| Transforming Lives | | | | Attachment J  **Assisted Living Facility  Resident Record Review** | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ASSISTED LIVING FACILITY NAME | | | | | | | | | | LICENSE NUMBER | | |
| INSPECTION DATE | | | | | LICENSOR NAME | | | | | | | |
| Inspection Type:  Initial  Full  Follow up  Monitoring  Complaint: Number | | | | | | | | | | | | |
|  | | | | | | | | | | | | |
| NAME | | | | | | ID NO. | DATE OF BIRTH | | ROOM NO. | | MOVE-IN DATE | PAY STATUS |
| FAMILY/MEMBER/RESIDENT’S REPRESENTATIVE/PHONE | | | | | | | | PERTINENT MEDICAL HISTORY/DIAGNOSES | | | | |
| **Yes** | **No** | **N/A** | **Assessment** | | | | | | | | | |
| Pre-admission (for residents admitted in last six months).  Annual to meet resident’s needs or semi-annual for EARC – Specialized Dementia Care contract.  Limited for change of condition as needed. | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | |
| **Yes** | **No** | **N/A** | **Monitoring Resident’s Well-Being** | | | | | | | | | |
| Documented.  Action taken as needed. | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | |
| **Yes** | **No** | **N/A** | **Negotiated Service Agreement (NSA)** | | | | | | | | | |
| Initial on admission and completed within 30 days (for residents admitted in last six months).  Updated as necessary.  Contents meet resident’s needs and preferences.   * Defined roles and responsibilities of resident, staff, resident’s representative, outside agency if used, and alternate plan when necessary. * Times services will be delivered including frequency and approximate time of day. * Resident’s preferences for activities and how supported. * Identifies and incorporates Resident Arranged Services (if applicable). * Identifies and incorporates External Health Providers (if applicable) | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | |
| **Yes** | **No** | **N/A** | **Medication Services:  Independent  Assistance  Administration** | | | | | | | | | |
| Family / plan.  Facility.  Appropriate for resident abilities and needs.  Review of medication record.  Documentation of refusal (if applicable) | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | |
| **Yes** | **No** | **N/A** | **Intermittent Nursing Services Provided** | | | | | | | | | |
| Nursing Service System developed.  Services identified and appropriate. | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | |
| **Yes** | **No** | **N/A** | **Modified / Therapeutic Diet** | | | | | | | | | |
| Receiving Food Services as ordered.  Receiving eating assistance. | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | |
| **Additional Notes Attachment J** | | | | | | | | | | | | |
| NAME | | | | | | | | | | | | |