| 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 |