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.**

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<tr>
<th>KEY: N = Never  O = Occasional  R = Regular  C = Continuous</th>
<th>N</th>
<th>O</th>
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<th>Comments</th>
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<td>Receptive/Expressive Aphasia</td>
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<td>Wanders</td>
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Revised 7/3/13  Page 3 of 7
Resident: __________________ DOB: ____________ Assessment Date: ____________

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<th>Psychosocial.</th>
<th>KEY: N = Never</th>
<th>O = Occasional</th>
<th>R = Regular</th>
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<td>Resists Care</td>
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<td>Disruptive Behavior</td>
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<td>Unsafe Behaviors</td>
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<td>Dangerous to Self or Others</td>
<td>(if response is anything other than never, explain)</td>
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**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: _______________________________________________________
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-slip 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.

<table>
<thead>
<tr>
<th>Medication/Treatment Name</th>
<th>Dose</th>
<th>Route</th>
<th>Frequency</th>
<th>Reason for Giving</th>
<th>Related Monitoring &amp; Testing (if any)</th>
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**LABORATORY SERVICES:**

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

Prescriber’s Signature: ___________________________  Date: ________________

Office Address: ____________________________________  Phone: ________________

Revised 7/3/13  Page 7 of 7