

RESIDENT ASSESSMENT TOOL

To be completed by a physician, certified nurse practitioner, registered nurse, or physician assistant within 30 days prior to admission, at least annually, & within 48 hours after a significant change of condition & each nonroutine hospitalization.

If this form is completed in its entirety by the Delegating Nurse/Case Manager (DN/CM), there is no need to complete an additional nursing assessment. If anyone other than the DN/CM completes this form, the DN/CM must document their assessment on a separate form.

An assisted living program may not provide services to an individual who at the time of initial admission requires:

- (1) More than intermittent nursing care; (2) Treatment of stage three or stage four skin ulcers; (3) Ventilator services;
(4) Skilled monitoring, testing, & aggressive adjustment of medications & treatments where there is the presence of, or risk for, a fluctuating acute condition; (5) Monitoring for a chronic medical condition that is not controllable through readily available medications & treatments; or
(6) Treatment for a disease or condition which requires more than contact isolation.

An exception is provided for residents who are under the care of a licensed general hospice program.

Resident: _____ DOB: _____ Assessment Date: _____

Primary Spoken Language: _____ Male Female

Allergies (drug, food, & environmental):

Current Medical & Mental Health Diagnoses:

Past Medical & Mental Health History:

Airborne Communicable Disease.

Test to verify the resident is free from active TB (*completed no more than 1 year prior to admission*):

PPD Date: _____ Result: _____ mm OR Chest X-Ray Date: _____ Result: _____

Does the resident have any active reportable airborne communicable diseases? No Yes

(specify)

Vital Signs.

BP: _____ / _____ Pulse: _____ Resp: _____ T: _____ °F Height: _____ ft _____ in Weight: _____ lbs

Pain? No Yes (specify site, cause, & treatment)

Resident: _____ DOB: _____ Assessment Date: _____

Neuro. Alert & oriented to: Person Place Time
Answers questions: Readily Slowly Inappropriately No Response
Memory: Adequate Forgetful - needs reminders Significant loss - must be directed
Is there evidence of dementia? No Yes (cause) _____
Cognitive status exam completed? No Yes (results) _____
Sensation: Intact Diminished/absent (describe below)
Sleep aids: No Yes (describe below) Seizures: No Yes (describe below)
Comments:

Eyes, Ears, & Throat. Own teeth Dentures Dental hygiene: Good Fair Poor
Vision: Adequate Poor Uses corrective lenses Blind - R L
Hearing: Adequate Poor Uses corrective aid Deaf - R L
Comments:

Musculoskeletal. ROM: Full Limited
Mobility: Normal Impaired → Assistive devices: No Yes (describe below)
Motor development: Head control Sits Walks Hemiparesis Tremors
ADLs: (S=self; A=assist; T=total) Eating: ____ Bathing: ____ Dressing: ____
Is the resident at an increased risk of falling or injury? No Yes (explain below)
Comments:

Skin. Intact: Yes No (if no, a wound assessment **must** be completed)
 Normal Red Rash Irritation Abrasion Other
Any skin conditions requiring treatment or monitoring? No Yes (describe condition & treatment)
Comments:

Respiratory. Respirations: Regular Unlabored Irregular Labored
Breath sounds: Right (Clear Rales) Left (Clear Rales)
Shortness of breath: No Yes (indicate triggers below)
Respiratory treatments: None Oxygen Aerosol/nebulizer CPAP/BIPAP
Comments:

Circulatory. History: N/A Arrhythmia Hypertension Hypotension
Pulse: Regular Irregular Edema: No Yes → Pitting: No Yes
Skin: Pink Cyanotic Pale Mottled Warm Cool Dry Diaphoretic
Comments:

Resident: _____ DOB: _____ Assessment Date: _____

Diet/Nutrition. Regular No added salt Diabetic/no concentrated sweets
 Mechanical soft Pureed Other _____ Supplements _____
 Is there any condition which may impair chewing, eating, or swallowing? No Yes (explain below)
 Is there evidence of or a risk for malnutrition or dehydration? No Yes (explain below)
 Is any nutritional/fluid monitoring necessary? No Yes (describe type/frequency below)
 Are assistive devices needed? No Yes (explain below)
 Mucous membranes: Moist Dry Skin turgor: Good Fair Poor
 Comments:

Elimination.
 Bowel sounds present: Yes No Constipation: No Yes Ostomies: No Yes
 Bladder: Normal Occasional Incontinence (less than daily) Daily Incontinence
 Bowel: Normal Occasional Incontinence (less than daily) Daily Incontinence
 (If any incontinence, describe management techniques)
 Comments:

Additional Services Required. No Yes (indicate type, frequency, & reason)
 Physical therapy Home health Private duty Hospice Nursing home care Other
 Comments:

Substance Abuse. Does the resident have a history of or current problem with the abuse of medications, drugs, alcohol, or other substances? No Yes (explain)
 Comments:

Psychosocial.	KEY: N = Never O = Occasional R = Regular C = Continuous				Comments
	N	O	R	C	
Receptive/Expressive Aphasia					
Wanders					
Depressed					
Anxious					
Agitated					
Disturbed Sleep					

Resident: _____ DOB: _____ Assessment Date: _____

Psychosocial.	KEY: N = Never O = Occasional R = Regular C = Continuous				Comments
	N	O	R	C	
Resists Care					
Disruptive Behavior					
Impaired Judgment					
Unsafe Behaviors					
Hallucinations					
Delusions					
Aggression					
Dangerous to Self or Others					<i>(if response is anything other than never, explain)</i>

Awake Overnight Staff. Based on the results of this assessment & your clinical judgment, indicate if the resident requires monitoring by awake overnight staff: Yes No (explain your reason)

Health Care Decision-Making Capacity. Indicate the resident's highest level of ability to make health care decisions:

- Probably can make higher level decisions *(such as whether to undergo or withdraw life-sustaining treatments that require understanding the nature, probable consequences, burdens, & risks of proposed treatment)*
- Probably can make limited decisions that require simple understanding
- Probably can express agreement with decisions proposed by someone else
- Cannot effectively participate in any kind of health care decision-making

Ability to Self-Administer Medications. Indicate the resident's ability to take his/her own medications safely & appropriately:

- Independently without assistance
- Can do so with physical assistance, reminders, or supervision only
- Needs to have medications administered by someone else

General Comments.

Health Care Practitioner's Signature: _____ Date: _____

Print Name & Title: _____

Resident: _____ DOB: _____ Assessment Date: _____

Skip this box if you are not the Delegating Nurse/Case Manager (DN/CM).

When the DN/CM completes this entire Resident Assessment Tool, including this box, there is no need to document a separate nursing assessment.

Has a 3-way check (orders, medications, & MAR) been conducted for all of the resident's medications & treatments, including OTCs & PRNs? Yes No (explain below)

Were any discrepancies identified? No Yes (explain below)

Are medications stored appropriately? Yes No (explain below)

Has the caregiver been instructed on monitoring for drug therapy effectiveness, side effects, & drug reactions, including how & when to report problems that may occur? Yes No (explain below)

Have arrangements been made to obtain ordered labs? Yes No (explain below)

Is the resident taking any high risk drugs? No Yes (explain below)

For all high risk medications (such as hypoglycemics, anticoagulants, etc), has the caregiver received instructions on special precautions, including how & when to report problems that may occur? Yes No (explain below) N/A

Is the environment safe for the resident? Yes No (explain below)

(Adequate lighting, open traffic areas, non-skid rugs, appropriate furniture, & assistive devices.)

Comments:

DN/CM's Signature: _____ Date: _____

Print Name: _____

*Six months after this assessment is completed, it must be reviewed.
If significant changes have occurred, a new assessment must be completed.
If there have been no significant changes, simply complete the information below.*

Six-Month Review Conducted By:

Signature: _____ Date: _____

Print Name & Title: _____

Resident: _____ DOB: _____ Date Completed: _____

PRESCRIBER'S SIGNED ORDERS

(You may attach *signed* prescriber's orders as an alternative to completing this page.)

ALLERGIES (list all): _____

MEDICATIONS & TREATMENTS:

List all medications & treatments, including PRN, OTC, herbal, & dietary supplements.

<i>Medication/Treatment Name</i>	<i>Dose</i>	<i>Route</i>	<i>Frequency</i>	<i>Reason for Giving</i>	<i>Related Monitoring & Testing (if any)</i>
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					

Resident: _____ DOB: _____ Date Completed: _____

17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					

LABORATORY SERVICES:

<i>Lab Test</i>	<i>Reason</i>	<i>Frequency</i>
1.		
2.		
3.		
4.		
5.		
6.		

Total number of medications & treatments listed on these signed orders? _____

Prescriber's Signature: _____ Date: _____

Office Address: _____ Phone: _____