------|



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT J

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

## Comprehensive Resident / Representative Interview

(Resident:  1  2)

**O. Respect of Individuality, Independence, Personal Choice, Dignity**  
(Two required \*\*HCBS questions in this section)

|                               |                               |                               |  |                                      |
|-------------------------------|-------------------------------|-------------------------------|--|--------------------------------------|
| Y<br><input type="checkbox"/> | N<br><input type="checkbox"/> | D<br><input type="checkbox"/> | ** Can you choose to lock your door?   | <input type="checkbox"/> No Concerns |
| Y<br><input type="checkbox"/> | N<br><input type="checkbox"/> | D<br><input type="checkbox"/> | ** If you have a roommate, were you informed you would have a roommate? Could you change roommates if you wanted to? | <input type="checkbox"/> No Concerns |

**P. Activities (Two required \*\*HCBS questions in this section)**

|                               |                               |                               |   |                                      |
|-------------------------------|-------------------------------|-------------------------------|---|--------------------------------------|
| Y<br><input type="checkbox"/> | N<br><input type="checkbox"/> | D<br><input type="checkbox"/> | ** Do you have an opportunity to participate in community activities? | <input type="checkbox"/> No Concerns |
| Y<br><input type="checkbox"/> | N<br><input type="checkbox"/> | D<br><input type="checkbox"/> | ** Do you receive services in the community?                          | <input type="checkbox"/> No Concerns |

**Q. Homelike Environment (Select the question asked by checking the box next to that question)**

|                               |                               |                               |  |                                      |
|-------------------------------|-------------------------------|-------------------------------|--|--------------------------------------|
| Y<br><input type="checkbox"/> | N<br><input type="checkbox"/> | D<br><input type="checkbox"/> | <input type="checkbox"/> Are you comfortable here?<br><input type="checkbox"/> Is the temperature comfortable to you?<br><input type="checkbox"/> Other: | <input type="checkbox"/> No Concerns |
|-------------------------------|-------------------------------|-------------------------------|--|--------------------------------------|

**R. Reasonable House Rules (Select the question asked by checking the box next to that question)**

|                               |                               |                               |   |                                      |
|-------------------------------|-------------------------------|-------------------------------|---|--------------------------------------|
| Y<br><input type="checkbox"/> | N<br><input type="checkbox"/> | D<br><input type="checkbox"/> | <input type="checkbox"/> Tell me about the house.<br><input type="checkbox"/> What have you been told about watching TV? How long can you stay up at night or how early or late can you stay up?<br><input type="checkbox"/> Other: | <input type="checkbox"/> No Concerns |
|-------------------------------|-------------------------------|-------------------------------|---|--------------------------------------|

**S. Sense of Well-Being and Safety (Select the question asked by checking the box next to that question)**

|                               |                               |                               |  |                                      |
|-------------------------------|-------------------------------|-------------------------------|--|--------------------------------------|
| Y<br><input type="checkbox"/> | N<br><input type="checkbox"/> | D<br><input type="checkbox"/> | <input type="checkbox"/> Do you feel safe here?<br><input type="checkbox"/> Other: | <input type="checkbox"/> No Concerns |
|-------------------------------|-------------------------------|-------------------------------|--|--------------------------------------|

**T. Notice (Select the question asked by checking the box next to that question)**

|                               |                               |                               |   |                                      |
|-------------------------------|-------------------------------|-------------------------------|---|--------------------------------------|
| Y<br><input type="checkbox"/> | N<br><input type="checkbox"/> | D<br><input type="checkbox"/> | <input type="checkbox"/> Do you handle your own finances or does someone help you with that?<br><input type="checkbox"/> What were you told about paying for your own care here?<br><input type="checkbox"/> Other: | <input type="checkbox"/> No Concerns |
|-------------------------------|-------------------------------|-------------------------------|---|--------------------------------------|



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT J

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

**Comprehensive Resident / Representative Interview**  
**(Resident:  1  2)**

NOTES



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT H

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Resident Observations

If no observations for the specified section occurred, mark the "Not Observed" box for that section and skip the rest of the items in that section. All observations must include time, identity of individuals observed, and details of what was observed. The intent is to capture the care and services provided to the residents in the home. Focus should be on the comprehensive residents when possible when observing care and medication services.

Staff Observed:

**Care (positioning, toileting, transfers, adaptive equipment, bathing)**  Not Observed

|  |                    |
|--|--------------------|
| Time of observation: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | RESIDENTS OBSERVED |
|--|--------------------|

NOTES

**Medication Services (preparation, delivery)**  Not Observed

|  |                    |
|--|--------------------|
| Time of observation: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | RESIDENTS OBSERVED |
|--|--------------------|

NOTES

**Meal Services (eating, including assistance provided or adaptive equipment used)**  Not Observed

|  |                    |
|--|--------------------|
| Time of observation: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | RESIDENTS OBSERVED |
|--|--------------------|

NOTES

**Interactions and Activities (visitors and professionals, exercise program, activities)**  Not Observed

|  |                    |
|--|--------------------|
| Time of observation: <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | RESIDENTS OBSERVED |
|--|--------------------|

NOTES





|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT H

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Resident Observations

Use this section to document any additional observations or notes.



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT L

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Resident Medication Review

Each topic on this form covers a required area of the medication review. All sections must be completed for the review to be considered complete

1. Does the home have a system in place to ensure each resident:
  - a. Has an assessment indicating the level of medication assistance needed by each resident?
  - b. Has a negotiated care plan identifying the medication service provided to that resident?
  - c. Has a medication log that is kept current?
  - d. Received medications as required; and
  - e. Has a current list of all prescribed and OTC medication in the resident's record?
    - Current list must include the name, dose, and frequency of the medication, as well as the name and phone number of the prescribing practitioner.

Yes     No; if no, explain why in the section below:

2. Does the home have a system to address medication refusals?

Yes     No; if no, explain why in the section below:

3. Are all medications appropriately identified, stored appropriately based on each medication's requirements, and locked?

Yes     No; if no, explain why in the section below:

4. Do all medications have an approved verification source?
  - Approved verification sources include Pharmacy produced MAR, Physician's Order, a written prescription, or a pharmacy produced medication label.
  - An AFH provider MAR is not an approved verification source.
  - Address electronic MARs (e-MARs) as you would a physical MAR.

Yes     No; if no, explain why in the section below:



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT L

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Resident Medication Review

Resident:  1  2 Resident Name:

5. Were any psychopharmacologic medications identified?  
Psychopharmacologic medications include **anti-depressants**, **anti-anxiety** (anxiolytics), **anti-psychotics**, and **mood stabilizers**. **Hypnotics** (sedative) are optional to include in the section. Include all medications in these categories, even if prescribed for an off-label use (reason unrelated to psychiatric diagnosis).  
• If the reason for medications is unknown or unspecified, indicate this.

Yes  No If yes, complete the section below.

| Medication Name | Verification Source (Check one applicable box for each medication.) |   |   |   | Reason for Medication |
|-----------------|---|---|---|---|-----------------------|
|                 | <input type="checkbox"/> Pharmacy MAR / Label                       | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Written Prescription | <input type="checkbox"/> No Approved Source |                       |
|                 | <input type="checkbox"/> Pharmacy MAR / Label                       | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Written Prescription | <input type="checkbox"/> No Approved Source |                       |
|                 | <input type="checkbox"/> Pharmacy MAR / Label                       | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Written Prescription | <input type="checkbox"/> No Approved Source |                       |
|                 | <input type="checkbox"/> Pharmacy MAR / Label                       | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Written Prescription | <input type="checkbox"/> No Approved Source |                       |
|                 | <input type="checkbox"/> Pharmacy MAR / Label                       | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Written Prescription | <input type="checkbox"/> No Approved Source |                       |
|                 | <input type="checkbox"/> Pharmacy MAR / Label                       | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Written Prescription | <input type="checkbox"/> No Approved Source |                       |

6. If psychopharmacologic medications were identified, does the negotiated care plan include strategies and modifications to the environment to address the symptoms for this the medication is prescribed?

Yes  No If no, complete the section below.  N/A, no psychopharmacologic medications



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT L

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Resident Medication Review

Resident:  1  2

Resident Name:

7. Were any psychopharmacologic medications identified?

Psychopharmacologic medications include **anti-depressants**, **anti-anxiety** (anxiolytics), **anti-psychotics**, and **mood stabilizers**. **Hypnotics** (sedative) are optional to include in the section. Include all medications in these categories, even if prescribed for an off-label use (reason unrelated to psychiatric diagnosis).

- If the reason for medications is unknown or unspecified, indicate this.

Yes  No If yes, complete the section below.

| Medication Name | Verification Source (Check one applicable box for each medication.) |   |   |   | Reason for Medication |
|-----------------|---|---|---|---|-----------------------|
|                 | <input type="checkbox"/> Pharmacy MAR / Label                       | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Written Prescription | <input type="checkbox"/> No Approved Source |                       |
|                 | <input type="checkbox"/> Pharmacy MAR / Label                       | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Written Prescription | <input type="checkbox"/> No Approved Source |                       |
|                 | <input type="checkbox"/> Pharmacy MAR / Label                       | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Written Prescription | <input type="checkbox"/> No Approved Source |                       |
|                 | <input type="checkbox"/> Pharmacy MAR / Label                       | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Written Prescription | <input type="checkbox"/> No Approved Source |                       |
|                 | <input type="checkbox"/> Pharmacy MAR / Label                       | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Written Prescription | <input type="checkbox"/> No Approved Source |                       |
|                 | <input type="checkbox"/> Pharmacy MAR / Label                       | <input type="checkbox"/> Physician's Orders | <input type="checkbox"/> Written Prescription | <input type="checkbox"/> No Approved Source |                       |

8. If psychopharmacologic medications were identified, does the negotiated care plan include strategies and modifications to the environment to address the symptoms for this the medication is prescribed?

Yes  No If no, complete the section below.  N/A, no psychopharmacologic medications



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT L

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Resident Medication Review

**Notes:**

This section can be used to capture any additional information related to the review. Use of this section is optional.



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT L

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Condensed Resident / Representative Interview

|                       |                              |
|-----------------------|------------------------------|
| RESIDENT'S NUMBER     | RESIDENT'S NAME              |
| REPRESENTATIVE'S NAME | TELEPHONE NUMBER (AREA CODE) |

**NOTE:** For representatives, one condensed representative interview is **required** for every inspection, when both residents are interviewable. This form may also be used to interview additional residents and representatives if concerns come up where more information is needed.

SELECT ONE

- Resident Interview     Representative Interview

\* The licensor may ask their own five questions to assess the resident's Quality of Life, Safety, Freedom of Choice, and Care and Services. Below are example questions that can be used. Follow up questions may be necessary, depending on information received.

**Check "Y" if the answer is yes; check "N" if the answer is no and document the interviewee's response; or check "D" if the interviewee declined to answer the question.**

- |                          |                          |                          |   |
|--------------------------|--------------------------|--------------------------|---|
| Y                        | N                        | D                        |   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do staff ensure the resident's safety, property, dignity, and rights are protected? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any concerns about how the resident(s) are treated?                     |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you feel the resident's care needs are being met?                                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Can the resident choose to lock their door?   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Can the resident receive visitors on a schedule of their choosing?                  |

**Please note any additional questions asked, responses received, observations, or comments in the section below.**

NOTES



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT L

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Condensed Resident / Representative Interview

**Notes:**

This section can be used to capture any additional information related to the review. Use of this section is optional.



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT M

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

**Administrative Records Review**

**Instructions:** Full review sample should include one current caregiver hired since the last inspection and one of the following: Provider, Resident Manager, or Entity Rep. Conduct a *focused* review of background checks for all current staff. If the home does not have a specialty designation, mark "N/A" for that specialty and leave the line blank.

| STAFF   | PROVIDER OR ENTITY REP  | RESIDENT MANAGER  | CAREGIVER   | CAREGIVER   | CAREGIVER   |
|---|---|---|---|---|---|
| NAME  |   |   |   |   |   |
| DATE OF HIRE  |   |   |   |   |   |
| HOME ORIENTATION  |   |   |   |   |   |
| DATE OF BIRTH   |   |   |   |   |   |
| CONTACT INFO ON FILE                                      | <input type="checkbox"/> YES <input type="checkbox"/> NO                            | <input type="checkbox"/> YES <input type="checkbox"/> NO                            | <input type="checkbox"/> YES <input type="checkbox"/> NO                            | <input type="checkbox"/> YES <input type="checkbox"/> NO                            | <input type="checkbox"/> YES <input type="checkbox"/> NO                            |
| BGI EXPIRE DATE*  | <input type="checkbox"/> NR <input type="checkbox"/> RR <input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR <input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR <input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR <input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR <input type="checkbox"/> DQ |
| FINGERPRINT CHECK DATE (CHECK N/A IF NOT REQUIRED)        | <input type="checkbox"/> PENDING<br><input type="checkbox"/> N/A                    | <input type="checkbox"/> PENDING<br><input type="checkbox"/> N/A                    | <input type="checkbox"/> PENDING<br><input type="checkbox"/> N/A                    | <input type="checkbox"/> PENDING<br><input type="checkbox"/> N/A                    | <input type="checkbox"/> PENDING<br><input type="checkbox"/> N/A                    |
| CCS EVALUATION*   | <input type="checkbox"/> N/A  | <input type="checkbox"/> N/A  | <input type="checkbox"/> N/A  | <input type="checkbox"/> N/A  | <input type="checkbox"/> N/A  |
| TB TESTING MET  | <input type="checkbox"/> YES <input type="checkbox"/> NO                            | <input type="checkbox"/> YES <input type="checkbox"/> NO                            | <input type="checkbox"/> YES <input type="checkbox"/> NO                            | <input type="checkbox"/> YES <input type="checkbox"/> NO                            | <input type="checkbox"/> YES <input type="checkbox"/> NO                            |
| ORIENTATION AND SAFETY (5 HOURS)                          |   |   |   |   |   |
| 70 HOUR BASIC <b>OR</b>                                   |   |   |   |   |   |
| FUNDAMENTALS OF CAREGIVING (WORKED PRIOR TO 01/01/202012) | <input type="checkbox"/> ATTESTATION  | <input type="checkbox"/> ATTESTATION  | <input type="checkbox"/> ATTESTATION  | <input type="checkbox"/> ATTESTATION  | <input type="checkbox"/> ATTESTATION  |
| CPR EXP. DATE   |   |   |   |   |   |
| FIRST AID EXP. DATE                                       |   |   |   |   |   |
| ND* TRAINING  |   |   |   |   |   |
| ND DIABETES FOCUS   |   |   |   |   |   |
| FOOD HANDLER EXP.   |   |   |   |   |   |
| <b>OR</b> FOOD SAFETY CE                                  |   |   |   |   |   |
| DOH LICENSE TYPE:   |   |   |   |   |   |
| DOH LICENSE EXP.  |   |   |   |   |   |
| NUMBER OF CE HOURS (N/A, IF NOT REQUIRED)                 | <input type="checkbox"/> N/A  | <input type="checkbox"/> N/A  | <input type="checkbox"/> N/A  | <input type="checkbox"/> N/A  | <input type="checkbox"/> N/A  |
| <b>SPECIALTY TRAINING</b>                                 |   |   |   |   |   |
| DEMENTIA<br><input type="checkbox"/> N/A                  |   |   |   |   |   |
| MENTAL HEALTH<br><input type="checkbox"/> N/A             |   |   |   |   |   |
| DDA<br><input type="checkbox"/> N/A                       |   |   |   |   |   |

\* BGI - Background Inquiry; NR - No Record; RR - Review Required; DQ - Disqualifying, CCS - Character, Competency, and Suitability; ND - Nurse Delegation; CE - Continuing Education





|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT M

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Administrative Records Review

#### TB Testing – Optional Worksheet

This section can be used to assist in determining compliance with TB Testing requirements.  
Once determined, indicate compliance status on Page 1.

| STAFF                               | PROVIDER OR ENTITY REP   | RESIDENT MANAGER   | CAREGIVER  | CAREGIVER  | CAREGIVER  |
|-------------------------------------|--|--|--|--|--|
| DATE ADMINISTERED                   |  |  |  |  |  |
| STEP 1 READ                         |  |  |  |  |  |
| RESULT                              | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative |
| DATE ADMINISTERED                   |  |  |  |  |  |
| STEP 2 READ                         |  |  |  |  |  |
| RESULT                              | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative |
| 1 ADDITIONAL TEST DATE ADMINISTERED |  |  |  |  |  |
| 1 ADDITIONAL TEST DATE READ         |  |  |  |  |  |
| RESULT                              | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative |
| BLOOD TEST                          |  |  |  |  |  |
| RESULT                              | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative |
| X-RAY                               |  |  |  |  |  |
| RESULT                              | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative | <input type="checkbox"/> Positive<br><input type="checkbox"/> Negative |

NOTES



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT N

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Administrative Records Review Continuation

**Instructions:** Document background check results for additional staff here.

| STAFF   | CAREGIVER  | CAREGIVER  | CAREGIVER  | CAREGIVER  | CAREGIVER  |
|---|--|--|--|--|--|
| NAME  |  |  |  |  |  |
| DATE OF HIRE                                  |  |  |  |  |  |
| BGI EXPIRE DATE                               | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ |
| FINGERPRINT CHECK (CHECK N/A IF NOT REQUIRED) | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       |
| CCS REVIEW (CHECK N/A IF NOT REQUIRED)        | <input type="checkbox"/> N/A   | <input type="checkbox"/> N/A   | <input type="checkbox"/> N/A   | <input type="checkbox"/> N/A   | <input type="checkbox"/> N/A   |
| STAFF   | CAREGIVER  | CAREGIVER  | CAREGIVER  | CAREGIVER  | CAREGIVER  |
| NAME  |  |  |  |  |  |
| DATE OF HIRE                                  |  |  |  |  |  |
| BGI EXPIRE DATE                               | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ |
| FINGERPRINT CHECK (CHECK N/A IF NOT REQUIRED) | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       |
| CCS REVIEW (CHECK N/A IF NOT REQUIRED)        | <input type="checkbox"/> N/A   | <input type="checkbox"/> N/A   | <input type="checkbox"/> N/A   | <input type="checkbox"/> N/A   | <input type="checkbox"/> N/A   |

New resident manager meets:  1,000 hours direct care experience  Educational experience  
 N/A, no new resident manager.

Succession Plan:  Yes  No

Medical Test Site:  Yes  No  N/A

Commercial Liability Insurance  
Expiration date:

Professional Liability Insurance  
Expiration date:

**Pet Records**  N/A, no pets in the home.

#### Evacuation Logs

Every two (2) months?  Under five (5) minutes?  Annual evacuation of all residents?

\* BGI - Background Inquiry; NR - No Record; RR - Review Required; DQ - Disqualifying, CCS - Character, Competency, and Suitability



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT N

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Administrative Records Review Continuation

NOTES



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT O

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Administrative Records Review - Former Staff and Others with Unsupervised Access

Instructions: Document background check results for former staff here.

| STAFF   | STAFF  | STAFF  | STAFF  | STAFF  | STAFF  | STAFF  |
|---|--|--|--|--|--|--|
| NAME  |  |  |  |  |  |  |
| DATE OF HIRE  |  |  |  |  |  |  |
| DATE OF DEPARTURE                                   |  |  |  |  |  |  |
| BGI EXPIRE DATE                                     | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ |
| FINGERPRINT CHECK<br>(CHECK N/A IF NOT<br>REQUIRED) | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       |
| CCS REVIEW*<br>(CHECK N/A IF NOT<br>REQUIRED)       | <input type="checkbox"/> N/A   | <input type="checkbox"/> N/A   | <input type="checkbox"/> N/A   | <input type="checkbox"/> N/A   | <input type="checkbox"/> N/A   | <input type="checkbox"/> N/A   |

Instructions: Document background check results for other individuals who have unsupervised access to vulnerable adults here.

| OTHERS WITH<br>UNSUPERVISED ACCESS                  | OTHER  | OTHER  | OTHER  | OTHER  | OTHER  | OTHER  |
|---|--|--|--|--|--|--|
| NAME  |  |  |  |  |  |  |
| BGI EXPIRE DATE                                     | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ | <input type="checkbox"/> NR <input type="checkbox"/> RR<br><input type="checkbox"/> DQ |
| FINGERPRINT CHECK<br>(CHECK N/A IF NOT<br>REQUIRED) | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       | <input type="checkbox"/> N/A<br><input type="checkbox"/> PENDING                       |
| CCS REVIEW*<br>(CHECK N/A IF NOT<br>REQUIRED)       | <input type="checkbox"/> N/A   | <input type="checkbox"/> N/A   | <input type="checkbox"/> N/A   | <input type="checkbox"/> N/A   | <input type="checkbox"/> N/A   | <input type="checkbox"/> N/A   |

\* BGI - Background Inquiry; NR - No Record; RR - Review Required; DQ - Disqualifying, CCS - Character, Competency, and Suitability

NOTES



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT O

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

**Administrative Records Review -  
Former Staff and Others with Unsupervised Access**

NOTES



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT P

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Provider / Resident Manager Interview

|  |      |      |   |
|--|------|------|---|
| <input type="checkbox"/> Provider<br><input type="checkbox"/> Resident Manager | NAME | TIME | <input type="checkbox"/> AM <input type="checkbox"/> PM |
|--|------|------|---|

The following questions are **required** during the interview. The licensor will write the answer to each question in the space provided. The interviewer may ask more questions or obtain more data if concerns are identified.

|   |  |
|---|--|
| <b>RESIDENT RIGHTS</b> <ul style="list-style-type: none"> <li>• What do you do to promote resident dignity, quality of life and privacy?</li> <li>• What do you do if you see or discover resident rights being violated?</li> </ul>  |  |
| <b>RESIDENT GRIEVANCES</b> <ul style="list-style-type: none"> <li>• What do you do if you have a resident who says they are unhappy about the care in this home?</li> </ul>   |  |
| <b>CARE AND SERVICES</b> <ul style="list-style-type: none"> <li>• What types of daily choices do the residents in the home make?</li> <li>• How do you help residents feel comfortable here?</li> </ul>   |  |
| <b>ABUSE / NEGLECT / EXPLOITATION</b> <ul style="list-style-type: none"> <li>• Please give an example of abuse, neglect or exploitation.</li> <li>• What do you do if you see or discovered abuse, exploitation, or neglect?</li> </ul>   |  |
| <b>RESIDENT BEHAVIOR / FACILITY PRACTICE</b> <ul style="list-style-type: none"> <li>• What do you do if a resident is missing?</li> <li>• Do any residents have challenging behaviors? If yes, what behaviors? How do you manage those behaviors?</li> </ul>                            |  |
| <b>ACCIDENT / INJURY / PREVENTION</b> <ul style="list-style-type: none"> <li>• What do you do if a resident falls?</li> <li>• How do you know what each resident needs in the event of an accident or injury?</li> <li>• Who do you need to notify if a resident is injured?</li> </ul> |  |
| <b>STAFFING</b> <ul style="list-style-type: none"> <li>• Do you work alone?</li> <li>• How do you get help?</li> <li>• How does staff contact the provider?</li> </ul>  |  |
| <b>EMERGENCY MANAGEMENT</b> <ul style="list-style-type: none"> <li>• When did you last participate in an evacuation drill?</li> <li>• Where is the meeting place?</li> </ul>  |  |



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT P

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

**Provider / Resident Manager Interview**

NOTES



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT P

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

**Staff Interview**

|                                    |       |      |      |   |
|------------------------------------|-------|------|------|---|
| <input type="checkbox"/> Caregiver | SHIFT | NAME | TIME | <input type="checkbox"/> AM <input type="checkbox"/> PM |
|------------------------------------|-------|------|------|---|

The following questions are **required** during the interview. Write the answer to each question in the space provided. The interviewer may obtain more data if concerns are identified.

|   |  |
|---|--|
| <b>RESIDENT RIGHTS</b> <ul style="list-style-type: none"> <li>• What do you do to promote resident dignity, quality of life and privacy?</li> <li>• What do you do if you see or discover resident rights being violated?</li> </ul>  |  |
| <b>RESIDENT GRIEVANCES</b> <ul style="list-style-type: none"> <li>• What do you do if you have a resident who says they are unhappy about the care in this home?</li> </ul>   |  |
| <b>CARE AND SERVICES</b> <ul style="list-style-type: none"> <li>• What types of daily choices do the residents in the home make?</li> <li>• How do you help residents feel comfortable here?</li> </ul>   |  |
| <b>ABUSE / NEGLECT / EXPLOITATION</b> <ul style="list-style-type: none"> <li>• Please give an example of abuse, neglect or exploitation.</li> <li>• What do you do if you see or discovered abuse, exploitation, or neglect?</li> </ul>   |  |
| <b>RESIDENT BEHAVIOR / FACILITY PRACTICE</b> <ul style="list-style-type: none"> <li>• What do you do if a resident is missing?</li> <li>• Do any residents have challenging behaviors? If yes, what behaviors? How do you manage those behaviors?</li> </ul>                            |  |
| <b>ACCIDENT / INJURY / PREVENTION</b> <ul style="list-style-type: none"> <li>• What do you do if a resident falls?</li> <li>• How do you know what each resident needs in the event of an accident or injury?</li> <li>• Who do you need to notify if a resident is injured?</li> </ul> |  |
| <b>STAFFING</b> <ul style="list-style-type: none"> <li>• Do you work alone?</li> <li>• How do you get help?</li> <li>• How does staff contact the provider?</li> </ul>  |  |
| <b>EMERGENCY MANAGEMENT</b> <ul style="list-style-type: none"> <li>• When did you last participate in an evacuation drill?</li> <li>• Where is the meeting place?</li> </ul>  |  |





|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT O

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

**Staff Interview**

NOTES



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT R

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Exit Preparation Worksheet

- SCANNED documents are stored on the local field office shared drive.
- COPIED documents are stored in the local field office paper file.
- No documents were scanned or copied during this inspection.

PROVIDER CONTACT (IF FURTHER INFORMATION REQUIRED)

TIME OF EXIT  AM  PM

| RESIDENT / STAFF NUMBER | ISSUE / CONCERNS | SUMMARY OF FINDINGS | WAC / RCW |
|-------------------------|------------------|---------------------|-----------|
|                         |                  |                     |           |
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|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT R

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Exit Preparation Worksheet

NOTES



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHMENT U

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

### Residential Care Services Notes

**NOTE:** This form should be used to document any additional information or data that does not fit in the designated space.

NOTES



|                                |                 |
|--------------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER  |
| PROVIDER / LICENSEE'S NAME     | INSPECTION DATE |
| LICENSOR'S NAME                |                 |

ATTACHEMENT S

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

## Adult Family Home Floor Plan Key

Each bedroom **approved** for resident use **is automatically approved** for independent residents.

| BEDROOM DESIGNATION | BEDROOM CAPACITY (CHECK ONE)                          | BEDROOM LABEL <sup>1</sup> (CHECK ONE)                  | <b>KEY: Determining evacuation level label for each resident bedroom as Independent (I) OR Independent / Assistance (I/A)</b>  |
|---------------------|---|---|--|
| A                   | <input type="checkbox"/> 1 <input type="checkbox"/> 2 | <input type="checkbox"/> I <input type="checkbox"/> I/A |  |
| B                   | <input type="checkbox"/> 1 <input type="checkbox"/> 2 | <input type="checkbox"/> I <input type="checkbox"/> I/A | <p><b>Bedroom labeled as "Independent (I)"</b></p> <p>The resident using this bedroom is able to ambulate out of the bedroom, through the house and main egress (exit) door to the ground, without use of physical assistance, cane, walker, or wheelchair, and one (1) cue.</p> <p>The exit path from the bedroom may have any of the following:</p> <ul style="list-style-type: none"> <li>• Steps / stairs</li> <li>• Ramp</li> <li>• No step / stairs or ramp</li> </ul> |
| C                   | <input type="checkbox"/> 1 <input type="checkbox"/> 2 | <input type="checkbox"/> I <input type="checkbox"/> I/A |  |
| D                   | <input type="checkbox"/> 1 <input type="checkbox"/> 2 | <input type="checkbox"/> I <input type="checkbox"/> I/A |  |
| E                   | <input type="checkbox"/> 1 <input type="checkbox"/> 2 | <input type="checkbox"/> I <input type="checkbox"/> I/A |  |
| F                   | <input type="checkbox"/> 1 <input type="checkbox"/> 2 | <input type="checkbox"/> I <input type="checkbox"/> I/A |  |
| G                   | <input type="checkbox"/> 1 <input type="checkbox"/> 2 | <input type="checkbox"/> I <input type="checkbox"/> I/A |  |
| H                   | <input type="checkbox"/> 1 <input type="checkbox"/> 2 | <input type="checkbox"/> I <input type="checkbox"/> I/A |  |

<sup>1</sup> LABEL THE EVACUATION LEVEL OF EACH RESIDENT BEDROOM ON THE AFH FLOOR PLAN AS (I) OR (I/A)

**NOTE:** FLOOR PLAN AND KEY MUST MATCH.

### 388-76-10865 Resident evacuation from adult family home

- (1) The adult family home must be able to evacuate all residents from the home to a safe location outside the home in five minutes or less.
- (2) The home must ensure that residents are able to evacuate the home as follows:
  - (a) Through a door designated as an emergency exit;
  - (b) Via a path from the resident's bedroom that does not go through other bedrooms; and
  - (c) Without the resident having to use any of the following:
    - i. Elevator;
    - ii. Chairlift; or
    - iii. Platform lift.
- (3) Residents who require assistance with evacuation must have a path via an emergency exit to the designated safe location that does not require the use of stairs.
- (4) Ramps for residents to enter, exit, or evacuate on homes licensed after November 1, 2016 must:
  - i. Comply with chapter 51-51 WAC;
  - ii. Have a slope measuring no greater than eight and three-tenths percent in the direction of travel; and
  - iii. Have required landings at the top, bottom, and at any change of direction, with a slope measuring no greater than two percent in the direction of travel.
- (5) Homes that serve residents who are not able to hear the fire alarm warning must install visual fire alarms.

### Bedroom labeled as both "Independent / Assistance (I/A)"

The resident using this bedroom can be identified as Independent OR is identified as needing physical assistance or mobility aid(s) (cane, walker, or wheelchair) and/or two (2) or more cue to travel the bedroom through the house and main egress (exit) door to the ground.

The exit path from the bedroom **MUST NOT** have any of the following:

- Steps / stairs
- Elevators
- Chairlifts
- Platform lift

### 388-76-10870 Resident evacuation capability levels – identification required

The adult family home must ensure that each resident's assessment identified, and each resident's preliminary care plan and negotiated care plan describes the residents ability to evacuate the home according to the following descriptions:

- (1) Independent Resident is physically and mentally capable of safely getting out of the home without the assistance of another individual or in the use of mobility aids. The department will consider a resident independent if capable of getting out of the home after one verbal cue;
- (2) Assistance required: Resident is not physically or mentally capable of getting out of the house without assistance from another individual or mobility aids.

I acknowledge receipt and understanding of the "Evacuation Label" of each bedroom in my AFH.

SIGNATURE

DATE



|                                |                |                            |                 |
|--------------------------------|----------------|----------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER | PROVIDER / LICENSEE'S NAME | INSPECTION DATE |
| LICENSOR'S NAME                |                |                            |                 |

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

ATTACHMENT D

### Resident List

|  |  |                                    |                     |                   |             |                 |                                   |                  |                                |                                  |           |      |                                   |          |             |                               |                  |                  |                    |                  |                 |                |
|--|--|------------------------------------|---------------------|-------------------|-------------|-----------------|-----------------------------------|------------------|--------------------------------|----------------------------------|-----------|------|-----------------------------------|----------|-------------|-------------------------------|------------------|------------------|--------------------|------------------|-----------------|----------------|
| <p><b>See attached resident List Key.</b><br/><b>Select two residents for comprehensive reviews. Any residents chosen as expanded sample residents should <u>not</u> be identified as comprehensive residents.</b></p> |  | <b>CHECK HERE IF COMPREHENSIVE</b> | 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   |  | <input type="checkbox"/>           |                     |                   |             |                 |                                   |                  |                                |                                  |           |      |                                   |          |             |                               |                  |                  |                    |                  |                 |                |
| R2   |  | <input type="checkbox"/>           |                     |                   |             |                 |                                   |                  |                                |                                  |           |      |                                   |          |             |                               |                  |                  |                    |                  |                 |                |
| R3   |  | <input type="checkbox"/>           |                     |                   |             |                 |                                   |                  |                                |                                  |           |      |                                   |          |             |                               |                  |                  |                    |                  |                 |                |
| R4   |  | <input type="checkbox"/>           |                     |                   |             |                 |                                   |                  |                                |                                  |           |      |                                   |          |             |                               |                  |                  |                    |                  |                 |                |
| R5   |  | <input type="checkbox"/>           |                     |                   |             |                 |                                   |                  |                                |                                  |           |      |                                   |          |             |                               |                  |                  |                    |                  |                 |                |
| R6   |  | <input type="checkbox"/>           |                     |                   |             |                 |                                   |                  |                                |                                  |           |      |                                   |          |             |                               |                  |                  |                    |                  |                 |                |
| R7   |  | <input type="checkbox"/>           |                     |                   |             |                 |                                   |                  |                                |                                  |           |      |                                   |          |             |                               |                  |                  |                    |                  |                 |                |
| R8   |  | <input type="checkbox"/>           |                     |                   |             |                 |                                   |                  |                                |                                  |           |      |                                   |          |             |                               |                  |                  |                    |                  |                 |                |

|   |                            |
|---|----------------------------|
| ANY PLANNED DISCHARGES IN NEXT 30 DAYS? | ADMISSIONS IN LAST 60 DAYS |
|---|----------------------------|

|   |
|---|
| HOSPITALIZATIONS IN LAST 30 DAYS AND REASON FOR HOSPITALIZATION |
|---|



|                                |                |                            |                 |
|--------------------------------|----------------|----------------------------|-----------------|
| ADULT FAMILY HOME'S (AFH) NAME | LICENSE NUMBER | PROVIDER / LICENSEE'S NAME | INSPECTION DATE |
| LICENSOR'S NAME                |                |                            |                 |

AGING AND LONG-TERM SUPPORT ADMINISTRATION (AL TSA)  
ADULT FAMILY HOME (AFH)

ATTACHMENT D

### Resident List

**NOTE:** This form should be used to document any additional information or data that does not fit in the designated space.

NOTES



|                                |                |                            |                 |
|--------------------------------|----------------|----------------------------|-----------------|
| 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 (AL TSA)  
ADULT FAMILY HOME (AFH)  
**Resident List**

|   |   |
|---|---|
| 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. |   |
| 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                                |