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

| Resident: | DOB: mm-dd-yy | Assessment Date: mm-dd-yy |
|---|---|---|
| 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: mm-dd-yy Result: mm OR Chest X-Ray Date: mm-dd-yy 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)

**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:

| Resident: | DOB: mm-dd-yy | Assessment Date: mm-dd-yy |
|---|---|---|

**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)

**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:

**Diet/Nutrition.** ☐ Regular ☐ No added salt ☐ Diabetic/no concentrated sweets
☐ Mechanical soft ☐ Pureed ☐ Other (explain below) ☐ Supplements (explain below)
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:

| Resident: | DOB: mm-dd-yy | Assessment Date: mm-dd-yy |
|---|---|---|

**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* | | | | | |
|---|---|---|---|---|---|
| | **N** | **O** | **R** | **C** | **Comments** |
| Receptive/Expressive Aphasia | ☐ | ☐ | ☐ | ☐ | |
| Wanders | ☐ | ☐ | ☐ | ☐ | |
| Depressed | ☐ | ☐ | ☐ | ☐ | |
| Anxious | ☐ | ☐ | ☐ | ☐ | |
| Agitated | ☐ | ☐ | ☐ | ☐ | |
| Disturbed Sleep | ☐ | ☐ | ☐ | ☐ | |
| Resists Care | ☐ | ☐ | ☐ | ☐ | |
| Disruptive Behavior | ☐ | ☐ | ☐ | ☐ | |
| Impaired Judgment | ☐ | ☐ | ☐ | ☐ | |
| Unsafe Behaviors | ☐ | ☐ | ☐ | ☐ | |
| Hallucinations | ☐ | ☐ | ☐ | ☐ | |
| Delusions | ☐ | ☐ | ☐ | ☐ | |
| Aggression | ☐ | ☐ | ☐ | ☐ | |
| Dangerous to Self or Others | ☐ | ☐ | ☐ | ☐ | *(if response is anything other than never, explain)* |

**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**.

| Resident: | DOB: mm-dd-yy | Assessment Date: mm-dd-yy |
|---|---|---|

Health Care Practitioner's Signature: _____ Date: mm-dd-yy

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 ☐ N/A ☐ No (explain below)

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: mm-dd-yy

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:* _____

*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: Assisted Living Manager (ALM)*

*Signature:* _____ *Date:* _____

*Print Name & Title:* _____

| Resident Name: | DOB: mm-dd-yy | Date Completed: mm-dd-yy |
|---|---|---|

# 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.

| *Medication/Treatment Name* | *Dose* | *Route* | *Frequency* | *Reason for Giving* | *Related Monitoring & Testing (if any)* |
|---|---|---|---|---|---|
| 1. | | | | | |
| 2. | | | | | |
| 3. | | | | | |
| 4. | | | | | |
| 5. | | | | | |
| 6. | | | | | |
| 7. | | | | | |
| 8. | | | | | |
| 9. | | | | | |
| 10. | | | | | |
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| 13. | | | | | |
| 14. | | | | | |
| 15. | | | | | |
| 16. | | | | | |
| 17. | | | | | |
| 18. | | | | | |

| Resident Name: | | | DOB: mm-dd-yy | Date Completed: mm-dd-yy | |
|---|---|---|---|---|---|
| 19. | | | | | |
| 20. | | | | | |
| 21. | | | | | |
| 22. | | | | | |
| 23. | | | | | |
| 24. | | | | | |
| 25. | | | | | |

**LABORATORY SERVICES**:

| *Lab Test* | *Reason* | *Frequency* |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |

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

Prescriber's Signature: _____ Date: _____

Office Address: Phone: - -