DEPARTMENT OF HEALTH

Resident Observation and Record Review

STATE EVALUATION: ASSISTED LIVING PROVIDERS (144G)

Provider Information

Provider:

HFID:

Date of Survey:

Time of Survey:

Resident Information

Name:

Identifier:

Diagnoses:

Start of Services:

Current Service Plan date:

Surveyor

Surveyor(s):

Discharged Resident Record Review

☐ Discharge summary (144G.43, Subd. 3)

☐ Disposition of medications (144G.71, Subd. 22 (c))

☐ If contract terminated, appropriate time frame and notice to OOLTC provided.

☐ Discharged Date:

Comments:

Current/Recent Emergency Relocation Review

☐ Date of emergency relocation:

☐ Location of relocation:

☐ Written notice provided to include all required content (144G.52 Subd. 9 (1-5))

☐ Date OOLTC notified if not returned within four days (144G.52 Subd. 9 (3)):

Comments:

Resident Daily Life Review

Caregiver Observed:

Throughout the survey, surveyors observe staff as they provide services to residents. Surveyors interview staff and residents to evaluate and validate surveyor observations and findings. Areas reviewed include but are not limited to:

- ☐ Resident was free from physical and verbal abuse.
- ☐ Care and services were provided in accordance with accepted medical and nursing standards.
- ☐ Current standards of practice for infection control were followed, including but not limited to appropriate hand hygiene, handling and transporting linen to prevent spread of infection and the use of protective gloves when appropriate.
- ☐ Resident was treated with courtesy, respect, and resident's rights were not violated.
- ☐ Staff listened and were responsive to resident requests. (Note staff interaction with both communicative and non-communicative resident).
- ☐ Resident's bathing, dressing, grooming, and toileting needs were met.
- ☐ Resident was free from physical and/or chemical restraints.
- ☐ Other observations/interviews as deemed necessary (i.e., behaviors, cognition, mobility, demeanor, environment, etc.).

Comments:

Resident Record Review

Surveyors review resident records to determine if documentation standards were met related to evaluation and assessments and the services the resident received.

Individual abuse prevention plan (IAPP) (144G.42, Subd.6 (b))

- ☐ An individualized assessment of resident's susceptibility to abuse by other individuals;
- ☐ Assessment of the resident's risk of abusing other vulnerable adults or minors; and
- ☐ Statements of the specific measures to be taken to minimize the risk of abuse to the resident and other vulnerable adults or minors and risk of self-abuse.
- ☐ Date of most current IAPP:

Comments:

Assessments: (144G.70, Subd. 2 (b-d))

- ☐ Initial RN assessment completed prior to contract signing or move in date. Date:
- ☐ Initial Review of needs/preferences completed within 30 days of start of assisted living services. Date:
- ☐ Reassessment no more than 14 days of starting services. Date:

- ☐ Ongoing resident assessment at least every 90 days. Date(s):
- ☐ Or with a change in condition. Date(s):

Comments:

Service Plan: (144G.70, Subd. 3, 4)

- ☐ Temporary Service Plan created prior to move in date. (shall not be in effect more than 72 hours). Date:
- ☐ Service plan was completed within 14 days of start of services and revised as needed. Date:
- ☐ Service plan had all required content.
- ☐ All services were provided and documented (ADLs, IADLs, medications and treatments) as noted in the resident's service plan.

Comments:

Assisted Living Contract: (144G.50 Subd. 1-3, 5)

- ☐ A signed Assisted Living Contract prior to providing services, including required content. Date:
- ☐ Must include the designation of representative verbatim notice.
- ☐ The contract must not include a waiver of facility liability for the health and safety or personal property of a resident.
- ☐ Any arbitration provision must be clear and conspicuous, and not limit choice of law or venue. (144G.51)

Comments:

Assisted Living with Dementia Care Additional Requirements:

- ☐ Required evidence present resident/legal representative and designated representatives received dementia care policies and procedures at time of move in. (144G.82, Subd.3) Date:
- ☐ Services are provided in a person-centered manner; non-pharmacological practices are person-centered, and evidence informed. (144G.84, (a))
- ☐ Individualized written activity evaluation/written activity plan completed/current. (144G.84, (b)(c)(d)) Date:
- ☐ Behaviors evaluated and included on service or care plan (if applicable). (144G.84 (e))

Comments:

Documentation of resident's receipt and review of:

- ☐ Minnesota Assisted Living bill of rights. (144G.90 Subd. 1, (d)) Date:
- ☐ Uniform disclosure of services (UDALSA). (144G.40, Subd. 2) Date:
- ☐ Written complaint notice. (144G.90 Subd. 1 (b-c)) Date:
- ☐ Documentation of complaints received, if applicable, and resolution.

- ☐ Resident records were kept confidential and secure. (144G.43 Subd. 1 (b))
- ☐ Entries in resident's record were current, authenticated, and legible. (144G.43 Subd. 1 (a))
- ☐ Significant changes or incident(s) and the actions taken in response were documented, (i.e. resident falls, post-hospital, ER visits, any resident deterioration). (144G.43 Subd. 3 (9))

Comments:

Medication Management Services

(144G.71 Subd.1-23)

Surveyors review resident record for compliance related to medication administration including all prescribed, non-prescribed, over the counter and dietary supplements taken by the resident.

- ☐ RN developed and implemented an individual medication management record prior to provision of services.
- ☐ Medication plan was current, and the service plan was updated (if needed).
- ☐ Current or annual reassessment occurred. Date:

Record included the following items:

(144G.71, Subd. 5)

- ☐ Medication management services provided by nurse and unlicensed personnel (ULP) (included PRN).
- ☐ Type of medication storage system, based on resident's needs.
- ☐ Specific written instructions for resident's medication administration.
- ☐ Person responsible for monitoring medication supplies and refills.
- ☐ Medication management tasks that may be delegated to ULPs.
- ☐ Procedures for staff to notify an RN when problems arose.
- ☐ Any resident-specific requirements (i.e., parameters: blood sugar, blood pressure, pulse, etc.).
- ☐ Medication Reconciliation was completed by nurse, licensed health professional, or authorized prescriber.

(144G.71, Subd. 6-16)

- ☐ Medication administration delegated to unlicensed personnel and documented resident specific instructions.
- ☐ Medication administration records were complete; medications were administered as ordered and documented correctly, or if not administered reasons were documented. (Record includes reasons to use PRN medications and their effectiveness.)
- ☐ Medication set-up and administration were documented.
- ☐ Documentation of medication administration was completed for resident who was away from home.
- ☐ Prescriber's orders were written and dated for medications administered and orders were complete.
- ☐ Medication orders were renewed at least every twelve months.

☐ Verbal orders were received only by a nurse or pharmacist, were entered into the resident record and forwarded for signature by licensed prescriber.

☐ Electronically transmitted orders were recorded, communicated to the RN and placed in resident record.

Comments:

Treatment and Therapy Management Services

(144G.72, Subd. 1-7)

Resident's record (including the service plan and treatment administration records) was reviewed for all prescribed treatments and therapies administered by the provider's employee(s).

Examples of treatments and therapies include but are not limited to using oxygen or a breathing apparatus or pulse oximetry, blood glucose checks or tube feedings, applying TED hose or splints, providing physical/occupational/speech-language therapy exercises, or wound care. Surveyors will also review maintenance procedures for equipment used in treatments and therapies.

Type(s) of treatment or therapy:

☐ RN or appropriate LHP developed a treatment and/or therapy record (before services were provided). Date:

☐ Treatment plan is current and included on the service plan.

Record included the following items:

☐ Written statement of treatments and therapies to provide.

☐ Written instructions for each treatment or therapy.

☐ A list of the treatment or therapy tasks delegated to ULPs.

☐ Procedures to notify an RN or other LHP professional when problems arose with treatments or therapies.

☐ Resident-specific instructions related to documentation of all treatments and/or therapies administered, or reason not administered, verified as administered and monitored to prevent complications or adverse reactions.

☐ Provider orders current and renewed annually for all provided treatments or therapies.

Comments:

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