| A picture containing text, clipart  Description automatically generated | | | | | | | | | | | | | ADULT FAMILY HOME’S (AFH) NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | LICENSE NUMBER | | | | | | | | | | | | |
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| PROVIDER / LICENSEE’S NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | INSPECTION DATE | | | | | | | | | | | | |
| LICENSOR’S NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT A  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT A  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Pre-Inspection Preparation** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT B  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT B  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ATTACHMENT C  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT C  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Entrance Information and Observation** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT E  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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 | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | |  | | |  | | | |  | | |
| CO-PROVIDER | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | |  | | |  | | | |  | | |
| RESIDENT MANAGER | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | |  | | |  | | | |  | | |
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| **OTHERS LIVING IN THE HOME** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **REQUIRES DIRECT CARE FROM CAREGIVERS** | | | | | | | | | | | | | | | | | | | | | **AGE 12 YEARS AND OLDER** | | | | | | |
| **YES** | | | | | | | | | | | | | **NO** | | | | | | | | **YES** | | | | **NO** | | |
|  | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | |  | | |
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| ATTACHMENT E  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT F  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Environmental Tour** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Physical Environment Outside YES NO YES NO** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| At least one egress door that opens from the inside without special effort or key? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | Bodies of water present (ponds, hot tubs, etc.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| If yes, secured? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| All exit doors have no additional locking devices? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | Water supply approved by local health authority? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| Well drained and free of safety hazards? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | Public sewer system; or | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| Adequate lighting? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | Septic system approved by local health authority? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Safety YES NO YES NO** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Emergency evacuation plan posted on each level? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | Toxic substances properly stored? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| Three gallons of water per person stored on site? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | Firearms in home? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| 72-hour emergency food supplies stored on site? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | If yes, secured? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| Flashlights? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | Medication refrigerated / locked? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| Smoke detector on each level of the house? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | First Aid kit with manual? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| At least one fire extinguisher on each floor? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| SERVICE DATE | | | | | | | | | | | | | | SERVICE DATE | | | | | | | | | | | | | | | N/A | | | | | | | | | | |
| LOCATION | | | | | | | | | | | | | | LOCATION | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Bathrooms YES NO YES NO YES NO YES NO** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Accessible to all residents? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | Clean and sanitary? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| Grab bars in tubs, showers, and next to toilets? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | One toilet for every five people? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| **Adequate water temperature** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | (OPTIONAL, IF NEEDED) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| LOCATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | LOCATION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TEMP  **OF** | | | | | | | | | | | | | | | | | TIME  AM  PM | | | | | | | | | | | | | | | | | | | | | | | TEMP  **OF** | | | | | | | | | | | | | | | | | | | | | | | TIME  AM  PM | | | | | | | | | | | | |
| **Kitchen / Dining Rooms YES NO YES NO YES NO YES NO** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Clean and sanitary? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | Adequate space for food handling, preparation, and storage? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| Food preparation observed? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| **Resident Right YES NO YES NO** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CRU hotline posted? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | AFH license (any conditions) posted? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| DRW poster visible? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | 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? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| Owner / operator information placed in a visible location in a common use area, with board meeting information, if applicable? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| **Quality of Life YES NO YES NO** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Home maintained in a clean, homelike setting? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | Indoor and outdoor common areas are safe, usable, and accessible to residents? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| Adequate furnishings? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |
| Enough space for residents? | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | |
| ATTACHMENT F  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Environmental Tour** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT G  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Environmental Tour - Bedrooms** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **BEDROOMS** | | | | | | | | | | | | | | | | | | **BEDROOM A** | | | | | | | | **BEDROOM B** | | | | | | | | | | | | | | | | **BEDROOM C** | | | | | | | **BEDROOM D** | | | | | | | | | | | | | **BEDROOM E** | | | | | | | | **BEDROOM F** | | | | | |
| Name of residents | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
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| Number of residents / capacity *(if vacant, skip Part 1 and proceed to Part 2)* | | | | | | | | | | | | | | | | | | **/** | | | | | | | | **/** | | | | | | | | | | | | | | | | **/** | | | | | | | **/** | | | | | | | | | | | | | **/** | | | | | | | | **/** | | | | | |
| **Part 1: Rooms with Residents** | | | | | | | | | | | | | | | | | | **YES NO** | | | | | | | | **YES NO** | | | | | | | | | | | | | | | | **YES NO** | | | | | | | **YES NO** | | | | | | | | | | | | | **YES NO** | | | | | | | | **YES NO** | | | | | |
| Side rails or transfer poles? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Privacy protected? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Call system? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Adequate space to allow direct, unrestricted, free access to common use areas? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Special equipment? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Part 2: All Licensed Rooms** | | | | | | | | | | | | | | | | | | **YES NO** | | | | | | | | **YES NO** | | | | | | | | | | | | | | | | **YES NO** | | | | | | | **YES NO** | | | | | | | | | | | | | **YES NO** | | | | | | | | **YES NO** | | | | | |
| Smoke detectors in each room? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Smoke detector in proximity to bedrooms? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Smoke detector heard throughout the house? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Windows open easily? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Window screens? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Windows unobstructed? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Doors open on both sides? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Doors unlocking mechanism available? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Space heaters in use? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| If yes, heaters get hot to touch? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Closet, dresser / armoire for each resident? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| ATTACHMENT G  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Environmental Tour - Bedrooms** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **BEDROOMS** | | | | | | | | | | | | | | | | | | **BEDROOM** | | | | | | | | **BEDROOM** | | | | | | | | | | | | | | | | **BEDROOM** | | | | | | | **BEDROOM** | | | | | | | | | | | | | **BEDROOM** | | | | | | | | **BEDROOM** | | | | | |
| Name of residents | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Number of residents / capacity *(if vacant, skip Part 1 and proceed to Part 2)* | | | | | | | | | | | | | | | | | | **/** | | | | | | | | **/** | | | | | | | | | | | | | | | | **/** | | | | | | | **/** | | | | | | | | | | | | | **/** | | | | | | | | **/** | | | | | |
| **Part 1: Rooms with Residents** | | | | | | | | | | | | | | | | | | **YES NO** | | | | | | | | **YES NO** | | | | | | | | | | | | | | | | **YES NO** | | | | | | | **YES NO** | | | | | | | | | | | | | **YES NO** | | | | | | | | **YES NO** | | | | | |
| Side rails or transfer poles? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Privacy protected? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Call system? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Adequate space to allow direct, unrestricted, free access to common use areas? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Special equipment? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Part 2: All Licensed Rooms** | | | | | | | | | | | | | | | | | | **YES NO** | | | | | | | | **YES NO** | | | | | | | | | | | | | | | | **YES NO** | | | | | | | **YES NO** | | | | | | | | | | | | | **YES NO** | | | | | | | | **YES NO** | | | | | |
| Smoke detectors in each room? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Smoke detector in proximity to bedrooms? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Smoke detector heard throughout the house? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Windows open easily? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Window screens? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Windows unobstructed? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Doors open on both sides? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Doors unlocking mechanism available? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Space heaters in use? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| If yes, heaters get hot to touch? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| Closet, dresser / armoire for each resident? | | | | | | | | | | | | | | | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |  | | | | | |
| ATTACHMENT G  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Environmental Tour - Bedrooms** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT I  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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 | | | | | | | | CLOSED RECORD    DISCHARGE DATE  N/A | | | | | | | | | | | | | | | | | | | | | | | | | | Medicaid policy  Notice of services every 24 months  Disclosure of charges completed and available | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DIAGNOSIS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **YES** | | | **NO** | **N/A** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Social Security Number included in the record? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Personal Belongings Inventory | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| **NOTE: “No” answers require narrative documentation.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **YES** | | | **NO** | **N/A** | | | | **ASSESSMENT** | | | | | | | | | | | | | | | | | | | | | | | | | **DATE:** | | | | | | | | | | | | | | | | | | **DATE OF PRIOR ASSESSMENT:** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Assessment prior to admission (if admitted since last inspection)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Initial assessment incudes preliminary service plan (if admitted since last inspection)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Assessment reflects the current health status / needs, preferences regarding resident rights? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Updated after a significant change in condition? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| **YES** | | | **NO** | **N/A** | | | | **NEGOTIATED CARE PLAN** | | | | | | | | | | | | | | | | | | | | | | | | | **DATE:** | | | | | | | | | | | | | | | | | | **DATE OF PRIOR CARE PLAN:** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Negotiated care plan developed within 30 days (for admission since last inspection)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Accurately addresses current:   * Care / service needs? * Hospice plan? * Crisis plan (if applicable)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Identifies preferences / choices? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Signed and dated by resident and/or representative? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| ATTACHMENT I  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Resident Record Review  (Resident:  1  2)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT J  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What is the best part about living here?  How long have you lived here?  Are you from around here?  If you could change one thing about living here, what would it be? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Other question (include the question and answer): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Select one: **Resident Interview  Representative Interview** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Instructions:** The questions identified as **\*\*HCBS** questions are **REQUIRED** questionsand **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Care and Service Needs (Required \*\*HCBS question in this section)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | \*\* Can you make choices about the care and services you receive here at the home? | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Response to Concerns (Required \*\*HCBS question in this section)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | \*\* Do they pay attention to what you have to say? | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Support of Personal Relationships (Required \*\*HCBS question in this section)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | \*\* Can you choose who visits you and when? | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Meals / Snack / Preferences (Required \*\*HCBS question in this section)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | \*\* Do you have access to food anytime? | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT J  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Comprehensive Resident / Representative Interview  (Resident:  1  2)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Respect of Individuality, Independence, Personal Choice, Dignity (Two required \*\*HCBS questions in this section)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | \*\* Can you choose to lock your door? | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | \*\* If you have a roommate, were you informed you would have a roommate? Could you change roommates if you wanted to? | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Activities (Two required \*\*HCBS questions in this section)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | \*\* Do you have an opportunity to participate in community activities? | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | \*\* Do you receive services in the community? | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Homelike Environment (Select the question asked by checking the box next to that question)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | Are you comfortable here?  Is the temperature comfortable to you?  Other: | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Reasonable House Rules (Select the question asked by checking the box next to that question)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | Tell me about the house.  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?  Other: | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Sense of Well-Being and Safety (Select the question asked by checking the box next to that question)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | Do you feel safe here?  Other: | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Notice (Select the question asked by checking the box next to that question)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | Do you handle your own finances or does someone help you with that?  What were you told about paying for your own care here?  Other: | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT J  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Comprehensive Resident / Representative Interview  (Resident:  1  2)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT I  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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 | | | | | | | | CLOSED RECORD    DISCHARGE DATE  N/A | | | | | | | | | | | | | | | | | | | | | | | | | | Medicaid policy  Notice of services every 24 months  Disclosure of charges completed and available | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DIAGNOSIS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **YES** | | | **NO** | **N/A** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Social Security Number included in the record? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Personal Belongings Inventory | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| **NOTE: “No” answers require narrative documentation.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **YES** | | | **NO** | **N/A** | | | | **ASSESSMENT** | | | | | | | | | | | | | | | | | | | | | | | | | **DATE:** | | | | | | | | | | | | | | | | | | **DATE OF PRIOR ASSESSMENT:** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Assessment prior to admission (if admitted since last inspection)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Initial assessment incudes preliminary service plan (if admitted since last inspection)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Assessment reflects the current health status / needs, preferences regarding resident rights? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Updated after a significant change in condition? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| **YES** | | | **NO** | **N/A** | | | | **NEGOTIATED CARE PLAN** | | | | | | | | | | | | | | | | | | | | | | | | | **DATE:** | | | | | | | | | | | | | | | | | | **DATE OF PRIOR CARE PLAN:** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Negotiated care plan developed within 30 days (for admission since last inspection)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Accurately addresses current:   * Care / service needs? * Hospice plan? * Crisis plan (if applicable)? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Identifies preferences / choices? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
|  | | |  |  | | | | Signed and dated by resident and/or representative? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | |
| ATTACHMENT I  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Resident Record Review  (Resident:  1  2)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT J  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| What is the best part about living here?  How long have you lived here?  Are you from around here?  If you could change one thing about living here, what would it be? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Other question (include the question and answer): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Select one: **Resident Interview  Representative Interview** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Instructions:** The questions identified as **\*\*HCBS** questions are **REQUIRED** questionsand **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Care and Service Needs (Required \*\*HCBS question in this section)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | \*\* Can you make choices about the care and services you receive here at the home? | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Response to Concerns (Required \*\*HCBS question in this section)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | \*\* Do they pay attention to what you have to say? | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Support of Personal Relationships (Required \*\*HCBS question in this section)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | \*\* Can you choose who visits you and when? | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Meals / Snack / Preferences (Required \*\*HCBS question in this section)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | \*\* Do you have access to food anytime? | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT J  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Comprehensive Resident / Representative Interview  (Resident:  1  2)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Respect of Individuality, Independence, Personal Choice, Dignity (Two required \*\*HCBS questions in this section)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | \*\* Can you choose to lock your door? | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | \*\* If you have a roommate, were you informed you would have a roommate? Could you change roommates if you wanted to? | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Activities (Two required \*\*HCBS questions in this section)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | \*\* Do you have an opportunity to participate in community activities? | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | \*\* Do you receive services in the community? | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Homelike Environment (Select the question asked by checking the box next to that question)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | Are you comfortable here?  Is the temperature comfortable to you?  Other: | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Reasonable House Rules (Select the question asked by checking the box next to that question)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | Tell me about the house.  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?  Other: | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Sense of Well-Being and Safety (Select the question asked by checking the box next to that question)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | Do you feel safe here?  Other: | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. **Notice (Select the question asked by checking the box next to that question)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Y N D | | | | | Do you handle your own finances or does someone help you with that?  What were you told about paying for your own care here?  Other: | | | | | | | | | | | | | | | | | | | | | | | | | | No Concerns | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT J  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Comprehensive Resident / Representative Interview  (Resident:  1  2)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT H  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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:   a.m.  p.m. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | RESIDENTS OBSERVED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Medication Services (preparation, delivery)  Not Observed** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Time of observation:   a.m.  p.m. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | RESIDENTS OBSERVED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Meal Services (eating, including assistance provided or adaptive equipment used)  Not Observed** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Time of observation:   a.m.  p.m. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | RESIDENTS OBSERVED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Interactions and Activities (visitors and professionals, exercise program, activities)  Not Observed** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Time of observation:   a.m.  p.m. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | RESIDENTS OBSERVED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT H  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Resident Observations** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Use this section to document any additional observations or notes. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT L  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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: 2. Has an assessment indicating the level of medication assistance needed by each resident? 3. Has a negotiated care plan identifying the medication service provided to that resident? 4. Has a medication log that is kept current? 5. Received medications as required; and 6. 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: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. Does the home have a system to address medication refusals? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes  No; if no, explain why in the section below: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. 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: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 1. 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: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ATTACHMENT L  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Resident Medication Review** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Resident:  1  2 | | | | | | | | | | | | | | | | Resident Name: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. 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 | | | | | | | | | | |
|  | | | | | | | | | | Pharmacy MAR / Label | | | | | | | | | | | Physician’s Orders | | | | | | | | | | | | | | | Written Prescription | | | | | | | | | | | | | | | No Approved Source | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | Pharmacy MAR / Label | | | | | | | | | | | Physician’s Orders | | | | | | | | | | | | | | | Written Prescription | | | | | | | | | | | | | | | No Approved Source | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | Pharmacy MAR / Label | | | | | | | | | | | Physician’s Orders | | | | | | | | | | | | | | | Written Prescription | | | | | | | | | | | | | | | No Approved Source | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | Pharmacy MAR / Label | | | | | | | | | | | Physician’s Orders | | | | | | | | | | | | | | | Written Prescription | | | | | | | | | | | | | | | No Approved Source | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | Pharmacy MAR / Label | | | | | | | | | | | Physician’s Orders | | | | | | | | | | | | | | | Written Prescription | | | | | | | | | | | | | | | No Approved Source | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | Pharmacy MAR / Label | | | | | | | | | | | Physician’s Orders | | | | | | | | | | | | | | | Written Prescription | | | | | | | | | | | | | | | No Approved Source | | | | | | | | | | | | | |  | | | | | | | | | | |
| 1. 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ATTACHMENT L  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Resident Medication Review** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Resident:  1  2 | | | | | | | | | | | | | | | | Resident Name: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. 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 | | | | | | | | | | |
|  | | | | | | | | | | Pharmacy MAR / Label | | | | | | | | | | | Physician’s Orders | | | | | | | | | | | | | | | Written Prescription | | | | | | | | | | | | | | | No Approved Source | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | Pharmacy MAR / Label | | | | | | | | | | | Physician’s Orders | | | | | | | | | | | | | | | Written Prescription | | | | | | | | | | | | | | | No Approved Source | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | Pharmacy MAR / Label | | | | | | | | | | | Physician’s Orders | | | | | | | | | | | | | | | Written Prescription | | | | | | | | | | | | | | | No Approved Source | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | Pharmacy MAR / Label | | | | | | | | | | | Physician’s Orders | | | | | | | | | | | | | | | Written Prescription | | | | | | | | | | | | | | | No Approved Source | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | Pharmacy MAR / Label | | | | | | | | | | | Physician’s Orders | | | | | | | | | | | | | | | Written Prescription | | | | | | | | | | | | | | | No Approved Source | | | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | Pharmacy MAR / Label | | | | | | | | | | | Physician’s Orders | | | | | | | | | | | | | | | Written Prescription | | | | | | | | | | | | | | | No Approved Source | | | | | | | | | | | | | |  | | | | | | | | | | |
| 1. 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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ATTACHMENT L  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT L  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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  Do staff ensure the resident’s safety, property, dignity, and rights are protected?  Do you have any concerns about how the resident(s) are treated?  Do you feel the resident’s care needs are being met?  Can the resident choose to lock their door?  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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT L  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT M  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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 | | | | | | | | | | | | YES  NO | | | | | | | | | | | YES  NO | | | | | | | | | | | | | | | | | | | | YES  NO | | | | | | | | | | | YES  NO | | | | | | | | | | | | | YES  NO | | | | | | | | |
| BGI EXPIRE DATE\* | | | | | | | | | | | | NR  RR  DQ | | | | | | | | | | | NR  RR  DQ | | | | | | | | | | | | | | | | | | | | NR  RR  DQ | | | | | | | | | | | NR  RR  DQ | | | | | | | | | | | | | NR  RR  DQ | | | | | | | | |
| FINGERPRINT CHECK DATE (CHECK N/A IF NOT REQUIRED) | | | | | | | | | | | | PENDING  N/A | | | | | | | | | | | PENDING  N/A | | | | | | | | | | | | | | | | | | | | PENDING  N/A | | | | | | | | | | | PENDING  N/A | | | | | | | | | | | | | PENDING  N/A | | | | | | | | |
| CCS EVALUATION\* | | | | | | | | | | | | N/A | | | | | | | | | | | N/A | | | | | | | | | | | | | | | | | | | | N/A | | | | | | | | | | | N/A | | | | | | | | | | | | | N/A | | | | | | | | |
| TB TESTING MET | | | | | | | | | | | | YES  NO | | | | | | | | | | | YES  NO | | | | | | | | | | | | | | | | | | | | YES  NO | | | | | | | | | | | YES  NO | | | | | | | | | | | | | YES  NO | | | | | | | | |
| ORIENTATION AND SAFETY (5 HOURS) | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| 70 HOUR BASIC **OR** | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| FUNDAMENTALS OF CAREGIVING (WORKED PRIOR TO 01/01/202012) | | | | | | | | | | | | ATTESTATION | | | | | | | | | | | ATTESTATION | | | | | | | | | | | | | | | | | | | | ATTESTATION | | | | | | | | | | | ATTESTATION | | | | | | | | | | | | | ATTESTATION | | | | | | | | |
| CPR EXP. DATE | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| FIRST AID EXP. DATE | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| ND\* TRAINING | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| ND DIABETES FOCUS | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| FOOD HANDLER EXP. | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| **OR** FOOD SAFETY CE | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| DOH LICENSE **TYPE**: | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| DOH LICENSE **EXP**. | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| NUMBER OF CE HOURS (N/A, IF NOT REQUIRED) | | | | | | | | | | | | N/A | | | | | | | | | | | N/A | | | | | | | | | | | | | | | | | | | | N/A | | | | | | | | | | | N/A | | | | | | | | | | | | | N/A | | | | | | | | |
| **SPECILTY TRAINING** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DEMENTIA  N/A | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| MENTAL HEALTH  N/A | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| DDA  N/A | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| \* BGI - Background Inquiry; NR - No Record; RR - Review Required; DQ - Disqualifying, CCS - Character, Competency, and Suitability; ND - Nurse Delegation; CE - Continuing Education | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT M  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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 | | | | | | | | | | | | Positive  Negative | | | | | | | | | | | Positive  Negative | | | | | | | | | | | | | | | | | | | | Positive  Negative | | | | | | | | | | | Positive  Negative | | | | | | | | | | | | | Positive  Negative | | | | | | | | |
| DATE ADMINISTERED | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| STEP 2 READ | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| RESULT | | | | | | | | | | | | Positive  Negative | | | | | | | | | | | Positive  Negative | | | | | | | | | | | | | | | | | | | | Positive  Negative | | | | | | | | | | | Positive  Negative | | | | | | | | | | | | | Positive  Negative | | | | | | | | |
| 1 ADDITIONAL TEST DATE ADMINISTERED | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| 1 ADDITIONAL TEST DATE READ | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| RESULT | | | | | | | | | | | | Positive  Negative | | | | | | | | | | | Positive  Negative | | | | | | | | | | | | | | | | | | | | Positive  Negative | | | | | | | | | | | Positive  Negative | | | | | | | | | | | | | Positive  Negative | | | | | | | | |
| BLOOD TEST | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| RESULT | | | | | | | | | | | | Positive  Negative | | | | | | | | | | | Positive  Negative | | | | | | | | | | | | | | | | | | | | Positive  Negative | | | | | | | | | | | Positive  Negative | | | | | | | | | | | | | Positive  Negative | | | | | | | | |
| X-RAY | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | |
| RESULT | | | | | | | | | | | | Positive  Negative | | | | | | | | | | | Positive  Negative | | | | | | | | | | | | | | | | | | | | Positive  Negative | | | | | | | | | | | Positive  Negative | | | | | | | | | | | | | Positive  Negative | | | | | | | | |
| NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT N  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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 | | | | | | | | | | | NR  RR  DQ | | | | | | | | | | | | | NR  RR  DQ | | | | | | | | | | | | | | | | | | | | NR  RR  DQ | | | | | | | | | | | NR  RR  DQ | | | | | | | | | | | | | NR  RR  DQ | | | | | | | |
| FINGERPRINT CHECK (CHECK N/A IF NOT REQUIRED) | | | | | | | | | | | N/A  PENDING | | | | | | | | | | | | | N/A  PENDING | | | | | | | | | | | | | | | | | | | | N/A  PENDING | | | | | | | | | | | N/A  PENDING | | | | | | | | | | | | | N/A  PENDING | | | | | | | |
| CCS REVIEW (CHECK N/A IF NOT REQUIRED) | | | | | | | | | | | N/A | | | | | | | | | | | | | N/A | | | | | | | | | | | | | | | | | | | | N/A | | | | | | | | | | | N/A | | | | | | | | | | | | | N/A | | | | | | | |
| **STAFF** | | | | | | | | | | | **CAREGIVER** | | | | | | | | | | | | | **CAREGIVER** | | | | | | | | | | | | | | | | | | | | **CAREGIVER** | | | | | | | | | | | **CAREGIVER** | | | | | | | | | | | | | **CAREGIVER** | | | | | | | |
| NAME | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |
| DATE OF HIRE | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | |
| BGI EXPIRE DATE | | | | | | | | | | | NR  RR  DQ | | | | | | | | | | | | | NR  RR  DQ | | | | | | | | | | | | | | | | | | | | NR  RR  DQ | | | | | | | | | | | NR  RR  DQ | | | | | | | | | | | | | NR  RR  DQ | | | | | | | |
| FINGERPRINT CHECK (CHECK N/A IF NOT REQUIRED) | | | | | | | | | | | N/A  PENDING | | | | | | | | | | | | | N/A  PENDING | | | | | | | | | | | | | | | | | | | | N/A  PENDING | | | | | | | | | | | N/A  PENDING | | | | | | | | | | | | | N/A  PENDING | | | | | | | |
| CCS REVIEW (CHECK N/A IF NOT REQUIRED) | | | | | | | | | | | N/A | | | | | | | | | | | | | N/A | | | | | | | | | | | | | | | | | | | | N/A | | | | | | | | | | | N/A | | | | | | | | | | | | | N/A | | | | | | | |
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| 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.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **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 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT N  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Administrative Records Review Continuation** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT O  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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 | | | | | | | | | | | | | | | NR  RR  DQ | | | | | | | NR  RR  DQ | | | | | | | | | | | | | NR  RR  DQ | | | | | | | | | | | | NR  RR  DQ | | | | | | | | | | | | | NR  RR  DQ | | | | | | | | | | | NR  RR  DQ | | | | |
| FINGERPRINT CHECK (CHECK N/A IF NOT REQUIRED) | | | | | | | | | | | | | | | N/A  PENDING | | | | | | | N/A  PENDING | | | | | | | | | | | | | N/A  PENDING | | | | | | | | | | | | N/A  PENDING | | | | | | | | | | | | | N/A  PENDING | | | | | | | | | | | N/A  PENDING | | | | |
| CCS REVIEW\*  (check N/A If not required) | | | | | | | | | | | | | | | N/A | | | | | | | N/A | | | | | | | | | | | | | N/A | | | | | | | | | | | | N/A | | | | | | | | | | | | | N/A | | | | | | | | | | | N/A | | | | |
| **Instructions:** Document background check results for other individuals who have unsupervised access to vulnerable adults here. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **OTHERS WITH UNSUPERVISED ACCESS** | | | | | | | | | | | | | | | **OTHER** | | | | | | | **OTHER** | | | | | | | | | | | | | **OTHER** | | | | | | | | | | | | **OTHER** | | | | | | | | | | | | | **OTHER** | | | | | | | | | | | **OTHER** | | | | |
| NAME | | | | | | | | | | | | | | |  | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | | |  | | | | | | | | | | | | |  | | | | | | | | | | |  | | | | |
| BGI EXPIRE DATE | | | | | | | | | | | | | | | NR  RR  DQ | | | | | | | NR  RR  DQ | | | | | | | | | | | | | NR  RR  DQ | | | | | | | | | | | | NR  RR  DQ | | | | | | | | | | | | | NR  RR  DQ | | | | | | | | | | | NR  RR  DQ | | | | |
| FINGERPRINT CHECK (CHECK N/A IF NOT REQUIRED) | | | | | | | | | | | | | | | N/A  PENDING | | | | | | | N/A  PENDING | | | | | | | | | | | | | N/A  PENDING | | | | | | | | | | | | N/A  PENDING | | | | | | | | | | | | | N/A  PENDING | | | | | | | | | | | N/A  PENDING | | | | |
| CCS REVIEW\*  (check N/A If not required) | | | | | | | | | | | | | | | N/A | | | | | | | N/A | | | | | | | | | | | | | N/A | | | | | | | | | | | | N/A | | | | | | | | | | | | | N/A | | | | | | | | | | | N/A | | | | |
| \* BGI - Background Inquiry; NR - No Record; RR - Review Required; DQ - Disqualifying, CCS - Character, Competency, and Suitability | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ATTACHMENT O  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Administrative Records Review - Former Staff and Others with Unsupervised Access** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ATTACHMENT P  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Provider / Resident Manager Interview** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Provider  Resident Manager | | | | | | | | | | | | | | | NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | TIME  AM  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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **RESIDENT RIGHTS**   * What do you do to promote resident dignity, quality of life and privacy? * What do you do if you see or discover resident rights being violated? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **RESIDENT GRIEVANCES**   * What do you do if you have a resident who says they are unhappy about the care in this home? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CARE AND SERVICES**   * What types of daily choices do the residents in the home make? * How do you help residents feel comfortable here? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ABUSE / NEGLECT / EXPLOITATION**   * Please give an example of abuse, neglect or exploitation. * What do you do if you see or discovered abuse, exploitation, or neglect? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **RESIDENT BEHAVIOR / FACILITY PRACTICE**   * What do you do if a resident is missing? * Do any residents have challenging behaviors? If yes, what behaviors? How do you manage those behaviors? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ACCIDENT / INJURY / PREVENTION**   * What do you do if a resident falls? * How do you know what each resident needs in the event of an accident or injury? * Who do you need to notify if a resident is injured? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **STAFFING**   * Do you work alone? * How do you get help? * How does staff contact the provider? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **EMERGENCY MANAGEMENT**   * When did you last participate in an evacuation drill? * Where is the meeting place? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT P  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Provider / Resident Manager Interview** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ATTACHMENT P  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Staff Interview** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Caregiver | | | | | | | SHIFT | | | | | | | | | | | | | | | | | | NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | TIME  AM  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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **RESIDENT RIGHTS**   * What do you do to promote resident dignity, quality of life and privacy? * What do you do if you see or discover resident rights being violated? | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **RESIDENT GRIEVANCES**   * What do you do if you have a resident who says they are unhappy about the care in this home? | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CARE AND SERVICES**   * What types of daily choices do the residents in the home make? * How do you help residents feel comfortable here? | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ABUSE / NEGLECT / EXPLOITATION**   * Please give an example of abuse, neglect or exploitation. * What do you do if you see or discovered abuse, exploitation, or neglect? | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **RESIDENT BEHAVIOR / FACILITY PRACTICE**   * What do you do if a resident is missing? * Do any residents have challenging behaviors? If yes, what behaviors? How do you manage those behaviors? | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ACCIDENT / INJURY / PREVENTION**   * What do you do if a resident falls? * How do you know what each resident needs in the event of an accident or injury? * Who do you need to notify if a resident is injured? | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **STAFFING**   * Do you work alone? * How do you get help? * How does staff contact the provider? | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **EMERGENCY MANAGEMENT**   * When did you last participate in an evacuation drill? * Where is the meeting place? | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT O  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Staff Interview** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ATTACHMENT R  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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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| ATTACHMENT R  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Exit Preparation Worksheet** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ATTACHMENT U  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| ATTACHEMENT S  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  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 1  (CHECK ONE) | | | | | | | | | | | | | | | | | | | | | | | | | | **KEY: Determining evacuation level label for each resident bedroom as Independent (I) OR Independent / Assistance (I/A)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| A | | | | | 1  2 | | | | | | | | | | | | | I  I/A | | | | | | | | | | | | | | | | | | | | | | | | | |
| B | | | | | 1  2 | | | | | | | | | | | | | I  I/A | | | | | | | | | | | | | | | | | | | | | | | | | | **Bedroom labeled as “Independent (I)”**  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.  The exit path from the bedroom may have any of the following:   * Steps / stairs * Ramp * No step / stairs or ramp | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| C | | | | | 1  2 | | | | | | | | | | | | | I  I/A | | | | | | | | | | | | | | | | | | | | | | | | | |
| D | | | | | 1  2 | | | | | | | | | | | | | I  I/A | | | | | | | | | | | | | | | | | | | | | | | | | |
| E | | | | | 1  2 | | | | | | | | | | | | | I  I/A | | | | | | | | | | | | | | | | | | | | | | | | | |
| F | | | | | 1  2 | | | | | | | | | | | | | I  I/A | | | | | | | | | | | | | | | | | | | | | | | | | |
| G | | | | | 1  2 | | | | | | | | | | | | | I  I/A | | | | | | | | | | | | | | | | | | | | | | | | | |
| H | | | | | 1  2 | | | | | | | | | | | | | I  I/A | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1 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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **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. | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **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: 3. Through a door designated as an emergency exit; 4. Via a path from the resident’s bedroom that does not go through other bedrooms; and 5. Without the resident having to use any of the following: 6. Elevator; 7. Chairlift; or 8. Platform lift. 9. 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. 10. Ramps for residents to enter, exit, or evacuate on homes licensed after November 1, 2016 must:     * 1. Comply with chapter 51-51 WAC;       2. Have a slope measuring no greater than eight and three-tenths percent in the direction of travel; and       3. 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. 11. Homes that serve residents who are not able to hear the fire alarm warning must install visual fire alarms. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **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 | | | | | | | | | | | | | | | | | | | | | | | | | |
| ATTACHMENT D  AGING AND LONG-TERM SUPPORT ADMINISTRATION (ALTSA)  ADULT FAMILY HOME (AFH)  **Resident List** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **See attached resident List Key.**  **Select two residents for comprehensive reviews. Any residents chosen as expanded sample residents should not be identified as comprehensive residents.** | | | | **CHECK HERE IF COMPREHENSIVE** | 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 |  | | |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |
| R2 |  | | |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |
| R3 |  | | |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |
| R4 |  | | |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |
| R5 |  | | |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |
| R6 |  | | |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |
| R7 |  | | |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |
| R8 |  | | |  |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |
| ANY PLANNED DISCHARGES IN NEXT 30 DAYS? | | | | | | | | | | | | ADMISSIONS IN LAST 60 DAYS | | | | | | | | | | | | | | | |
| HOSPITALIZATIONS IN LAST 30 DAYS AND REASON FOR HOSPITALIZATION | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **NOTE:** This form should be used to document any additional information or data that does not fit in the designated space. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NOTES | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 | | | | | | | | | | | | | | | | | | | | | | | | |