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|  | RESIDENTIAL CARE CLINICAL RECORD REVIEW State Form 53715 (R / 4-21)  INDIANA STATE DEPARTMENT OF HEALTH / DIVISION OF LONG-TERM CARE | | | | |
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| Name of facility | | | | Facility number | |
| Name of resident | | | | Resident identifier | |
| Date of birth *(month, day, year)* | | Room number | | Date of admission *(month, day, year)* | |
| Name of surveyor | | Identification number of surveyor | | Date of review *(month, day, year)* | |
| Primary diagnosis | | | | | |
|  | | | | | |
| Interviewable: | | | Yes  No | |  |
| Service Plan for services provided, revised as needed and signed and dated by the resident: | | | Yes  No | | **R 0217** |
| Pre-Admission Evaluation: | | | Yes  No | | **R0214 / R0215 / R0216** |
| Semi-Annual Evaluation: | | | Yes  No | | **R0216** |
| Weight Recorded on Admission and Semi-Annually: | | | Yes  No | | **R0216** |
| Does Resident Self-Administer Medications? | | | Yes  No | |  |
| If Yes, Self-Administration Evaluation: | | | Yes  No | | **R0216** |
| Are medications secured in the resident’s room? | | | Yes  No | | **R0295** |
| Physician Orders for Medications: | | | Yes  No | | **R0241 / R0242** |
| PRN Medications Administered by QMA Authorized Before Given: | | | Yes  No | | **R0246** |
| Pharmacist Drug Regimen Review at least every sixty (60) days *(if facility controls, handles, and administers resident’s medications)*: | | | Yes  No | | **R0298** |
| Diet Orders Reviewed and Revised by the Physician as Resident’s Condition Requires: | | | Yes  No | | **R0275** |
| Chest X-Ray Within six (6) Months of Admission: | | | Yes  No | | **R0408** |
| Tuberculin Test on, or Prior to, Admission: | | | Yes  No | | **R0410** |
| Second Step: | | | Yes  No | | **R0410** |
| Tuberculin Test Annually: | | | Yes  No | | **R0412** |
| If applicable, Risk Assessment: | | | Yes  No | | **R0412** |
| Annual Health Statement: | | | Yes  No | | **R0409** |
| Mental Health Screening for individuals who are recipients of Medicaid or Federal SSI: | | | Yes  No | |  |
| If Major Mental Illness, is there a Comprehensive Care Plan Addressing Those Needs? | | | Yes  No | | **R0379** |
| Care Plan Developed in Cooperation with Mental Health Provider: | | | Yes  No | | **R0383** |
| Resident Rights Acknowledgement Signed: | | | Yes  No | | **R0026** |
| Current Emergency Information File: | | | Yes  No | | **R0356** |

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| **SURVEYOR NOTES** |
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