|  | AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ENHANCED SERVICES FACILTY (ESF)  **ESF Resident Record Review** | | | | | | Attachment H |
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| ENHANCED SERVICES FACILITY NAME | | | | LICENSE NUMBER | ENTRANCE DATE | | |
| LICENSOR’S NAME | | Inspection Type:  Full  Complaint: Number | | | | | |
| NAME | | ID NUMBER | DATE OF BIRTH | ROOM NUMBER | | MOVE-IN DATE | |
| FAMILY / MEMBER / RESIDENT’S REPRESENTATIVE’S NAME | | REPRESENTATIVE’S PHONE NUMBER | | REASON FOR SAMPLE SELECTION | | | |
| PERTINENT MEDICAL HISTORY / DIAGNOSES | | | | | | | |
| 1. **Assessment** | | | | | | | |
| YES NO N/A  Preadmission Assessment (0040) – prior to admission (review if admitted within the last six months, expand if needed).  Comprehensive Assessment (0070) – completed within14 days from admission (review if admitted within the last six months, expand if needed).  Ongoing Comprehensive Assessment (0080) – completed after a significant change or every 180 days. | | | | | | | |
| NOTES | | | | | | | |
| 1. **Monitoring Resident’s Well-Being** | | | | | | | |
| YES NO N/A  Documented  Action taken as needed | | | | | | | |
| NOTES | | | | | | | |
| 1. **Person-Centered Service Plan (PCSP)** | | | | | | | |
| YES NO N/A  Initial PCSP (0110) – completed prior to admission (review if admitted within the last six months, expand if needed).  Initial Comprehensive PCSP (0120) – 14 days from admission  Ongoing Comprehensive PCSP (0130) – updated after a significant change, resident request, following CARE assessment, or every 180 days.  PCSP planning team meets at least monthly (or more often as needed) to review or modify plan (0100)  Contents meet resident’s assessed needs and preferences (0120 and 0130) to include:   * Care and Services provided * Documented modification to resident rights (if applicable)   Signed by Person Centered Service Planning Team (0100) to include: resident, resident representative (if applicable), Mental Health Professional, nursing staff, and Medicaid department case manager (0120)(3)(c)  Contains a Behavioral Support Plan that:   * Documents interventions for behavioral support in response to a resident’s de-escalation * Documents resident strengths that support preventative and intervention strategies * Documents steps to be taken by each of the facility staff if intervention strategies are unsuccessful | | | | | | | |
| NOTES | | | | | | | |
| 1. **Medication Services:**  **Independent**  **Assistance  Administration** | | | | | | | |
| YES NO N/A  Medication services provided by family (review plan)  Medication services provided by facility (review plan)  Appropriate for resident abilities and needs  Review of medication record  Documentation of refusal (if applicable) (0350, 0360) | | | | | | | |
| NOTES | | | | | | | |
| 1. **Modified / Therapeutic Diet** | | | | | | | |
| YES NO N/A  Receiving Food Services as ordered  Receiving eating assistance  Residents can make or select snacks and beverages without staff assistance as indicted on PCSP. | | | | | | | |
| NOTES | | | | | | | |
| **Notes** | | | | | | | |
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