ALF SURVEY PREPARATION TIPS AND TRICKS

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June 10, 2025

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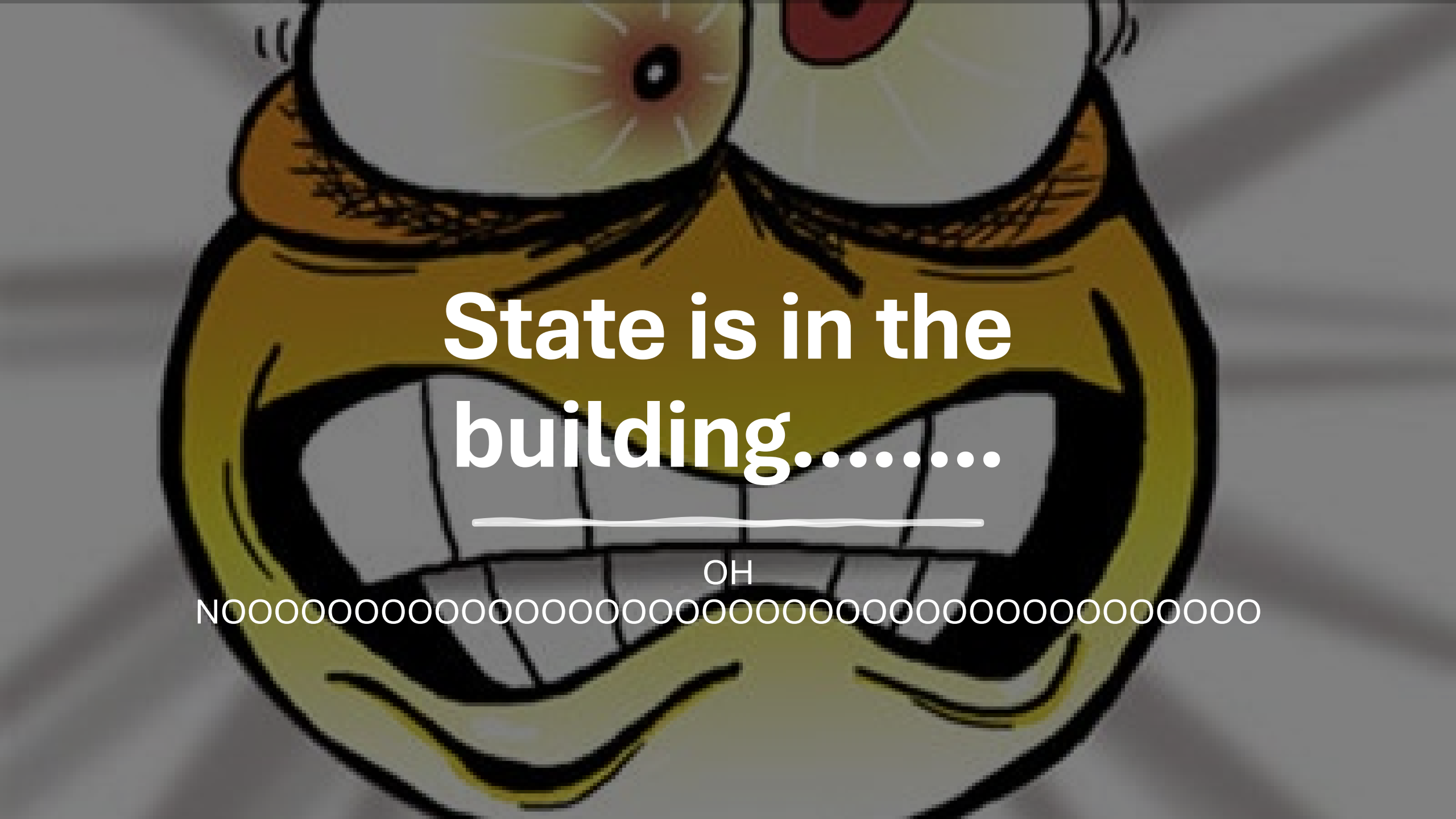
AGENDA


State is in the building.....
OH
NOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOOO

RESIDENT CARE SURVEY

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FACILITY NAME	☐ RCFI ☐ RCFII ☐ ALFI ☐ ALFII	FACILITY ID NUMBER
ADDRESS (STREET, CITY)		

CAPACITY	CENSUS	ADULT DAY CARE PARTICIPANTS	DMH PLACED RESIDENTS

NO. OF RESIDENTS	CATEGORY
	1. Residents using canes _____ walkers _____ wheelchairs _____ **(List number of each)**
	2. Residents requiring staff assistance with transfer or ambulation - List names in comments or attach a list
	3. Residents who are blind _____ or deaf or require use of hearing aids _____ **(List number of each)**
	4. Residents with catheters
	5. Residents who are frequently to totally incontinent of bladder and/or bowel
	6. Residents with a mental illness diagnosis and/or a developmental disability
	7. Residents who receive a physician prescribed special diet (other than regular)
	8. Residents who have pressure sores/ulcers _____ or other skin issues _____ **(List number of each)**
	9. Residents who self-administer prescription or over-the-counter medication
	10. Residents who are diabetic and insulin dependent
	11. Residents who have experienced falls in the past 60 days
	12. Residents with a diagnosis of Alzheimer's disease or dementia
	13. Residents hospitalized during the last 45 days
	14. Residents experiencing a short period of incapacity (45 day timeframe) due to illness, injury or recuperation from surgery
	15. Residents who required infectious disease treatment within the last 30 days
	16. Residents receiving hospice
	17. New residents in the last 30 days
	18. Residents who reside above the first floor
	19. Residents who require the use of oxygen
	20. Residents who are an elopement risk
	21. Residents who require physical or chemical restraints
	22. Residents who have exhibited behaviors that present a reasonable likelihood of harm to themselves or others
	23. Residents who are mentally incapable and/or require physical assistance or the use of an assistive device in order to negotiate a pathway to safety. List names in comments or attach a list.
	24. **ALF IIs only:** Residents with a physical, cognitive, or other impairment who require more than minimal assistance in order to safely evacuate the facility. The following actions required of staff are considered to be more than minimal assistance: assistance to traverse down stairways, assistance to open a door, and assistance to propel a wheelchair. List names in comments or attach a list.

COMMENTS

DOCUMENTATION NEEDED: EMPLOYEE

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FACILITY NAME	SURVEYOR NAME / ID NUMBER
FACILITY NUMBER	DATE / ACTIVITY

TIME/SOURCE OF EVIDENCE	DOCUMENTATION
	○ **Employee Name:** ○ Job Title
	○ Address:
	○ Social Security Number:
	○ Date of Birth: ○ Date of Hire
	○ Certification/Education
	○ Criminal Background Check/○ FCSR: Request_____ Received _____
	○ Findings:
	○ Reason for Termination (if applicable)
	○ EDL check:
	○ TB status:
	○ Physician Statement:
	Orientation Training:
	○ Job responsibilities:
	○ Emergency response:
	○ Infection control/hand washing:
	○ Hippa:
	○ Preservation of Resident Dignity:
	○ Abuse/Neglect
	○ Resident Rights/Protection of Property:
	○ EDL info
RCF II N/A	○ Mental Illness:
RCF II N/A	○ Alzheimer's Training:
	○ *ALF Transfer Training:*
	○ *ALF Person Centered Care/ Social Model of Care:*

DOCUMENTATION NEEDED: RESIDENT

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FACILITY NUMBER	DATE	ACTIVITY

TIME/SOURCE OF EVIDENCE	DOCUMENTATION	
	○ Resident Name:	
	○ Admission Date:	
	○ Confidential Number:	
	○ Previous Address:	
	○ Date of Birth:	
	○ Sex	
	○ Marital Status:	
	○ Social Security Number:	
	○ Medicare/Medicaid Number:	
	○ Name/Phone Number of Physician:	
	○ Alternate Physician:	
	○ Pharmacist:	○ Diet Order
	○ Dentist:	○ Funeral Director:
	○ Admission Agreement:	○ Resident Rights:
	○ Personal Inventory:	○ TB testing:
	○ Name/Address of legal Authorized responsible party/designee to be notified in emergency:	
	○ History and Physical:	
	○ Diagnosis:	

DOCUMENTATION NEEDED: RESIDENT

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FACILITY NUMBER	DATE	ACTIVITY

TIME/SOURCE OF EVIDENCE	DOCUMENTATION
	○ **Resident Name:**
	○ Physician Reviews:
	○ Pharmacy Reviews:
	○ Medications: ○Date of POS: ○ Labs:

DOCUMENTATION NEEDED: RESIDENT, MONTHLY SUMMARY AND NOTES

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FACILITY NUMBER	DATE	ACTIVITY

TIME/SOURCE OF EVIDENCE	DOCUMENTATION
	○ **Resident Name:**
	○ Monthly Summaries: Include weights
	○ Review of Nursing Notes:

DOCUMENTATION NEEDED: RESIDENT, PRE-SCREEN, CBA, ISP/IEP

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FACILITY NUMBER	DATE	ACTIVITY

TIME/SOURCE OF EVIDENCE	DOCUMENTATION
	○ **Resident Name:**
	○ *Assisted Living Facilities:*
	○ Pre-Screen
	○ CBA (Community Based Assessment)
	○ ISP/IEP (Individual Service Plan) (Individual Evacuation Plan)

DOCUMENTATION NEEDED: RESIDENT, PRE-SCREEN

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ADDRESS (STREET, CITY, STATE, ZIP)

PERSON IS CURRENTLY

☐ Living Independently ☐ Living in Residential Care Facility ☐ Hospitalized
☐ Other _____

COMMENTS

TELEPHONE	DOB	SEX
		☐ Male ☐ Female

MARITAL STATUS

☐ Single ☐ Married ☐ Never Married ☐ Divorced/Separated ☐ Widow(er)

Resident able to participate in providing above information?	☐ YES	☐ NO
Resident bed-bound or similarly immobilized?	☐ YES Disqualify	☐ NO Qualify
Has the resident exhibited behaviors that present a reasonable likelihood of serious harm to self or others?	☐ YES Disqualify	☐ NO Qualify
Resident requires a physical restraint?	☐ YES Disqualify	☐ NO Qualify
Resident uses a medication as a chemical restraint? (medication not used to treat a medical condition)	☐ YES Disqualify	☐ NO Qualify
Resident requires more than one person to simultaneously physically assist with any activities of daily living other than bathing and/or transferring?	☐ YES Disqualify	☐ NO Qualify
Resident has a condition that requires skilled nursing services? If yes, please list:	☐ YES	☐ NO

TO BE DETERMINED BY PERSON DOING RESIDENT ASSESSMENT

☐ Yes Resident meets criteria for admission to Assisted Living Facility. **Proceed to complete a community based assessment using the attached or a form which has received prior approval from the Section for Long Term Care Regulation.**

☐ Yes Resident meets criteria for admission to Assisted Living Facility which provides services to residents with a physical, cognitive or other impairment that prevents the resident from safely evacuating the facility with minimal assistance. **Proceed to complete a community based assessment using the attached or a form which has received prior approval from the Section for Long Term Care Regulation.**

☐ No Resident is not eligible for admission to an Assisted Living Facility.

DOCUMENTATION NEEDED: RESIDENT, CBA

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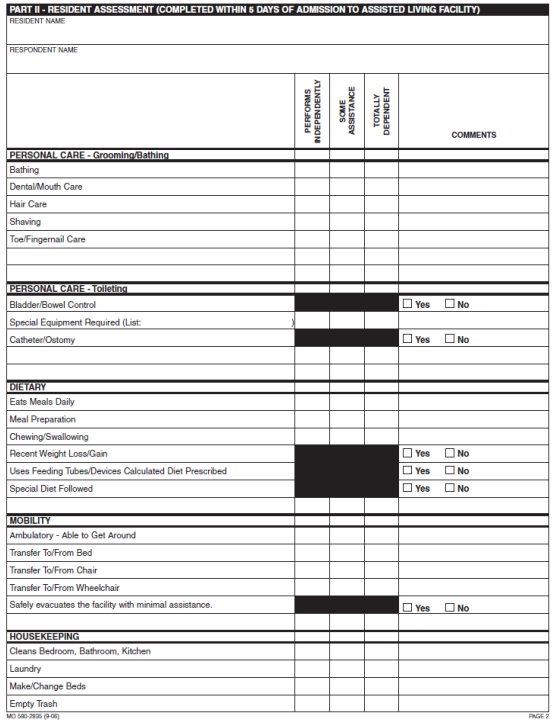

PART II - RESIDENT ASSESSMENT (COMPLETED WITHIN 5 DAYS OF ADMISSION TO ASSISTED LIVING FACILITY)

RESIDENT NAME

RESPONDENT NAME

	PERFORMS INDEPENDENTLY	SOME ASSISTANCE	TOTALLY DEPENDENT	COMMENTS
PERSONAL CARE - Grooming/Bathing				
Bathing				
Dental/Mouth Care				
Hair Care				
Shaving				
Toe/Fingernail Care				
PERSONAL CARE - Toileting				
Bladder/Bowel Control				☐ Yes ☐ No
Special Equipment Required (List:)				
Catheter/Ostomy				☐ Yes ☐ No
DIETARY				
Eats Meals Daily				
Meal Preparation				
Chewing/Swallowing				
Recent Weight Loss/Gain				☐ Yes ☐ No
Uses Feeding Tubes/Devices Calculated Diet Prescribed				☐ Yes ☐ No
Special Diet Followed				☐ Yes ☐ No
MOBILITY				
Ambulatory - Able to Get Around				
Transfer To/From Bed				
Transfer To/From Chair				
Transfer To/From Wheelchair				
Safely evacuates the facility with minimal assistance.				☐ Yes ☐ No
HOUSEKEEPING				
Cleans Bedroom, Bathroom, Kitchen				
Laundry				
Make/Change Beds				
Empty Trash				

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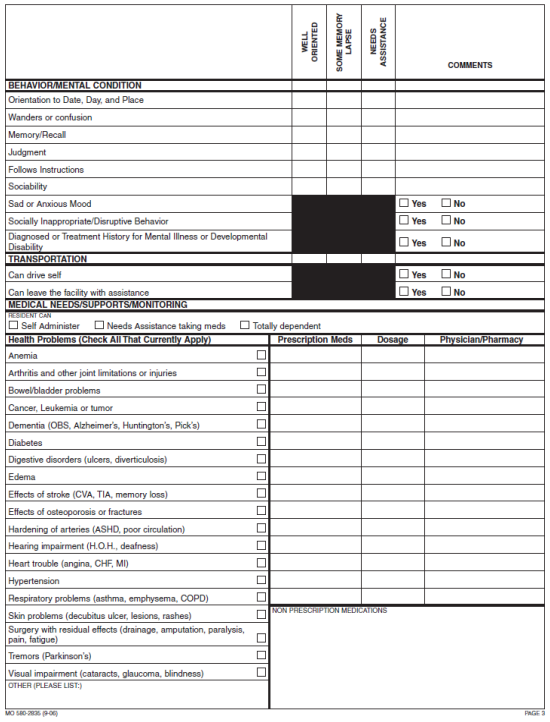

	WELL ORIENTED	SOME MEMORY LAPSE	NEEDS ASSISTANCE	COMMENTS
BEHAVIOR/MENTAL CONDITION				
Orientation to Date, Day, and Place				
Wanders or confusion				
Memory/Recall				
Judgment				
Follows Instructions				
Sociability				
Sad or Anxious Mood				☐ Yes ☐ No
Socially Inappropriate/Disruptive Behavior				☐ Yes ☐ No
Diagnosed or Treatment History for Mental Illness or Developmental Disability				☐ Yes ☐ No
TRANSPORTATION				
Can drive self				☐ Yes ☐ No
Can leave the facility with assistance				☐ Yes ☐ No

MEDICAL NEEDS/SUPPORTS/MONITORING

RESIDENT CAN

☐ Self Administer ☐ Needs Assistance taking meds ☐ Totally dependent

Health Problems (Check All That Currently Apply)	Prescription Meds	Dosage	Physician/Pharmacy
Anemia ☐			
Arthritis and other joint limitations or injuries ☐			
Bowel/bladder problems ☐			
Cancer, Leukemia or tumor ☐			
Dementia (OBS, Alzheimer's, Huntington's, Pick's) ☐			
Diabetes ☐			
Digestive disorders (ulcers, diverticulosis) ☐			
Edema ☐			
Effects of stroke (CVA, TIA, memory loss) ☐			
Effects of osteoporosis or fractures ☐			
Hardening of arteries (ASHD, poor circulation) ☐			
Hearing impairment (H.O.H., deafness) ☐			
Heart trouble (angina, CHF, MI) ☐			
Hypertension ☐			
Respiratory problems (asthma, emphysema, COPD) ☐			
Skin problems (decubitus ulcer, lesions, rashes) ☐	NON PRESCRIPTION MEDICATIONS		
Surgery with residual effects (drainage, amputation, paralysis, pain, fatigue) ☐			
Tremors (Parkinson's) ☐			
Visual impairment (cataracts, glaucoma, blindness) ☐			
OTHER (PLEASE LIST:)			

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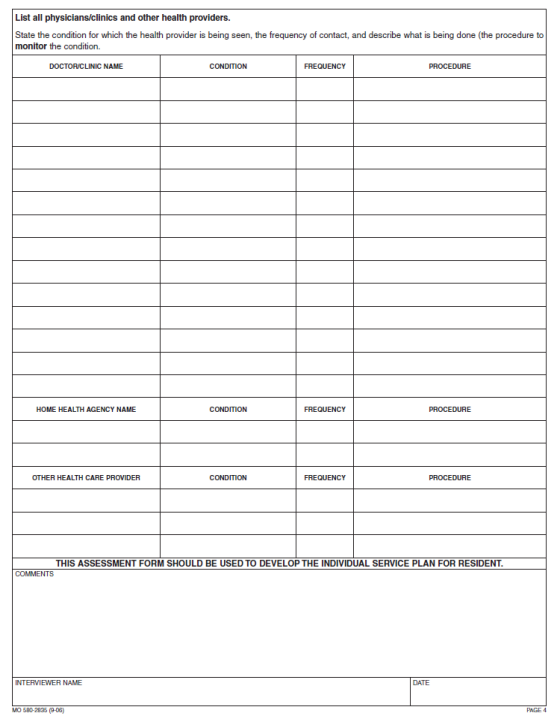

List all physicians/clinics and other health providers.

State the condition for which the health provider is being seen, the frequency of contact, and describe what is being done (the procedure to **monitor** the condition.

DOCTOR/CLINIC NAME	CONDITION	FREQUENCY	PROCEDURE
HOME HEALTH AGENCY NAME	**CONDITION**	**FREQUENCY**	**PROCEDURE**
OTHER HEALTH CARE PROVIDER	**CONDITION**	**FREQUENCY**	**PROCEDURE**

THIS ASSESSMENT FORM SHOULD BE USED TO DEVELOP THE INDIVIDUAL SERVICE PLAN FOR RESIDENT.

COMMENTS

INTERVIEWER NAME DATE

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ISP

IEP

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TIPS AND TRICKS

ADMISSION PACKETS

Move in Checklist

Admission Audit

Resident Orientation Checklist

Pre-Screen and CBA

AUDITS AND TRACKING

Schedule of assessments

Clinical Chart Audits quarterly

Update resident care survey

HR files and education

ADMISSION PACKET: MOVE IN CHECKLIST

AL/ALMC Clinical Move in Check List

__Fax cover letter and Med Cert to Physician. Date sent_____

__Received Med Cert and orders from physician, to include med list, H & P, etc. Date Received_____

__MO Pre-Screen (MO 580-2835 (9-06), section 1 completed prior to admission but must be completed before admission. Date completed_____Date sent to med records_____

__MO Community Based Assessment (CBA), (MO 580-2835 (9-06)) to be completed no more than 5 days post admission in MyUnity. If on paper, send to med records. Date sent to med records, if applicable_____

__Resident needs assessment completed upon admission

__Resident rights review/education to resident and/or family upon admission

__New Resident AL Acknowledgements signed by resident and/or family upon admission. Date sent to med records_____

__Inventory of Personal Belongings by staff upon admission. Place in hard chart until DC – then forward to med records.

__Billing notification of move in date completed and sent to Business office (BO). Date sent to BO_____

__Authorization of Use and Disclosure signed by resident and/or family. Date sent to med records_____

__My Story Packet upon admission

__TB test order(s) placed in MyUnity utilizing TB order set

__ISP to completed in MyUnity within 7 days of admission. Assess for IEP. Complete if applicable.

__Scheduler set up in MyUnity to include touchscreen documentation.

__Pendants, if needed, request sent to maintenance. Date sent_____

__Key cards for family members, request sent to maintenance. Date sent_____

__Keys to Apartment for AL requested from maintenance. Date sent_____

__Name plate on door completed by Al receptionist prior to move in

__Upload picture into MyUnity completed by AL receptionist upon move in

__DNR signed (if applicable). Keep in chart – send copy to med records. Date sent_____

- Follows guidelines for:
  - Pre-screen
  - CBA
  - ISP/IEP

Also includes surveyor information requested:

- Resident rights
- Admission agreement
- Personal Inventory
- TB order
- Code Status

ADMISSION PACKET: ADMISSION AUDIT

PAGE 1

Admission Process Audit—AL/ALMC

Name of Guest: _____ Rm # _____ Admit Date: _____

Admission Item	Met	Unmet—Action	Recommendation
RIBBON			
1. **Bed Assignment:** Verify Guest is in the correct room			
2. **Verify/Add Allergies:** Verify allergies are entered • No allergies=NKA			
3. **Verify/Add Physician:** Verify there is a physician assigned			
4. **Code Status** • Make sure there is an order in Orders and in Ribbon			
5. **Diagnosis** • Primary diagnosis is correct • Co-morbidities			
6. **Resident photo**: • Verify the photo is in the ribbon			
Alerts			
1. **Anticoagulant** • **PT/INR ordered** • **Add to ISP**			
Vitals			
1. **Vitals signs upon admission** 2. **Weight upon admission** 3. **Height upon admission**			
Assessments			
Admission Assessment completed, signed, locked			
Community Based Assessment (CBA) • **Pre-Screen—**prior to admission **Assessment—**within 5 days of admission			
Individual Needs Assessment (AL only)—Upon admission			
TB 2 step initiated • **1st step must be given within 24 hours of admission** • **2nd step given 10-14 days later**			
Medication Self Administration—as needed for residents that self-medicate			
Individualized Evacuation Plan—(MO only) Complete for affected residents (No more than 1			

1

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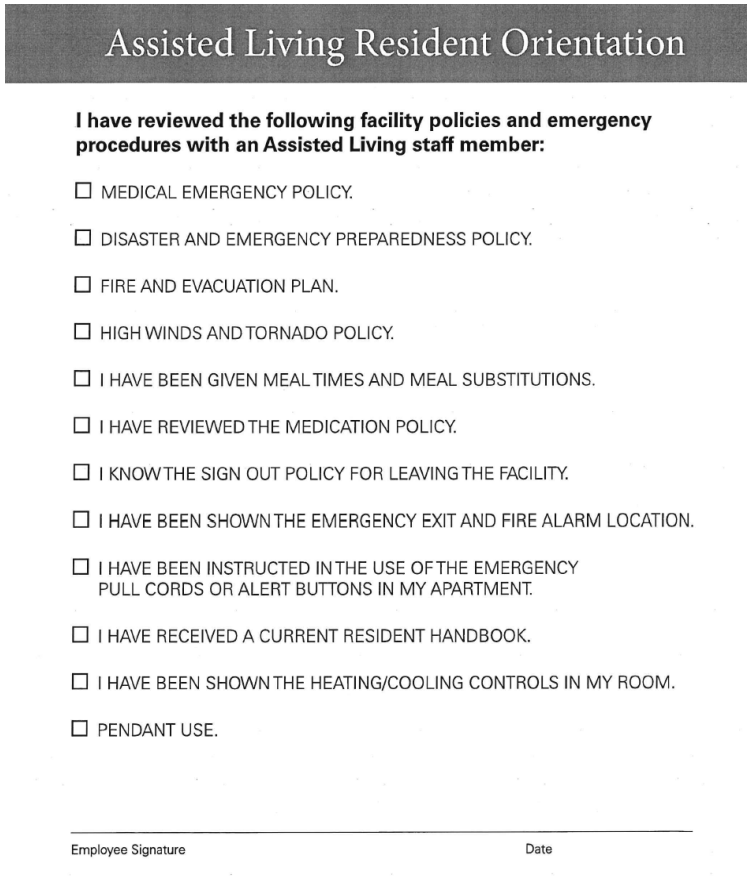
physical intervention and not more than 3 verbal interventions)			
52 Week Wound Assessment as needed ○ Complete weekly and PRN ○ Reason in the Reason column			
Individualized Service Plan • Upon admission then review/edit yearly and with significant change • Signed by staff and resident/representative ○ Fall ○ Wound ○ Weight Change ○ Behavior ○ Anticoagulant			
ORDERS TAB			
Medication Orders: • **Diagnosis/Reason**: Check for diagnosis or reason in the Notes field or Diagnosis code • **Physical Monitors:** Added to medications requiring monitoring			
Treatment Orders: • **Enteral Feeding:** Flushes, type of tube feeding • **Nebulizer and O2 orders**: Need order to change tubing/humidifier and mask monthly, clean humidifier filters monthly • **Wound treatments:** Medication/Dressing, site, how often • **Pacemaker Checks:** • **Therapy orders**: • **Equipment:** Use, cleaning, maintenance			
• **Diet order**			
• **Lab and xray orders**: Verify these were entered into myUnity and the lab site			
• **COVID monitoring orders in place**			
Clinical Notes			
• Admission Note • Date/Time of admission • Where admitted from, how arrived, who accompanied • General condition • Other			
Providers			
• **Physician:** ○ **MO—**within 10 days of admission ○ **IL--** No more than 120 days prior to admission • **Notes scanned into myUnity or entered**			
Belongings Inventory completed			

Nurse Leader Signature: _____

2

Continues to follow requested information and ensures compliance with documentation standards.

ADMISSION PACKET: RESIDENT ORIENTATION CHECKLIST



Assisted Living Resident Orientation

I have reviewed the following facility policies and emergency procedures with an Assisted Living staff member:

- ☐ MEDICAL EMERGENCY POLICY.
- ☐ DISASTER AND EMERGENCY PREPAREDNESS POLICY.
- ☐ FIRE AND EVACUATION PLAN.
- ☐ HIGH WINDS AND TORNADO POLICY.
- ☐ I HAVE BEEN GIVEN MEAL TIMES AND MEAL SUBSTITUTIONS.
- ☐ I HAVE REVIEWED THE MEDICATION POLICY.
- ☐ I KNOW THE SIGN OUT POLICY FOR LEAVING THE FACILITY.
- ☐ I HAVE BEEN SHOWN THE EMERGENCY EXIT AND FIRE ALARM LOCATION.
- ☐ I HAVE BEEN INSTRUCTED IN THE USE OF THE EMERGENCY PULL CORDS OR ALERT BUTTONS IN MY APARTMENT.
- ☐ I HAVE RECEIVED A CURRENT RESIDENT HANDBOOK.
- ☐ I HAVE BEEN SHOWN THE HEATING/COOLING CONTROLS IN MY ROOM.
- ☐ PENDANT USE.

Employee Signature Date

AUDITS AND TRACKING

SCHEDULE

- On admit – schedule assessments and annual screens using tool of choice or your eMAR

ONGOING AUDITS

- Clinical Chart Audit
  - + Quarterly
  - + Sig change

UPDATE RCS

- Keep updated – especially during survey window

HR AND EDUCATION

- HR “state” files
- Education tracking

ADDITIONAL INFO TO HAVE AVAILABLE

- Staff schedules
- Medication policies
- Fire alarm documentation (training and live)
- Fall reports
- Special diets
- Copy of NEO information that includes Dementia training
- Staff contacts

TOP DEFICIENCIES JAN 1 – MARCH 31, 2025

- ALF
  - + Fire alarm system – test/maintain
  - + Substantially constructed and maintained
  - + Electrical wire, maintained, inspected
  - + Individual service plan development
  - + TB screen residents and staff
  - + Fire drill requirements, evacuation
  - + Sprinkler system maintenance/testing
  - + Hazardous area requirements
  - + Complete sprinkler system – NFPA 13
  - + Physician's orders followed

ALF – Additional requirements

- + Individual evacuation plan – staff requirements
- + More than min. assist – staff, awake
- + Resident evacuation plan – readily available
- + Comply with all require. of section (3) of rule

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FINAL THOUGHTS