

Assisted Living Facility Resident Characteristic Roster and Sample Selection

TOTAL CENSUS
INSPECTION DATE

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER	INSPECTION DATE
LICENSOR NAME	Visit Type: <input type="checkbox"/> Initial <input type="checkbox"/> Full <input type="checkbox"/> Follow up <input type="checkbox"/> Complaint: Number _____	

RESIDENT ROOM	ADMIT DATE	RESIDENT ID NUMBER	RESIDENT NAME	Nursing Services	Medication: Ind. (I), Assist (A), Adm. (Ad), Fam. (F)	Mobility / Falls / Ambulation Devices	Behavior / Psycho Social Issues	Dementia / Alzheimer's / Cognitive impairment	Exit Seeking / Wandering	Smoking	DD / Mental Health	Language / Communication Issue / Deafness / Hearing issues	Vision Deficit / Blindness	Diabetic: Insulin/Non-Insulin	Assist with ADL's	Wounds / Skin Issue	Incontinent / Appliance (catheter) Dialysis	Special Dietary Needs / Scheduled Snacks	Weight Loss / Weight Gain	Medical Devices	Pay Status: Private = P State = S	Recent Hospitalization	Oxygen / Respiratory Therapy	Home Health / Hospice / Private Caregiver	Other

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Coding: In order to assist in more accurate communication of resident characteristics, the following coding legend has been provided.

If characteristics do not apply, leave box blank.

	MARK THE BOX:
Nursing Services (services only a licensed nurse can provide)	O - resident receiving <u>O</u> stomy care; T - resident receiving <u>T</u> ube feeding; I – resident receiving <u>I</u> njections; ND – resident receiving <u>N</u> urse <u>D</u> elegation.
Medication: Independent Administration Assistance Family Assistance	I – resident assessed as <u>I</u> ndependent with their medication; A – resident assessed as needing <u>m</u> edication <u>a</u> ssistance; AD – resident assessed medication administration; F – resident receiving <u>F</u> amily assistance with medications.
Mobility / Falls / Ambulation Devices	A – resident requires <u>A</u> ssistance with transfers or cannot ambulate independently without assistance from staff or assistive devices; F – resident experienced a <u>F</u> all within the last 30 days; D – resident uses a <u>D</u> evice to assist with ambulation.
Behavior / Psycho Social Issues	X – resident shows or has behaviors such as those requiring special training or assistance increasing the amount of time staff needs to assist resident.
Dementia / Alzheimer’s / Cognitive impairment	X – resident shows or has behaviors requiring special training or assistance increasing the amount of time staff needs to assist resident.
Exit Seeking / Wandering	ES – resident has shown <u>E</u> xit <u>S</u> eeking behaviors; W – resident has shown <u>W</u> andering behaviors
Smoking	S – resident <u>S</u> mokes.
DD / Mental Health	DD – resident has a <u>D</u> evelopmental <u>D</u> isability case manager; MH – resident receives <u>M</u> ental <u>H</u> ealth services and/or has a mental health case manager.
Language / Communication Issues / Deafness / Hearing Issues	X – resident has a language or communication issue which requires additional staff support; HI – resident is <u>H</u> earing <u>I</u> mpaired; D – resident is <u>D</u> eaf.
Vision Deficit / Blindness	X – resident if blind or has severe vision deficit which requires additional staff support
Diabetic: Insulin / Non-Insulin	I – resident if <u>I</u> nsulin dependent; N – resident is <u>N</u> on-insulin dependent diabetic.
Assist with ADL's	I – resident assessed as <u>I</u> ndependent; MIN – resident assessed as needing <u>M</u> INimal assistance with ADL's such as curing reminders, supervision, and/or encouragement; MOD – resident assessed as needing <u>M</u> ODerate assistance with ADL's such as guiding, standby assistance for transfers, or ambulation, bathing and toileting; MAX – resident assessed as needing <u>M</u> AXimum assistance with ADL's such as needing a one person or two person transfer, resident was incontinent of bowel or bladder and required staff to assist with care; resident needed assistance with turning, sitting up or laying down, staff must physically turn the resident every two hours.
Wounds / Skin Issue	P – resident has a <u>P</u> ressure ulcer; S – resident has a <u>S</u> tasis wound; W – resident has a <u>W</u> ound or skin issue other than pressure or stasis ulcer.
Incontinent / Appliance (catheter) / Dialysis	UI – resident <u>I</u> ncontinent of bladder and/or bowel; C – resident has <u>C</u> atheter; D – resident requires <u>D</u> ialysis.
Special Dietary Needs / Scheduled Snacks	X – resident requires a special prescribed diet.
Weight Loss / Weight Gain	WL – resident has had more than a 3 – 5 pound <u>W</u> eight <u>L</u> oss within last 60 days; WG – resident has had more than a 3 – 5 pound <u>W</u> eight <u>G</u> ain within the last 60 days.
Medical Devices	X – resident receives dialysis treatments; M – if part of a residents care is the use of side rails, transfer poles, chair / bed alarms / belt restraints.
Pay Status	P – all or part of a resident’s care is paid by the resident or their family; S – all of part of a resident care is paid for by the state.
Recent Hospitalization	X – resident has been hospitalized within the last 60 days.
Oxygen / Respiratory Therapy	X – resident receives oxygen and/or respiratory therapy or treatments.
Home Health / Hospice / Private Caregiver	HH – resident receives <u>H</u> ome <u>H</u> ealth services; HOS – resident receives <u>H</u> OSpice services; P – resident receives care from <u>P</u> rivate caregiver.