

Quality Management Forms

Nananom Assisted Living

Quality Assurance Checklist

(To be performed by the Manager/designee at the beginning of each month.)

Date: _____

Resident's Rooms:

- Appear clean.
- Floors clean.
- No odors.
- Furniture dusted.
- Men are shaven.
- Beds clean and made.
- Everyone dressed.
- Windows clean.
- All appear content.
- Drapes clean and in good condition.
- Appear healthy.
- Mirrors cleaned.
- Smiling, appears happy.
- Walls clean.
- Skin integrity good.
- Paint intact.
- Drawers clean and straightened.
- Closets clean and straightened.
- Vents clean.

Kitchen:

- Floor clean.
- Storage straightened.
- Garbage area clean.
- Dishwasher clean.
- Oven clean.
- Dishwasher chemicals locked.
- Microwave clean.
- Drawers clean.
- Stovetop clean.
- Cupboards clean.
- Dishes clean.
- Thermometer in refrigerator/freezer.
- Stove fan filter clean.
- Freezer clean.
- Refrigerator clean
- Ceiling fan clean and in good repair.

- Freezer straightened.
- Pantry clean and organized.
- Countertop clean.
- Coffee pot clean.
- Leftovers labeled and dated.

Living Room:

- Magazine's present.
- Windows clean.
- Floors clean.
- Curtains clean and in good condition.
- Furniture dusted.
- Furniture clean and in good condition.
- Walls clean.
- TV screen clean.
- Paint intact.

Dining Room:

- Floors clean.
- Table clean.
- Furniture dusted.
- Chairs clean.
- Room decorated.
- Windows clean.
- Doors clean.

Bathrooms:

- Floors clean.
- Sink clean.
- No odors.
- Mirror clean.
- Tub clean.
- Walls clean.
- Non-slip mat in tub.
- Paint /tile in good repair.
- Toilet clean and stain free
- All bars secured.

Laundry Room:

- Floor clean.
- Dryer lint trap clean.
- Clean behind washer/dryer.
- Area orderly.
- Laundry done.
- Clean laundry distributed.
- All laundry chemicals locked.

Patio/outside area:

- Furniture clean.
- No cobwebs present.
- Ashtrays clean.
- Yard clean and orderly.
- Paint in good repair.
- Parking area clean.
- Plants watered.

Nananom Assisted Living

Activity programs:

- Scheduled activities done.
- Changes documented on activity schedule.
- Activity storage area clean & organized.

Mealtime/snack time:

- Meals done on time.
- Food attractive and well prepared.
- Food hot or cold if needed.
- Pleasant atmosphere.
- Music played.
- AM snack offered/given.
- Noon snack offered/given.
- PM snack offered/given.

If there are any items that are not on this list but appear to need attention, please document on this form and inform the manager.

Quality Assurance Checklist completed by:

Signature

Position

Nananom Assisted Living

**Quality Management Program
Incident Report Form**

Date of Incident: _____ Time of Incident: _____

Location of Incident: _____

Resident(s) Involved: _____

Staff Involved (including witnesses): _____

Describe the Incident (Who/What/When/Where/How/Why):

Was there an injury requiring PCP/hospital visit? () Yes () No

If Yes, Name and Address of PCP/hospital: _____

Phone number: _____ Fax: _____

Date Transported: _____ Time Transported: _____

Method of Transport? (Ambulance, taxi, POV, etc.): _____ Phone: _____

If police were involved: Officer Name: _____

Badge Number: _____ Report Number: _____

Notifications:

Emergency Contact Name: _____ Date/Time Notified: _____

PCP Name: _____ Date/Time Notified: _____

Others Notified: _____ Date/Time Notified: _____

Action Taken Immediately: _____

Actions to Prevent Reoccurrence: _____

Printed name of person completing this report: _____

Signature: _____ Date: _____

Nananom Assisted Living

Quality Management Program
Quarterly (or As Needed) Summary Report Form

Number/type of incidents which did, or had the potential to, adversely affect the health and/or safety of one or more residents (For example: 4 falls, 3 medication errors, etc.):

Number of errors in the documentation of medications (MARs), treatments, ADLs, etc. provided to residents:

Number of residents experiencing weight loss and the amount: _____

Residents with decubitus ulcers: Stage 1: _____ Stage 2: _____ Stage 3: _____ Stage 4: _____

Unstageable: _____

Number of residents with infections (MRSA, C. Diff., etc.):

Incidents requiring the response of Emergency Services (Fire Department, Paramedics, Police, etc.):

Number of residents reporting the loss of personal property/money: _____

Other: (identify type and number as above):

Are there any patterns in these incidents, either with multiple residents or a specific resident? If so, what are they? _____

Printed name of person completing this report: _____

Signature: _____ Title: _____ Date: _____

This form is to be completed every 3 months by the Manager/designee and provided to the Board of Directors of Nananom Assisted Living.

Note: This form is NOT to be used for, or to include any information which can be used to identify individuals.

Nananom Assisted Living

Quality Plan Summary Report

1. Resident's Name: _____ Admission Date: _____

Resident Care Concern Identification:

Corrective Actions for Concern:

2. Resident's Name: _____ Admission Date: _____

Resident Care Concern Identification:

Corrective Actions for Concern:

3. Resident's Name: _____ Admission Date: _____

Resident Care Concern Identification:

Corrective Actions for Concern:

Nananom Assisted Living

Review and Evaluation of the Quality Management Program Record

Date: _____

Description of Review or Evaluation:

Any Improvement of the Quality Program? () Yes () No

Explain the result of the Program (if applicable): _____

Goal: _____

Date: _____

Description of Review or Evaluation:

Any Improvement of the Quality Program? () Yes () No

Explain the result of the Program (if applicable): _____

Goal: _____

Date: _____

Description of Review or Evaluation:

Any Improvement of the Quality Program? () Yes () No

Explain the results of the Program (if applicable): _____

Goal: _____

Nananom Assisted Living

Quality Management Program

Incident Report Form

Date of incident: _____ Time of incident: _____

Location of incident: _____

Resident(s) involved: _____

Staff members involved (including witnesses): _____

Describe the incident (who/what/when/where/how/why):

Was there an injury requiring a physician/hospital visit? Yes _____ No _____

If yes, name & address of physician/hospital: _____

Phone number: _____ Fax: _____

Date transported: _____ Time transported: _____

Transportation mode? (Ambulance, taxi, POV, etc.): _____ Phone: _____

If police are involved:

Officer name: _____ Badge number: _____ Report number: _____

Notifications:

Emergency contact name: _____ Date/Time notified: _____

Primary care physician name: _____ Date/Time notified: _____

Other person(s) notified: _____ Date/Time notified: _____

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Action taken immediately:

Action to prevent recurrence:

Print name of person completing this report: _____

Title: _____

Signature: _____ Date: _____

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Quality Management Program

Every six months (or As Needed) Summary Report Form

Note: This form is *NOT* to be used for, or to include any information which can be used to identify individuals.

Number/type of incidents which did, or had the potential to, adversely affect the health and/or safety of one or more residents (for example: 4 falls, 3 medication errors, etc.):

Number of errors in the documentation of medications (MARs), treatments, ADLs, etc. provided to residents (No identifiers):

Number of residents experiencing weight loss and amount (as above):

Residents with decubitus ulcers: Stage I: ____ Stage II: ____ Stage III: ____ Stage IV: ____

Unstageable: ____

Number of residents with infections (MRSA, C. Diff., etc.):

Incidents requiring the response of emergency services (fire department, paramedics, police, etc.):

Number of residents reporting the loss of personal property/money:

Other: (Identify type and number as above):

Are there any patterns in these incidents, either with multiple residents or a specific resident? If so, what are they?

Printed name of person completing this report: _____

Signature: _____ Title: _____ Date: _____

Nananom Assisted Living

Quality Plan Summary Report

1. Resident's name: _____ Admission date: _____

Resident's care concern identified:

Corrective actions for concern:

2. Resident's name: _____ Admission date: _____

Resident's care concern identified:

Corrective actions for concern:

3. Resident's name: _____ Admission date: _____

Resident's care concern identified:

Corrective actions for concern:

4. Resident's name: _____ Admission date: _____

Resident's care concern identified:

Corrective actions for concern:

Nananom Assisted Living

Review and Evaluation of the Quality Management Program Record

Date: _____

Description of review or evaluation:

Any improvement of the Quality Program? ____ Yes ____ No

Explain the result of the program (if applicable): _____

Goal: _____

Date: _____

Description of review or evaluation:

Any improvement of the Quality Program? ____ Yes ____ No

Explain the result of the program (if applicable): _____

Goal: _____

Nananom Assisted Living

Monthly Quality Control Worksheet

Month of _____ 20____

Note: Date and initial when tasks are performed.

Tasks:	Date:	Cg initial and Notes
Clean refrigerator and Freezer. Refrigerator temperature (41° F or below). Freezer temperature (0° F or below).		
Clean/inspect oven (including vent). Clean/inspect microwave. Clean/inspect toaster (shake off crumbs). Clean/inspect blender.		
Smoke alarms (check monthly).		
Fire extinguisher (tag or receipt annually).		
All air filters (replace every 3 months or as needed). Clean/inspect vents.		
Bells for monitoring (working condition).		
Flashlights work (have extra batteries for back up).		
Light bulbs work (have extra bulbs for back up).		
Facility temperature (between 70° to 84° F). HVAC working (heating and cooling). Hot water temperature (95° to 120° F): Bathrooms: 1 and 2 Kitchen sink Dishwasher and clean vents. Washing machine and clean dryer vents.		
Hot water tank working.		
Oxygen storage secure.		
Medication storage: Medication organizers (filled and verified). Controlled medications. Medications need to be refrigerated.		
Chemicals stored and secured.		
Handicap appliances Ramps and grab bars. Bathroom/tub/showers clean and no slip hazard. Beds/wheelchairs (DME) clean and maintained.		
General facility free from odors and hazards. Check outlets and chords for trip hazards. Outdoor appearance neat and maintained. Pest control and yard maintenance.		

Date reported: _____ Caregiver: _____

Reported to Manager/ Designee: _____