



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – S. Anthony McCann, Secretary

The Honorable Thomas M. Middleton, Chair
Senate Finance Committee
3 East, Miller Senate Building
Annapolis, MD 21401

The Honorable Peter A. Hammen, Chair
House Health & Government Operations Committee
Lowe House Office Building, Room 241
Annapolis, MD 21401

RE: House Bill 1322 – Assisted Living Programs – Licensure (2006) – Interim Report

Dear Senator Middleton and Delegate Hammen:

During the 2006 Legislative Session, the General Assembly passed House Bill 1322, entitled “Assisted Living Programs – Licensure” which strengthened minimum licensure standards for assisted living programs and required the Department, in consultation with various specialists and stakeholders, to develop a methodology based on resident need from criteria in the Resident Assessment Tool to determine when awake overnight staff and on-site nursing should not be required for an assisted living program.

The attached interim report is intended to provide your Committees with an update on the progress the Department is making to identify questions on the Resident Assessment Tool that will require enhanced staffing in assisted living facilities to ensure basic safety across Maryland’s Assisted Living Program based upon resident need and balancing fiscal impact upon consumers and providers.

Should you have any questions regarding this report, please have your staff contact Ms. Wendy Kronmiller, Director of the Office of Health Care Quality, at 410-402-8001. Thank you very much for your continued support of the Department.

Sincerely,


S. Anthony McCann
Secretary

Enclosure

cc: Robyn Elliott, Director, Office of Governmental Affairs
Wendy Kronmiller, Director, Office of Health Care Quality
Kim Mayer, Director, Policy and Administration - OHCQ

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DEPARTMENT OF HEALTH & MENTAL HYGIENE

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MARYLAND'S ASSISTED LIVING PROGRAM
IMPLEMENTATION OF
ENHANCED STAFFING REQUIREMENTS
PURSUANT TO HOUSE BILL 1322

INTERIM REPORT

Report to the Senate Finance and the House Health and
Government Operations Committees



June 2006

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MARYLAND'S ASSISTED LIVING PROGRAM
IMPLEMENTATION OF ENHANCED STAFFING REQUIREMENTS
PURSUANT TO HOUSE BILL 1322 - INTERIM REPORT

Introduction

During the 2006 Legislative Session, the General Assembly passed House Bill 1322, entitled "Assisted Living Programs – Licensure" which strengthened minimum licensure standards for assisted living programs. Uncodified language in House Bill 1322 required the Department, in consultation with various specialists and stakeholders, to develop a methodology based on resident need from criteria in the existing Resident Assessment Tool to determine when awake overnight staff and on-site nursing should not be required for an assisted living program. The bill also requires the Department to report to the Senate Finance and House Health and Government Operations Committees within a certain specified timeframe.¹

This interim report will describe the process used by the Department to develop a methodology; provide an overview of the Department's progress in establishing enhanced staffing standards for assisted living facilities; and, identify issues requiring further discussion.

Background

Maryland's Assisted Living Program has grown rapidly since its implementation in 1996. Consumers with health care needs that previously would have resulted in nursing home placement are selecting assisted living instead. While many consumers report positive experiences in this alternative to traditional long-term care facilities, the Office of Health Care Quality has identified patterns of quality of care issues. In the summer of 2003, the Department initiated a multi-year, comprehensive evaluation process and convened an Assisted Living Forum to assist with the evaluation. Interim reports were issued in 2003 and 2004 and a final report was issued in 2005 containing a series of recommendations to improve the quality of care in the State's Assisted Living Program.² These recommendations form the basis for the Department's new resident centered regulatory framework for assisted living.

Two major components of regulatory reform for assisted living focus on enhanced staffing – awake overnight and on-site nursing. These are issues that the Department has been

¹ House Bill 1322 - Assisted Living Programs – Licensure - This bill, as amended, also strengthens minimum licensing standards to ensure that assisted living program operators have relevant experience to run a program. It requires applicants to provide the Department with (1) information concerning any license or certification held under the Health Occupations or Health-General Articles; (2) information demonstrating financial and administrative ability to operate an assisted living program; (3) policies and procedures; (4) identification of personnel and relief personnel; and (5) any other information relevant to the provider's ability to care for assisted living residents. It also authorizes the Department to approve, conditionally approve, or deny an application for licensure. The bill also specifies that an assisted living program does not include those programs certified by the Department of Human Resources as Project Home.

² The 2003, 2004, and 2005 Evaluation Reports of Maryland's Assisted Living Program can be found on the Office of Health Care Quality's web site (<http://dhmh.md.gov/ohcq/>) under the Reports banner.

wrestling with for about three years. Similarly, the National Assisted Living Workgroup also struggled in developing standards for awake overnight staff and on-site nursing. It recommended in 2003 that assisted living programs should be required to have awake overnight staff, but could not reach consensus for on-site nursing requirements.³

The Department in 2003 recommended requiring awake overnight staff for those programs that served 17 or more individuals⁴ and in 2004, refined its recommendations to include those programs that serve five or more individuals, sufficient to meet the needs of the residents, and included a provision for a Department-approved electronic monitoring system.⁵ In 2003 and 2004, the Department recommended on-site nursing requirements on a sliding scale for specified programs based on the number of residents served. In 2005, the Department moved beyond requirements based primarily upon program size and linked the requirement for awake overnight staff to the specific care needs of the residents. For on-site nursing, the Department recommended on-site nursing for those programs that aggregate more than 17 individuals and those with residents with needs requiring an enhanced nursing presence.

The Department strongly supports requiring awake overnight staff in assisted living programs when residents have demonstrated overnight care needs or on-site nursing when residents' needs require such a presence. These "triggers" to enhanced care include dementia, wandering behaviors, residents who are unable to toilet independently, and residents who have wound care and medication needs requiring overnight assistance. We know from a Johns Hopkins study that two-thirds of individuals in assisted living programs have some form of dementia or cognitive impairment.⁶ Other national studies have been conducted with similar results.⁷

Process

The Department invited the various specialists and stakeholders referenced in House Bill 1322 to participate on a workgroup to develop the methodology for enhanced staff based on the Resident Assessment Tool.⁸ The Department will weigh all interests so that there is a threshold of safety in all assisted living programs, balancing the cost of enhanced staffing requirements. The methodology will ensure the appropriate management of risk through basic recognition, identification, reporting, documentation, and monitoring in order avoid preventable complications. There have been two meetings held thus far.⁹

³ The Assisted Living Workgroup. "A Report to the U.S. Senate Special Committee on Aging: Assuring the Quality for Assisted Living: Guidelines for Federal and State Policy, State Regulation, and Operations." April 2003.

⁴ Maryland's Assisted Living Program: 2003 Evaluation Report. Pages 10 – 11.

⁵ Maryland's Assisted Living Program: 2004 Evaluation Report. Page 6.

⁶ Johns Hopkins University, Division of Geriatric Psychiatry and Neuropsychiatry. Study on Dementia Care in Maryland's Assisted Living Program.

⁷ Hawes, Catherine. "Assisted Living: Policy Implications of Data." Presentation to the Association of Health Facility Survey Agencies, October 2005. Studies that indicate moderate to severe cognitive impairment: Nebraska 58%, Maine – 44%, North Carolina - 64%, and Maryland 65%. Under-recognition and under-treatment cognitive impairment results of three studies – Less than 50% had no diagnosis, less than 75% were not treated for dementia, and 22% self-administered medications.

⁸ See Appendix A for a copy of the Resident Assessment Tool.

⁹ See Appendix B for meeting dates and attendance records.

Status of Methodology Development

Awake Overnight Staff. The workgroup, at its second meeting, successfully identified “triggers,” or specific elements, in the Resident Assessment Tool for awake overnight staff.

Table One. “Triggers” for On-Site Nursing from the Resident Assessment Tool	
No.	Item
1	Current medical and psychiatric history;
2	Past illness or chronic conditions (including hospitalizations), past suicide attempts, and physical functional and psychological conditions or changes;
6	Risk factors for falls and injury;
7	Skin conditions (specifically those requiring overnight attention);
8	Sensory impairments affecting functioning (specifically those requiring overnight attention);
9e	Evidence of dehydration or risk for dehydration;
10	Cognitive/behavioral status: a – Is there evidence of dementia, c – Diagnosis (cause of dementia), e – behavioral elements if at level b , c, or d (discussion of going beyond the diagnosis to effects);
11	Ability to self-administer medications – b or c, if medications are required at night;
13	Resident must be fed or needs tube feeding, if required at night;
14	Resident mobility – 2 or 3 ¹⁰ ;
15	Resident transfer to bed, chair or toilet – 2 or 3 ¹¹ ;
16	Bed mobility – how resident moves to and from lying position, turns to side to side, and positions body in bed – 2 or 3 ¹² ;
17	if bathroom is on different floor from bedroom;
18	Resident continence – 1, 2, or 3 ¹³ ;
29	Wanders – c or e at regular or continuous;
30	Sleep disturbance – a at regular or continuous;
31	Verbally inappropriate – b at regular or continuous, if behaviors occur at night;
32	Disruptive behaviors – c, d, or e at regular or continuous, if behaviors occur at night;
33	Combative behaviors – at regular or continuous, if behaviors occur at night;
34	Resistive/uncooperative behaviors – d or g at regular or continuous; if behaviors occur at night; and,
35	Communication – c or d at regular or continuous (unable to communicate needs).

When any of these elements are identified during assessment, a physician or assessing nurse will be required to document why the resident does not require awake overnight staff.

On-Site Nursing. Many stakeholders resisted implementing mandatory on-site nursing hours on the grounds that hours of nursing required is not a mechanical formula but dependent upon the residents’ specific needs. Yet, the Department continues to identify instances where the lack of nursing care has led to resident harm.

¹⁰ Numbers indicate score of prevalence.

¹¹ Id.

¹² Id.

¹³ Id.

Current regulations require a delegating nurse to oversee and manage patient care, and there is consensus among stakeholders, including the Department, that the roles of the delegating nurse and assisted living manager must be clarified and strengthened. It was clearly evident from the discussion in the workgroup that there is often a disconnect between the roles of the assisted living manager and delegating nurse/case manager. Fortifying the existing roles by giving the delegating nurse/case manager the responsibility to provide or order on-site nursing and the manager responsibility for implementing these orders may alleviate the need for a mandated hour requirement. It is also believed that most of the larger assisted living programs already have on-site nursing that meet the recommendations outlined in the 2005 Report.

Therefore, the Department will focus first on ensuring the following elements are incorporated into the regulations: (1) triggers for when an assisted living manager needs to call the case manager/delegating nurse¹⁴; (2) development of change of condition guidelines to assist staff in identifying any significant change of status; (3) improving the relationship between the assisted living manager and case manager/delegating nurse; (4) clarifying the responsibilities of each; and (5) assessing existing on-site nursing presence in large facilities.

Issues Remaining

Issues remain which must be addressed before regulations may be written, and they include: assessment frequency, the use of technology for awake overnight staff, and enforcement. Most importantly, the Department will need to determine how best to implement the new requirements for enhanced staffing so that there is minimal disruption to current assisted living residents. It is likely for this reason that implementation will be phased in – new providers must meet the new standards and existing providers given a reasonable period of time to implement the new standards. Providers must be allowed sufficient time to reassess residents and determine whether or not they will staff their facility accordingly or assist the resident in finding a new provider.

Conclusion

This is an exciting time for Maryland's Assisted Living Program. The Office of Health Care Quality has hired a Program Manager for the Assisted Living Program who has initiated a comprehensive review of the program to ensure efficiency in our oversight and monitoring of facilities. The Department has also already begun the process of drafting proposed regulations to implement the provisions of House Bill 1322, as well as those recommendations in its 2005 Evaluation Report and other assisted living bills that passed during the 2006 General Assembly Session.¹⁵ The new regulations will also clarify some of the existing standards.

¹⁴ There are 18 items noted the Board of Nursing's case manager/delegating nurse curriculum.

¹⁵ House Bill 826 - Assisted Living Programs – Services Disclosure Statement - This bill, as amended, authorizes the DHMH, in consultation with stakeholders, to develop a standard Assisted Living Program Services Disclosure Statement. The purpose of the disclosure statement is to provide consumers with information about the actual services an assisted living program provides and to aid consumers in choosing the most appropriate program to meet their needs. The bill also requires the Department, in coordination with the Oversight Committee on Quality of Care in Nursing Homes and Assisted Living Facilities, the Department of Aging, providers, advocates, and other State

Draft proposed regulations will be shared with the Assisted Living Forum in late summer and an informal comment period will be provided to all stakeholders. The Department will review and evaluate all comments received to balance safety, regulatory oversight, and cost. The Department anticipates promulgating the new assisted living regulations in the fall.

These efforts will move Maryland's Assisted Living Program forward and ensure that assisted living is not just an option, but a dependably safe option for vulnerable citizens and that citizens are given meaningful information to make an educated selection when choosing an assisted living facility.

and local stakeholders, to develop a process to educate consumers regarding the services disclosure statement and to submit a report to the Senate Finance Committee and the House Health and Government Operations Committee addressing specified issues as well as the resources required to make the services disclosure available on-line. The Department's first workgroup meeting is scheduled for June 16, 2006.

Senate Bill 385/House Bill 204 - Assisted Living Program Facilities – Emergency Electrical Power Generator - This bill, as amended, requires assisted living programs that are licensed to serve 50 or more individuals to have an emergency electrical power generator on premises that meets specified criteria and that provides lighting and supports certain systems. It also requires the Department to adopt regulations regarding the requirements for designating areas of the facility as common areas or areas of refuge. An assisted living program is exempt from the bill's requirements if the facility can safely transfer residents through an enclosed corridor to a building that is equipped with an electrical power generator. The Department may also grant waivers for this requirement for up to 3 years, but not more than 5 years.

House Bill 1036 Assisted Living Programs – Prohibited Acts, Penalties, and Quality Account - This bill, as amended, prohibits a person from knowingly and willfully operating, maintaining or owning an unlicensed assisted living program, enhances criminal penalty for operating without a license to a felony, and establishes penalties for false advertisement. The bill clarifies that an individual who has applied in good faith, is awaiting a licensure decision, and has not been denied an application may not be subject to the criminal penalty for operating an unlicensed facility. The Department is also required to provide the unlicensed program with 30 days notice before filing criminal charges. In assessing and recommending penalties factors including the nature, number, and seriousness of the violation and the ability of the program to pay the penalty must be considered. The bill also creates a Health Care Quality Account for assisted living similar to the account established for nursing homes. The account will be funded through civil money penalties assessed to assisted living programs for violations of standards. Penalties would be assessed when a deficiency exists or if there is an ongoing pattern of deficiencies. The account would be non-lapsing, special funds to be used for training, grant awards, demonstration projects, or other purposes designed to improve the quality of care in Maryland's assisted living programs.

Appendix A: Resident Assessment Tool.

**UNDERSTANDING AND USING
THE ASSISTED LIVING
ASSESSMENTS AND THE
LEVEL OF CARE SCORING TOOL**

Revised by the Assisted Living Assessment Workgroup 02/04/05

UNDERSTANDING AND USING THE ASSISTED LIVING ASSESSMENT AND LEVEL OF CARE SCORING TOOL

INTRODUCTION

The Assisted Living Assessment and Scoring Tool are designed to work together. They are based on the Assisted Living regulations. The purpose of this guide is to explain the Assessment and the Scoring Tool and how you may use the two parts of the assessment effectively to evaluate and care for residents in your facility or program.

THE RESIDENT POPULATION

Assisted Living residents are diverse. They may be of almost any adult age, 18 years or older, and span the spectrum of personality types, lifestyles, values, attitudes, habits, preferences, and expectations. Their functional status may range from being totally independent to needing total care. Some of them choose Assisted Living primarily for its lifestyle. Many others need some degree of help because of the impact of aging, illness, developmental disabilities, or other problems.

Thus, while Assisted Living is primarily a residential program, many of its residents have significant physical, functional, and psychosocial problems that may affect their quality of life, ability to make choices, ability to function and to care for themselves, and even their health and survival. It is essential to identify and address these significant issues.

THE SPECTRUM OF ASSISTED LIVING PROVIDERS

Assisted Living providers are also a diverse group, spanning the spectrum from private homes to large multi-facility companies. As an Assisted Living provider, you are responsible for addressing the physical, functional, and psychosocial needs of your residents. The Assisted Living Assessment tool and Scoring Tool have been designed to help you identify those needs and prepare to meet them.

THE BASIS FOR THE ASSESSMENT TOOL AND SCORING TOOL

The Assisted Living Assessment Tool takes these many variations into account. Because it is resident-oriented, it can be used for any individual in any Assisted Living setting.

The Assessment is designed to help you collect essential information about each individual's physical, functional, and psychosocial strengths and deficits. The Health Care Practitioners Physical Assessment requires completion or verification by a health care practitioner. The Assisted Living Managers Assessment is to be completed by the Assisted Living Manager or their designee. Your ability to paint an accurate picture of a resident's strengths, and needs, and to identify the scope of services you

will need to provide or make arrangement for, will depend heavily on the amount and accuracy of information you can obtain. The assessment must be based on the resident's ability to perform: (1) the activities of daily living, (2) instrumental activities of daily living tasks, (3) self administration of medication. The assessment must focus on the resident's ability to perform the task(s), not on facility policy about what the staff shall perform for the resident. As much as possible, both the provider and practitioner portions have been designed to allow for check-offs and circling of answers, with written areas primarily to provide details.

The Scoring Guide is based on a simple principle: The amount of care and service a resident needs depends on the complexity of his/her physical, functional, and psychosocial problems. Provider responsibilities to meet those needs may be divided into the following areas.

PROVIDER MONITORING AND ASSESSMENT The provider has responsibilities to observe, evaluate, document, and report information. This includes:

- Medical illnesses and conditions; and
- Cognitive impairments, psychiatric illnesses, and behavior issues
 - Monitoring would include observation and/or reporting of any behavior changes or mood disturbances, including suicidal ideation

PROVIDER CARE AND SERVICE The provider has responsibilities to assist, cue, coach, treat, or manage various conditions, problems, or situations. These include:

- Performing treatments for physical / medical conditions;
- Medication management;
- Assistance with Activities of Daily Living (ADLs); risk factor management (falls / skin breakdown / etc.); and
- Management of problematic behavior.

As specified in the Assisted Living regulations, the provider may arrange any combination of direct and outside services that adequately fulfill these responsibilities.

THE LEVEL OF CARE SCORING TOOL The Scoring Tool helps you calculate a level of care for the resident being evaluated. The Level of Care reflects the complexity of the services required to meet the needs of each *this* resident. The Level of Care scoring concept recognizes that all residents may not need the same amount of services, or need them as often.

The resident's overall Level of Care score (Level 1, 2, or 3) gives you a picture of the total care and service needs of an individual resident. The completed assessment should help you identify the resources and staff that you will need to care for a specific resident.

THE PROCESS

The process for assessing prospective or current residents and figuring their Level of Care is divided into the following steps:

1. Complete the Health Care Practitioner and Assisted Living Manager components of the assessment.
2. Review the assessments.
3. Use the Level of Care Scoring Tool to score each component of the assessment.
4. Add up the scores for each Section, as indicated on the Level of Care Scoring Tool. Add up the score for each of the seven (7) sections to arrive at your total score. A maximum total of 115 points is possible.
5. The levels of care are identified as follows:
 - **Level 1 = a total score of 0-20**
 - **Level 2 = a total score of 21-40**
 - **Level 3 = a total score of 41 or higher**

GUIDE TO THE ASSESSMENT TOOL

All items must be answered completely. Notations of “see attached” are not acceptable for scoring purposes.

PART I: The Health Care Practitioner Portion

Item 1: Current Medical and Psychiatric History

Briefly describe changes in health or behavioral status within the past 6 months. This may include, but is not limited to, acute episodes of medical or psychiatric illness, recent changes in function or behavior, symptom progression requiring changes in medications or treatments, falls with or without injury and any suicide attempts. Provide enough detail to indicate the course of the problem (resolved, improved somewhat, worse, etc.), any complications (for example, became dehydrated from repeated vomiting, or bruised left hip from fall because of balance problems due to a recent transient ischemic attack), and any new or changed treatments. A change in one's environment can be considered a potential crisis event. The change and a recent onset of mood disturbance suicide attempt (e.g. past 6 months) can

be a potential risk for depression or another suicide attempt. If available, the health care practitioner may attach any additional information (physician notes, hospital discharge summary, consultation forms, etc. to help provide and clarify the details.

Item 2: Briefly describe any past illness or chronic conditions.

Briefly list or describe any past illnesses (including hospitalizations), and longer-term physical, functional, and psychological condition changes, over the years. Some individuals have had numerous types of illness or may have had numerous bouts of the same illness, operations, and injuries. Include all known chronic conditions with any bearing on their current condition e.g. Dementia, chronic renal failure, COPD, hypertension, congestive heart failure, HIV/AIDS, Hepatitis, diabetes mellitus, and suicide attempts. If available, the health care practitioner may attach any additional information (physician notes, hospital discharge summary, consultation forms, etc. to help provide and clarify the details). These attachments are not a substituted for completing this item on the form.

Item 3: Allergies

List any allergies or sensitivities to foods, medications or environmental factors. Environmental factors may include cleaning products or air fresheners. A person's descriptions of "allergies" may actually reflect various reactions ranging from a disagreeable sensation or upset stomach to anaphylaxis. Therefore, as much as you can (and if known), identify the nature of any problems such as rash, anaphylactic reaction, GI symptoms, etc. Please be sure to also enter all medication or substance (food or environmental) allergies under Item 12.

Item 4: Communicable illnesses

The Assisted Living regulations require that the individual be free from communicable TB and any other active reportable airborne communicable diseases. Therefore, indicate if the individual is **free** from active disease. Provide enough information in the indicated spaces about the basis for this conclusion. This requires either a negative PPD or chest X-Ray or evidence that a positive converter or previous TB patient does not currently have active disease. Please contact your local health department for guidance to determine frequency of the testing for residents and staff. Active disease means a disease process that is present and flourishing, that may or may not demonstrate symptoms.

As needed, provide additional information about required treatments or monitoring in answering Items 12(c) and (d).

Item 5: History of substance abuse

Indicate if the individual has any history or current problem related to abuse of prescription, non-prescription, or illegal drugs, alcohol, inhalants, or herbal supplements. If such a problem is present, then identify the substance(s) and the actual or approximate last known date of use (to the best of your knowledge). Indicate whether the individual is in a treatment program for substance abuse, and where the

resident is receiving treatment. Monitoring by staff for compliance with therapeutic programs should be part of your Service Plan.

- **Abuse:** means the continued use of drugs or substances, including alcohol that may cause physical and/or psychological problems: for example; pain medications, or prolonged daily dependency on non-prescription laxatives
- **Misuse:** means to use for a purpose other than intended: for example; diuretics for weight loss.
- **Non-compliance:** means the failure of the resident to carrying out that portion of the medical care plans under his/her control, or the failure to use/take medication as prescribed.

Item 6: Risk factors for falls and injury

Many impaired individuals are at risk for falling. Falling is a major cause of disability and death in the elderly. Knowing an individual is at risk for falls, it may make it possible to try various interventions to prevent falling. Risk factors could include but are not limited to; poor balance, low blood sugar, low blood pressure, dehydration, poor fluid intake, medication side effects *e.g.* poor or vision disturbances, or diuretics which would result in frequent urination. These risk factors and how you are going to protect the resident should be addressed as part of your Service Plan.

Item 7: Skin condition(s)

Impaired skin integrity may need current treatment or may represent a risk factor for subsequent skin breakdown. Easy bruising may indicate a medical condition or a risk factor for injury. Identify any current or past history of ulcers (vascular, stasis or pressure), rash, skin tears, easy bruising, and their causes. Monitoring for problems related to skin should be addressed as part of your Service Plan.

Item 8: Significant sensory impairments affecting functioning

Severe sensory impairments can be significant risk factors, or may interfere with functioning or quality of life (for example, enjoying food or socializing). Sometimes, these impairments can be improved, which helps improve quality of life. Indicate all applicable impairments:

- a) Hearing:** Quality of hearing in each ear. Address the resident refusal to wear/use a hearing aid in item #34 as well as your service plan
- b) Vision:** Quality of vision in each eye. Address the resident refusal to wear/use a visual aid in item #34 as well as your service plan
- c) Smell:** Whether smell is intact or diminished. Address in your service plan due to resident risk during a fire.
- d) Taste:** Whether taste is intact or diminished. Address in your service plan if this affects food intake.

e) Temperature sensitivity: Whether the individual has any loss of sensitivity to temperature (for example, because of neuropathy or stroke)

Item 9: Current nutritional status

Understanding current nutritional status is very important, to enable monitoring for risk factors and for the management of current problems or conditions. Height and weight are clues to current nutritional status. Any forms or mechanism to document monitoring shall be developed by the Case Manager/Delegating Nurse and the ALM.

a) Identify the presence of any significant weight change in the past 6 months. This may mean a steady decline, a gain or loss of >10% of weight, or some other significant pattern.

b) Identify the amount and the period of time over which it has occurred.

c) Monitoring necessary: Weight is a key indicator of a resident's health. It is appropriate and reasonable for a facility to monitor each resident's weight on a monthly basis. You do not need a physician's order for this routine monitoring. A physician should be notified if the resident has an unplanned or unanticipated weight loss or gain. An unanticipated weight gain may reflect fluid retention. An unanticipated weight loss may reflect a loss of appetite due to a medical cause or medication effect, or overall decline in condition. Monitoring may include not only monthly weights but a change in food or fluid intake, ability to feed oneself, chew and swallow food; or decreased energy level to feed self or progression of cognitive impairment; e.g. forgets to eat when presented with a meal or during the course of a meal.

d) Identify any evidence of malnutrition, **or** if the individual is at risk for undernutrition; for example, because of increasing confusion, forgetting how to eat or use utensils, poor oral intake, taking medications that affect appetite or sense of taste, or recent acute illness.

- Nutritional supplements such as Ensure, Boost or Carnation Instant Breakfast need to be ordered by the health care practitioner

e) Identify any evidence of dehydration, **or** if the individual is at risk for dehydration; for example, because of poor oral intake, heart failure requiring use of higher amounts of diuretics and ACE inhibitors, etc.

f) Monitoring of risk for undernutrition or dehydration will need to be addressed and the service plan should include the method and frequency of monitoring

g) Identify if medical or dental conditions are affecting chewing, swallowing, or eating; for example, a new or old stroke causing dysphasia, depression causing loss of appetite, or periodontal disease causing mouth pain and in turn affecting chewing. Some examples of problems that could cause chewing or eating problems could include loose teeth, unfilled cavities, and poorly fitting dentures. Address use/need for assistive devices such as a weighted spoon, plate rim or special plate, or Geri-cup to

prevent spilling in the service plan. Use of assistive devices may enable the resident to maintain their independence with eating and drinking as well as encourage the necessary food and fluid intake. If the resident is gastrostomy tube fed the service plan should address management and monitoring requirements.

h) Special or therapeutic diets are to be noted in this section. For the resident who is on a food restricted diet such as renal or no concentrated sweets the CM/DN may assist in educating the ALM in making modifications to the meals.

If the resident is gastrostomy tube (GT) fed the order needs to be specific as to formula to be used, rate of flow of the feeding per hour or gravity drip and total volume to be given in a 24 hour period. Orders for water flush shall include frequency and volume.

The service plan will address how the GT orders are to be carried out with documentation on forms designated or designed by the ALM and CM/DN.

Item 10: Cognitive/Behavioral Status

Cognitive and behavioral status can be heavily influenced by medical conditions. Knowing more about the reasons for an individual's impaired cognition and behavior, and the frequency or scope of various disturbances of cognition, mood, and behavior will greatly help the Assisted Living provider assist and monitor the individual.

- If the individual has dementia, indicate the diagnosis or cause(s), such as Alzheimer's disease, multi-infarct dementia, Parkinsonism, or others. Since some individuals have multiple causes, mark all that apply.
- Indicate the date and score of any Mini-Mental Status Exam, if tested. If alternative tests of cognitive function have been done, write in the test name and the results.
- Section 10e lists a series of cognitive, communication, mood, and behavioral problems or conditions. For each item in the grid, indicate either the frequency or severity of the problem by *circling the most appropriate answer*. It is understood that some of these will be best estimates, while others can be based on direct observation or testing. This information will be very important for the Assisted Living provider to define the frequency and complexity of essential support needed for the impaired individual.
- **Agitation:** means excessive motor activity, usually non-productive, repetitious and difficult for the individual to control. This includes the inability to sit still, pacing, hand wringing, picking or pulling at clothing or other objects, rocking back and forth, restlessness/fidgeting, facial contortions that are not drug induced, shouting, low tolerance for frustration, irritability and physical or verbal outbursts that are not disease related. It is accompanied by feelings of tension.

- **Continuous:** means ongoing, with little or no break between episodes.
 - Example: Behaviors that can not be redirected, or reappear shortly after redirection
 - Example: Use of oxygen needed by the resident that is needed at all times, but may be removed for brief periods of transfer or bathing.
- **Inappropriate social behavior:** means behavior that is not generally accepted and may include but is not limited to any of the following e.g. urinating in wastebaskets, flowerpots or heating units; unwanted sexual advances or conduct such as attempting to get into bed with another resident (who is not a spouse or significant other of a long established relationship) or touching other residents or staff in inappropriate places, disrobing, hoarding, or rummaging through others belongings.
- **Occasional:** means not daily, but at least approximately 2 -3 times per week
- **Regular:** means that the resident demonstrates this behavior daily.
- **Wandering:** means moving about without purpose, looking for non-existent place or trying to actively leave the facility.
 - Examples of behaviors that may reflect impaired cognition or judgment may include, but are not limited to: touching a hot stove or surface, or going outside in cold weather without a coat; unsafe behaviors may include getting out of a wheelchair without help or wandering in or outside of the facility, or trying to leave the facility while wandering. Dangerous to self or others may include unsupervised smoking, lighting fires in trash cans due to using the trash can as an ashtray, combative or aggressive behaviors (kicking, biting, hitting, scratching or spiting).

Item 11: Ability to self-administer medications – The answers to this section should be based upon the resident’s ability to safely perform the task, not on the facilities policy on medication administration.

The ability to self-administer medications depends on a combination of individual factors: physical ability to manipulate containers and take medications, cognitive capability to know which ones to take and when, enough intact judgment to know of the general risks and dangers of missing too many medications, taking the wrong ones, or taking too many.

Based on the preceding review of this individual's functional capabilities, and physical and cognitive status and limitations, **rate this individual's ability to take his or her own medications safely and appropriately. This should be assessed at least every 90 days or at the time of a significant change in physical or cognitive status.**

a) Independently without assistance: means that the individual has the physical and cognitive ability to take medications without any support or assistance from others

b) Can do so with physical assistance, reminders, or supervision only: means that the individual has some minor physical or cognitive limitation, but only to the point of requiring some cuing and coaching or minimal supervision. The individual may need help opening the medication containers or pouring the medications. However, the individual can take and swallow the medications and has some understanding of the reason for taking medications.

c) Needs to have them administered by someone else: means that the individual lacks either physical or cognitive capabilities, or both, requiring that a staff member regularly identify, pour, and give the medications to that individual. Assessment tools are available to help determine if the individual may safely self-administer, needs assistance or must have medications administered. Consult with your CM/DN for these tools.

If b) or c), are checked this will need to be addressed in your Service Plan. For the facility that has residents requiring assistance or cuing and coaching for medication, contact the Office of Health Care Quality for the form to obtain the Cuing and Coaching Video and Workbook.

Item 12: Prescriber's Medication and Treatment Form, and Other Information

There is often a link between medical conditions, medications and impaired function and behavior. This portion of the practitioner assessment was designed to serve as both a prescribing practitioner's order form and a way to help the Assisted Living provider understand the link between a resident's diagnoses and their medications and treatments.

Many Assisted Living residents have a number of medical conditions as well as functional and cognitive impairments, and they may take many medications. Most Assisted Living providers are not health care practitioners. Some of these medications may be considered high-risk medications. Assisted Living providers should know something about a resident's illnesses and conditions to understand: the reasons for a resident's impaired function; the purpose of their medications; and the possible risks of their treatments and medications (including high-risk medications).

Therefore, it is very important for the physician or other health care practitioner to indicate clearly and as fully as possible:

- a) The individual's active diagnoses,
- b) What medications they are taking in relation to that diagnosis,
 - **Medication means:** a pharmacological agent (including OTC -over the counter medications), to relieve or manage the symptoms of a disease, or a condition, e.g. Nebulizer, Anti-coagulants, or Cardiovascular (heart) drugs. If crushing of medications or liquid form needed, it should be noted in 12 a).

- The use of over the counter herbal supplements of “Alternative Medicine” are not medications, but due to the risk of possible interaction with conventional prescription and non prescription medications need to be noted under medications in item 12 a).

c) What treatments are noted as ordered in relation to diagnoses or conditions,

➤ **Treatment means:** a special procedure used for the cure or to relieve the symptoms of a pathological condition or disease, e.g. oxygen for shortness of breath, wound care or pressure ulcer care, flushing of indwelling urinary catheters.

- Psychiatric interventions other than medications including individual or group therapy and ECT are considered treatments.
- Treatments may include those services that are physician ordered for physical, occupational and/or speech therapies that would require staff time and assistance to follow up on the treatment recommendations.
- This would include those treatments that have been arranged for and delivered by any Home Health Agency staff.

d) What the provider needs to monitor or report to you related to the condition, the medication, or the treatment. Examples could be reporting blood pressure over 150/100, a finger stick result under 60 or greater than 120, two or more consecutive days of pulse below 60 and Digoxin having to be held.

The Service Plan should reflect a resident’s condition(s) or problem(s) that impacts on their functioning. This includes any additional monitoring or safety issues related to high-risk medications. For example, diagnosis of osteoporosis (brittle bones) would require that a resident’s living space be free from throw rugs or obstacles which may present a risk for falling with injury such as bruising or a fracture.

High-risk medications or supplements include, but are not limited to the following examples:

1. Digoxin or Lanoxin
2. Theo-dur (theophylline)
3. Anti-seizure medications such as Dilantin
 - These medications would require laboratory testing for therapeutic levels
4. Coumadin (Warfarin), Plavix or any other anti-coagulant (blood thinner) medications
 - Warfarin would require laboratory testing for therapeutic levels
 - This does not included Aspirin as part of a prophylactic regimen for past history of stoke or cardiac problems.
5. Over the counter herbal supplements e.g. St John’s Wort, Kava, Valerian, Echinacea or Gingko
6. Herbal or Green teas because of potential interaction with prescribed medications.

7. *A resident's medication regime may represent potential high risk for that particular resident. "High risk" can occur with drug to drug interactions (either prescribed or OTC) and may be unique to the resident. Consultation with the delegating nurse and pharmacist can help the provider identify these risks. Numerous resources available to you via drug books, the Physicians Desk Reference (PDR) and on the internet.*

Procedure for Item 12. Use the following procedure to complete this Section.

- List all medications, including OTC (over-the-counter) and dietary supplements and/or herbal supplements in Column A. Also list any medications that the individual is taking but which are not associated with a specific diagnosis or condition.
 - List all related diagnoses/problems/conditions in Column B.
 - List all treatments, including the frequency in Column C, e.g. Lab testing for protime/INR for anticoagulant therapy, standing orders for routine skin creams or prescribed lotions.
 - In Column D, indicate any monitoring associated with the diagnosis or the treatment, including any need to report information to the physician (for example, "Monitor finger sticks b.i.d., notify physician if results are over 300", finger sticks to monitor the diet controlled diabetic, check pulse prior to giving Digoxin and hold if the pulse is below 60, observation of and dressing to skin tears or ulcers and cleaning around GT site.).

You may have several medications and treatments for one diagnosis. If the medications are being given for several purposes (for example an ACE inhibitor for both Congestive heart failure and hypertension), list those diagnoses together but only list the medication once.

Having completed the form, the physician or prescribing practitioner should sign it and complete the other requested information, so the form may be used as an Admission Order form. The Service Plan should address any monitoring by the AL staff or outside testing requirements and how the outside services will be provided.

The Service Plan is to be considered an ongoing and evolving document. It is to reflect the current and changed needs of the resident. Resident s that require medications to be crushed or in liquid form due to swallowing problems may be at greater risk for aspiration. Precautions and monitoring should be included in the service plan.

Part 2: The Assisted Living Manager Portion

A review and new or adjusted score of the Assisted Living Managers portion of the assessment (Part 2, items 13-21 and 28-35) may be done independently of the Health Care Practitioners portion of the assessment (Part 1), providing that there are no changes in any of the items numbered 1-12.

ITEMS 13-21 / ACTIVITIES OF DAILY LIVING

Activities of Daily Living (ADLs) are considered to be essential functions needed to help an individual survive, be safe, and meet social and personal expectations. They include processes related to personal care such as eating, waste elimination, dressing. An Assisted Living providers must assist and individual with significant ADL deficits maximize the individual's functioning and quality of life, and to protect their health and safety.

For each item choose and mark the one response that best describes the individual's ability to perform or participate in the task or function. As much as possible, determine the individual's ADL function by direct observation. When this cannot be done, you may complete this portion of the assessment based on evaluation by a health care provider, or by direct discussion with someone who has seen the individual and can accurately describe and define his or her functional capabilities and limitations. For example 1) The AL program may not have stairs but the resident still has the ability to negotiate stairs, 2) The AL program may no permit residents to shower alone because of facility policy but the resident could shower independently. Because ADLs are important in determining the individual's overall Level of Care, each ADL function has been assigned a score. Based on your assessment, write the score for each item in the blank space provided. Then, add together the individual scores for Items 13 through 21, and place that total ADL score in the blank provided in Item 21(a).

The Service Plan is to be considered an ongoing and evolving document. It is to reflect the current and changed needs of the resident. The use of adaptive eating devices such as built up spoons, forks, plate guards or Geri-cups should be noted as part of the service plan.

Item 21a): SCORING FOR ADL's

Add the scores of Items 13-21, and enter the total in the blank space. Then transfer the score to the Scoring Tool (Section 5).

ITEMS 22-27 / INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Instrumental Activities of Daily Living (IADL's) include capabilities related to the tasks of everyday social and personal life such as cooking, chores or keeping personal space clean, using the telephone, manage money for purpose of daily personal needs and shopping.

While IADL's do not figure in the Level of Care scoring, they are significant in identifying a resident's strengths and needs, and may need to be included in the Service Plan.

ITEMS 28-35 BEHAVIORS/COMMUNICATION

For items 28-34, Choose and check as **many** answers as applicable that best describe the residents, behaviors and ability to communicate. You could have more than one answer for each item. If you have multiple answers for each question then you must use the highest scoring value. For example if you scored question 29 as occasional regular and continuous then the scoring value is continuous.

- **Agitation:** means excessive motor activity, usually non-productive, repetitious and difficult for the individual to control. This includes the inability to sit still, pacing, hand wringing, picking or pulling at clothing or other objects, rocking back and forth, restlessness/fidgeting, facial contortions that are not drug induced, shouting, low tolerance for frustration, irritability and physical or verbal outbursts that are not disease related. It is accompanied by feelings of tension.
- **Continuous:** means ongoing, with little or no break between episodes.
 - Example: Behaviors that can not be redirected, or reappear shortly after redirection
 - Example: Use of oxygen needed by the resident that is needed at all times, but may be removed for brief periods of transfer or bathing.
- **Inappropriate social behavior:** means behavior that is not generally accepted and may include but is not limited to any of the following e.g. urinating in wastebaskets, flowerpots or heating units; unwanted sexual advances or conduct such as attempting to get into bed with another resident (who is not a spouse or significant other of a long established relationship) or touching other residents or staff in inappropriate places, disrobing, hoarding, or rummaging through others belongings.
- **Occasional:** means not daily, but at least approximately 2 -3 times per week
- **Regular:** means that the resident demonstrates this behavior daily.
- **Wandering:** means moving about without purpose, looking for non-existent place or trying to actively leave the facility.
 - Examples of behaviors that may reflect impaired cognition or judgment may include, but are not limited to: touching a hot stove or surface, or going

outside in cold weather without a coat; unsafe behaviors may include getting out of a wheelchair without help or wandering in or outside of the facility, or trying to leave the facility while wandering. Dangerous to self or others may include unsupervised smoking, lighting fires in trash cans due to using the trash can as an ashtray, combative or aggressive behaviors (kicking, biting, hitting, scratching or spiting).

Residents, who have the cognitive ability to make informed decisions about their care, may (exercise their) have the right to refuse elements of care without being considered resistive or uncooperative.

For example:

- The resident who refuses to take a pain pill for joint or other type of pain because they would rather tolerate the pain than take a pill.
- The resident who refuses regularly scheduled twice weekly bath/shower and will take only one bath/shower a week. The resident with dementia, who refuses to bathe or shower when first approached, but will take the bath or shower upon being approached again in a few minutes or at a later time that same morning/evening, should not to be considered as refusing.
- An example of agitation may include racing back and forth in a chair and pushing things away with repeated vocalizations.
- Item 35 is counted in scoring tool in risk factors and will need to be transferred to the scoring tool for the purpose of determining level of care. Any response other than “always” needs to be addressed in the Service Plan because the staff will need to deal with the behaviors that will take more time to provide a safe environment for the resident and others residing in your home.

Items 28-35 are counted as part of the scoring for level of care, and will need to be transferred to the scoring tool for the purpose of determining the level of care. Any response other than never for items 28-35, needs to be addressed in the Service Plan, because of the need by the staff to deal with behaviors that will take more time to provide a safe environment for the resident and others residing in your home. Item number 36 is not included in the scoring but will need to be addressed in the resident’s Service Plan.

ITEMS 37-43 DAILY SOCIAL AND RECREATIONAL NEEDS

The following items do not impact on scoring, but will need to be addressed in the resident’s Service Plan as needed.

Item 37: Family Support and Personal Relationships

Check all responses that apply to the resident. Briefly explain the nature of any family problems; for example, "Four children, 3 local and 1 out-of-town who is the responsible party. Husband very ill and cannot visit often. Contact limited because of significant family conflicts". Include any things such as social isolation or problems in (*that impact upon*) getting along with others.

Item 38: Spiritual needs and status

Briefly describe noteworthy information about the individual's spiritual status, preferences, and needs; for example, likes to attend religious services, wants to attend Mass daily.

Item 39: Education/Work history

There is more than one possible answer for this section. The educational level and past occupation may assist you in planning and understanding any problems that might be pertinent to the individual's current situation, e.g. employed as night watchman in warehouse, former police officer or firefighter could impact on your dealing with wandering problems with a resident who has dementia.

Item 40: Interests/Hobbies

Briefly describe what is known about the individual's past and present interests and hobbies. These past interests or hobbies should be incorporated into the resident's service plan, whenever possible.

Item 41: Activity Status

Briefly describe what is known about the individual's interest and ability to participate in a) structured and group activities and b) self-directed activities such as reading, computer use, or watching television. Maintaining participation in program activities will need to be addressed in the resident's Service Plan based upon interests and hobbies noted in Item 40.

Item 42: Current Daily Routine

Briefly describe what is known about the individual's current daily routine such as usual wake-up time, bedtime, meal time preferences. Things noted here could have potential impact on resident care and need to be included in your Service Plan.

Item 43: Interest in programs away from the facility

Briefly describe what is known about the individual's interest in attending, or need to attend, programs away from the facility such as Senior Centers, Adult Day Care, or Rehabilitation Programs. Assisting the resident in making arrangements for transportation to attend these programs may need to be included as part of your Service Plan.

The Service Plan is to be considered an ongoing and evolving document. It is to reflect the current and changed needs of the resident.

THE SCORING TOOL

The scoring tool has been developed to link various information about the resident, which has been recorded on the assessment tool, to the amount of care and service likely to be required to meet those needs. Points have been assigned to various items based on how they are likely to impact the scope (number or amount) and frequency of provider services.

Match each item on the Assessment tool to the corresponding item on the Scoring Tool. Record the number of points in the space provided. When each Section is finished, total the score for that Section and place the total in the indicated box marked "Score for This Section."

Identifying a Level of Care

Add the **total score** all the sections of the tool and enter in the blank at the bottom of the Level of Care Scoring Tool, page 2 of the form. If a score change in any of the following areas is noted *Items 10e, 11, or 28-35* a further evaluation by the Health Care Practitioner is to be conducted and the necessary changes made to the Service Plan..

Level 1 = 0 – 20

Level 2 = 21 – 40

Level 3 = 41 or higher

When any of the following conditions or resident needs is noted, contact OHCQ, Assisted Living Division for guidance:

- | | |
|---|--|
| <ul style="list-style-type: none"> (1) More than intermittent nursing care (2) Treatment for stage three or four skin ulcers (3) Ventilator services (4) Skilled monitoring, testing and aggressive adjustment of medications and treatments where there is the presence of, or risk for, a fluctuating acute condition | <ul style="list-style-type: none"> (5) Monitoring of chronic medical conditions that are not controllable through readily available medications and treatments (6) Treatment for active reportable communicable disease (7) Treatment for a disease or condition which requires more than contact isolation |
|---|--|

Exception: individuals who (a) are in a specialized program for HIV/AIDS, which the department has approved, or, (b) are under the care of a general hospice program.

WHAT NEXT?

Use all of the above information to develop a Service Plan. You may need to revise your Service Plan as you gather any additional information. The Service Plan is to be considered an ongoing and evolving document. It is to reflect the current and changed needs of the resident. Residents may have a period of time where there are skin problems with skin tears, change in sleep pattern, not eating for a short period of time. While this is only temporary, it may require increased monitoring by the staff. Should this become an ongoing issue for two weeks or

greater, a change/revision to the Service Plan may be indicated. When your assessments are complete, your Level of Care Score is determined, and your Service Plan is completed, you should be able to provide each resident with consistent, competent, and compassionate care in a safe environment.

Acknowledgements

A sincere thank you from the Office of Health Care Quality to the Assisted Living Workgroup for all their time and efforts to affect the revisions to the Health Care Practitioners Assessment, Assisted Living Managers Assessment, Scoring Tool and Users Guide: Alva Baker MD, Darlene Fabrizio RN, Marie Ickreath, Wesley Malin, Barbara Newman RN, Valerie Richardson RN, and Karin Lakin. Special thanks Editor Steve Levenson MD.

Lynne Condon RNC, Chair of the Committee

Resident Name _____ Date of Birth _____

Date completed _____

Health Care Practitioner Physical Assessment

This form is to be verified by signature for accuracy by a physician, certified nurse practitioner, registered nurse or certified nurse midwife

Please note the following before filling out this form - An applicant for admission who needs any of the following services may not move into an assisted living facility: (1) more than intermittent nursing care; (2) treatment for stage three or four skin ulcers; (3) ventilator services; (4) skilled monitoring, testing and aggressive adjustment of medications and treatment where there is the presence of or risk for, a fluctuation acute condition; (5) monitoring of chronic medical conditions that are not controllable though readily available medications and treatments; (6) treatment for active reportable communicable disease; or (7) treatment for a disease or condition which requires more than contact isolation. (Exception: individuals who (a) are in a specialized program for HIV/AIDS which the department has approved or, (b) are under the care of a general hospice program.

1. Current Medical and Psychiatric History [Briefly describe recent changed in health or behavioral status, suicide attempts, hospitalizations, falls, etc. within the past 6 months]:

2. Briefly describe any past illnesses or chronic conditions (including hospitalizations), past suicide attempts, and physical functional and psychological condition or changes, over the years:

3. Allergies [List any allergies or sensitivities for food, medications or environmental factors, and if known, the nature of the problem (rash, anaphylactic reaction, GI symptom, etc.) Please enter medication allergies here and also in item # 12 for medication allergies]:

4. Communicable illnesses: Is the individual free from communicable TB and any other active reportable airborne communicable disease(s)? (Check one) ____ Yes ____ No - If "No", the indicate the communicable disease:

Which tests were done to verify the individual is free from active TB:
PPD Date _____ Result _____ mm
Chest X-ray (if PPD positive or unable to administer a PPD) Date _____
Result _____

Resident Name _____ Date of Birth _____
Date completed _____

2

5. History of: [Does individual have any history or current problem related to abuse of prescription, non-prescription, OCT, illegal drugs, alcohol, or inhalants, etc.?)

a) Substance: OTC, non-prescription medication abuse or misuse (check one)

1. Recent (last 6 months) Yes No

2. History Yes No

b) Abuse or misuse of prescription medication or herbal supplements

1. Currently Yes No

2. Recent (last 6 months) Yes No

c) History of non-compliance with prescribed medication

1. Currently Yes No

2. Recent (last 6 months) Yes No

d) Describe misuse or abuse: _____

6. Risk factors for falls and injury. Identify any conditions about this individual that increase their risk of falling or injury (check all that apply): orthostatic hypotension osteoporosis gait problem

impaired balance confusion Parkinsonism foot deformity pain assistive devices

other (explain) _____

7. Skin condition(s) Identify any current or history of ulcers, rash, skin tears with any standing treatment orders also noted in item #12 C, easy bruising, etc. and their causes: _____

8. Sensory impairments affecting functioning (check all that apply):

a) Hearing: Left ear: _____ Adequate _____ Poor _____ Deaf _____ Uses corrective aid

Right ear: _____ Adequate _____ Poor _____ Deaf _____ Uses corrective aid

b) Vision: _____ Adequate _____ Poor _____ Deaf _____ Uses corrective lenses

_____ Blind (check all that apply) R L

c) Temperature sensitivity (check): _____ Normal Decreased in sensation to: ___ Heat ___ Cold

9. Current nutritional status: Height _____ inches Weight _____ lbs.

a) Any weight change gain or loss in past 6 months? Yes No

b) How much weight change? _____ lbs. in the past _____ months (check one) Loss Gain

c) Monitoring necessary (check one)? Yes No

If items a), b) or c) is checked: Explain how and at what frequency the monitoring is to occur _____

d) Is there evidence of malnutrition or a risk for undernutrition? Yes No

e) Is there evidence of dehydration or a risk for dehydration? Yes No

f) Monitoring of nutritional or hydration status necessary? Yes No

If items d), and/ or e) are checked: Explain how and at what frequency the monitoring is to occur: _____

g) Does the individual have medical or dental conditions affecting (check all that apply):

_____ Chewing _____ Swallowing _____ Eating _____ Pocketing food _____ Gastronomy Tube Fed

h) Note any special therapeutic diet (e.g. sodium restricted, renal, calorie or sugar restricted): _____

i) Modified consistency (e.g. Pureed, Mechanical soft or thickened liquids): _____

j) Is there a need for assistive devices with eating (check all that apply): Yes No

_____ weighted spoon or built up fork _____ plated guard _____ special cup/glass

k) Monitoring necessary: Yes No

If items g), h), or i) are checked please explain how and at what frequency: _____

Resident Name _____ Date of Birth _____

Date completed _____

10. Cognitive/Behavioral Status

- a) Is there evidence of dementia (check one)? Yes No
- b) Has the individual undergone an evaluation for dementia (check one) Yes No
- c) Diagnosis (cause[s] of dementia) Alzheimer's Disease Multi-infarct/Vascular Parkinsonism
- Other _____
- d) Mini Mental Status Exam (if tested) Date _____ Score _____

10 e) Instructions for the following items: For each item, circle the appropriate level of frequency or intensity, depending on the item. Use the "Comments" column to provide any relevant details.

Item 10e)	A	B	C	D	Comments
Cognition					
I) Disorientation	Never	Mild	Moderate	Severe	
II) Impaired recall (recent/distant events)	Never	Occasional	Regular	Continuous	
III) Impaired judgment	None	Mild	Moderate	Severe	
IV) Hallucinations	Never	Occasional	Regular	Continuous	
V) Delusions	Never	Occasional	Regular	Continuous	
Communication					
VI) Receptive / expressive aphasia	None	Mild	Moderate	Severe	
Mood and emotions					
VII) Anxiety	Never	Occasional	Regular	Continuous	
VIII) Depression	None	Mild	Moderate	Severe	
Behaviors					
IX) Unsafe Behaviors	Never	Occasional	Regular	Continuous	
X) Dangerous to self or others	Never	Occasional	Regular	Continuous	
XI) Agitation (Describe behaviors in comments section)	Never	Occasional	Regular	Continuous	

10 f) Health care decision making capacity:

Based on the preceding review of functional capabilities and physical and cognitive status and limitations, indicate this individual's highest level of ability to make health care decisions:

- ___ a) probably can make higher level decisions (such as whether to undergo or withdraw life-sustaining treatments) that require understanding the nature, probable consequences and burdens and risks of proposed treatment.
- ___ b) probably can make limited decisions that require simple understanding
- ___ c) probably can express agreement with decisions proposed by someone else
- ___ d) cannot effectively participate in any kind of health care decision-making

11. Ability to self-administer medications

Based on the preceding review of functional capabilities, and physical and cognitive status and limitation, rate this individuals ability to take his/her own medications safely and appropriately:

- ___ a) independently without assistance
- ___ b) can do so with physical assistance, reminders or supervision only
- ___ c) need to have medications administered by someone else

_____ Date _____
Print Name

Signature and license category of health care practitioner

Resident Name _____ Date of Birth _____
 Date completed _____

PRESCRIBERS MEDICATION AND TREATMENT ORDERS AND OTHER INFORMATION

Birth Date: _____

Allergies: (please list *all*) _____

Note: Does resident require medications crushed or in liquid form? Please indicate in 12 a) with medication order. If the medication is *not* to be crushed please indicate.

12 a) Medication(s) including PRN, OTC herbal and dietary supplements	12 b) All related Diagnoses/Problems/Conditions	12 c) Treatments (include frequency and any instructions about when to call MD)	12 d) Related testing or monitoring
Include dosage, route (p.o., etc.) frequency, duration (if limited)	Please include all diagnoses that are currently being treated by medication	Please link diagnosis, condition or problems as noted in prior sections	Include frequency, and any instructions to notify MD

Prescriber's Signature _____ Date _____

Office address _____ Phone # _____

 Signature of RN who has reviewed and reported the above by family, resident and pharmacy dispensed medications supplied at time of review Date _____

Resident's Name _____

ALM page 1

Date of Birth _____

ASSISTED LIVING MANAGER'S ASSESSMENT

[To Be Completed By The Assisted Living Manager or Designee]

ACTIVITIES OF DAILY LIVING

Instructions: Record score in the blank after each question number

13. _____ Resident Eats

0 Independently

1 With supervision, or set-up, or cuing & coaching

2 With physical assistance or use adaptive devices to feed self (built up utensil or plate guard or Geri-cup)

3 Must be fed or needs tube feeding

14. _____ Resident's Mobility (moves from place to place)

0 Independent (or with assistive device)

1 With supervision, or stand by, or cuing & coaching

2 One-person physical assistance

3 Two person physical assistance, or needs complete assistance mechanical assistance (e.g., Hoyer lift)

15. _____ Resident Transfers to Bed, Chair or Toilet

0 Independent (or with assistive device)

1 With supervision, or stand by or set-up, or cuing & coaching

2 One-person physical assistance

3 Two person physical assistance, needs complete assistance or mechanical assistance (e.g., Hoyer lift)

16. _____ Bed Mobility: How resident moves to and from lying position, turns side to side, and positions body while in bed

0 Independent (or with assistive device)

1 With supervision, or set-up, or cuing & coaching

2 One-person physical assistance

3 Two person physical assistance, needs complete assistance

17. _____ Resident use of stairs

0 Independent (or with assistive device)

1 With supervision, or stand-by, or cuing & coaching

2 One-person physical assistance

3 Two person physical assistance, or unable to use stairs

18. _____ Resident Continence

0 Independent, including incontinence products

1 With supervision or set-up, or cuing & coaching

2 Needs physical assistance from one other person

3 Incontinent, needs complete assistance

19. _____ Resident Completes Bathing

0 Independently

1 With supervision, or stand by, set-up, or cuing & coaching

2 Needs physical assistance i.e. help in and out of tub, washing hair, etc.

3 Must be bathed, needs complete assistance or mechanical assistance i.e., Hoyer lift

20. _____ Resident Completes Grooming (teeth, make-up, shaving, hair)

0 Independently

1 With supervision, or stand by, set-up, or cuing & coaching

2 Needs physical assistance

3 Must be groomed, needs complete assistance

Resident's Name _____

Date of Birth _____

21. ____ Resident Gets Dressed/Changes Clothes

- 0** Independently
- 1** With supervision, or set-up, or cuing & coaching
- 2** With physical assistance
- 3** Must be dressed, needs complete assistance

21a) ____ Add scores for Items 13-21. Enter total in blank space at the left.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING

Note: Incapacities identified in this section do not imply services will be provided.

Instructions: Check the letter that most closely reflects the individual's capabilities

22. Resident Can Prepare Light Meal

- A** Independent, plans and prepares adequate meals
- B** With supervision, set-up, or cuing & coaching
- C** One-person physical assistance
- D** Unable to prepare meals

23. Resident Can Do Light Chores

- A** Independent
- B** With supervision, set-up, or cuing & coaching, e.g. bed making
- C** One-person physical assistance
- D** Unable to do light chores

24. Resident Can Do Shopping

- A** Independent
- B** With supervision or cuing & coaching, e.g. choosing items
- C** With one-person assistance/someone to go with them
- D** Unable to do shopping

25. Ability to manage finances

- A** Family or resident manages all financial matters independently, writes checks, pays bills/rent, goes to bank
- B** With supervision writes checks, pays bills/rent, goes to bank
- C** Manages day-to-day purchases, but needs help with purchases and banking
- D** Unable to manage finances or handle money

26. Transportation

- A** Travels by self, all modes of transportation
- B** Needs some assistance/escort
- C** Complete assistance/needs specialized vehicle

27. Resident Can Use Telephone

- A** Independent
- B** With assistance dialing/using directory
- C** Unable to use telephone

BEHAVIORS/COMMUNICATION

Does the resident exhibit any of the following behaviors? Check the appropriate box to indicate frequency of each behavior. For scoring purposes use the highest frequency noted See the users guide for definitions of frequency.

28. Withdrawn: Frequency of behavior(s) (check appropriate response):

A Refuses to leave room

- Never Occasional Regular Continuous

B Refuses to socialize with others

- Never Occasional Regular Continuous

Explain _____

29. Wanders: Frequency of behavior(s) (check appropriate response):**A** Persistent moving/walking about without purposeNever Occasional Regular Continuous**B** Looks for non-existent place (former house/apartment/bus)Never Occasional Regular Continuous**C** Actively tries to leave the facilityNever Occasional Regular Continuous**D** Wanders during dayNever Occasional Regular Continuous**E** Wanders in evening &/or at nightNever Occasional Regular Continuous**Explain** _____**30. Sleep disturbance: Frequency of behavior(s)** (check appropriate response):**A** Unable to sleep or agitated a nightNever Occasional Regular Continuous**B** Frequently falls asleep during dayNever Occasional Regular Continuous**Explain** _____**31. Verbally inappropriate: Frequency of behavior(s)** (check appropriate response):**A** Uses foul languageNever Occasional Regular Continuous**B** Sounds angry or threatens othersNever Occasional Regular Continuous**Explain** _____**32. Disruptive behaviors Frequency of behavior(s)** (check appropriate response):**A** YellsNever Occasional Regular Continuous**B** Demands attention without regard to othersNever Occasional Regular Continuous**C** Takes other's possessionsNever Occasional Regular Continuous**D** Socially inappropriate behaviors (e.g., disrobes, urinates, or defecates in public)Never Occasional Regular Continuous**E** Sexually inappropriate behaviors (e.g. unwanted touching, public masturbation)Never Occasional Regular Continuous**Explain** _____**33. Combative behaviors Frequency of behavior(s)** (check appropriate response):**A** Throws objects indiscriminatelyNever Occasional Regular Continuous**B** Strikes out, kicks or punches at othersNever Occasional Regular Continuous**C** Pinches, bites, spits at others, scratches, or pulls hairNever Occasional Regular Continuous**Explain** _____**34. Resistive/uncooperative behaviors Frequency of behavior(s)** (check appropriate response):**A** Refuses to washNever Occasional Regular Continuous**B** Refuses to eatNever Occasional Regular Continuous**C** Refuses to drinkNever Occasional Regular Continuous**D** Refuses to care for selfNever Occasional Regular Continuous**E** Refuses to allow others to assistNever Occasional Regular Continuous**F** Refuses medicationsNever Occasional Regular Continuous**G** Refuses to comply with safety adviceNever Occasional Regular Continuous**Explain** _____

Resident's Name _____

Date of Birth _____

35. Communication (check and/or explain appropriate response):

A Communicates needs, ideas and wishes

Never Occasional Regular Continuous

B Sometimes unable to communicate needs, ideas and wishes

Never Occasional Regular Continuous

C Unable to communicate needs, ideas and wishes

Never Occasional Regular Continuous

D Unwilling to communicate needs/wishes

Never Occasional Regular Continuous

Explain _____

36. Eating patterns and food preferences (check all that apply)

Eats full meals Eats only two meals Eats small portions

Finger foods Eats only **what** they want, but maintains weight

Eats only **when** they want Supplements (type ordered) _____

Prefers: Fruits Veggies Meats Snacks or snack foods

DAILY SOCIAL AND RECREATIONAL NEEDS

37. Resident Support System (check all that apply):

Resident has:

Legal representative for health care decisions

Surrogate decision maker (family member/significant other)

Family lives local

Involved

Not involved

Family lives out of area

Involved

Not involved

Problems with family circumstances

Yes

No

Problems with personal relationships

Yes

No

Explain _____

38. Spiritual needs and status _____

39. Education/Work history (check/complete all that apply):

Did not complete High School

Completed High School or GED

College

Lifetime or last occupation _____

40. Interests/Hobbies: _____

41. Activity Status (Interest and ability to participate in, check and explain):

A) Structured and group activities:

Yes

No

Varies

Explain _____

B) Self-directed activities:

Yes

No

Varies

Explain _____

42. Current Daily Routine (e.g., up in the morning, bedtime, normal sleep cycle prior to move in, meal time preferences) _____

43. Interest/participates in programs away from the facility (e.g., Senior Centers, Adult Day Care, or Rehabilitation Programs) _____

Signature of person completing assessment/position

Date completed

Print Name _____

Resident name: _____

Date Completed: _____

LEVEL OF CARE SCORING TOOL

PROVIDER MONITORING AND ASSESSMENT FUNCTIONS	POINTS SCORE
<p>1) Monitoring of medical illness and conditions</p> <p>Question 1: If current illness or psychiatric changes within past 6 months that requires monitoring..... Add 1 _____</p> <p>Question 1: Has there been more than one change in past 6 months for any reason?..... Add 1 _____</p> <p>Question 1: If recent suicide attempt..... Add 3 _____</p> <p>Question 9 (g): If gastrostomy tube feeding is checked..... Add 1 _____</p> <p>Question 9: If two or more answers to 9 c) f) or k) are checked..... Add 3 _____</p> <p>Question 12 (a): If 9 or more medications are ordered..... Add 1 _____</p> <p>Question 12 (a): If any high risk medications (as noted in the Guide)..... Add 1 _____</p> <p>Question 12 a): If any anticoagulant therapy requires outside lab services to monitor..... Add 2 _____</p> <p>Question 12 (d): If one or more items require any monitoring by the provider staff..... Add 1 _____</p> <p>Question 12 (d): If one or more items require at least daily monitoring..... Add 1 _____</p> <p style="text-align: right;">Total score for this section</p>	
<p>2) Monitoring of cognitive impairments, psychiatric illnesses and behavior</p> <p>Question 1: If acute psychiatric episode (within past 6 months)..... Add 1 _____</p> <p>Question 5: If any response is answered Yes..... Add 1 _____</p> <p>Question 5: If any two (2) choices area checked..... Add 1 _____</p> <p>Question 10 (e): If any items in 10 (e) other than iii, ix, or x, are checked as occasional or mild..... Add 1 _____</p> <p>Question 10 (e): If any items in 10 (e) other than iii, ix, or x, are checked as moderate or severe..... Add 2 _____</p> <p>Questions 28 – 34: If the frequency for any item is marked as Regular or Continuous..... Add 1 _____</p> <p>Questions 28 – 34: If the frequencies for 3 or more items are marked as Regular or Continuous..... Add 2 _____</p> <p style="text-align: right;">Total score for this section</p>	
PROVIDER CARE AND SERVICE FUNCTIONS	
<p>3) Performing treatments for physical/medical conditions</p> <p>Question 12 (b): If any diagnoses/conditions require any treatment besides medication(s)..... Add 1 _____</p> <p>Question 12 (b): If 3 or more diagnoses/conditions require any treatment besides medication(s)..... Add 3 _____</p> <p>Question 12 (c): If any treatment listed in this column must be given weekly..... Add 1 _____</p> <p>Question 12 (c): If any treatment listed in this column must be given daily..... Add 2 _____</p> <p style="text-align: right;">Total score for this section</p>	
<p>4) Medication management</p> <p>Question 12 (a): If 9 or more medications (including OTCs and PRNs)..... Add 1 _____</p> <p>Question 12 (a): If 3 or more high risk medications (See the Guide)..... Add 2 _____</p> <p>Question 12 (d): If additional staff training is required for staff to safely administer medication..... Add 2 _____</p> <p>Question 12 (d): If anything in this column requires health care practitioners notification..... Add 1 _____</p> <p>Question 12 (d): If any coordination with outside laboratory testing and/or health care practitioner visits..... Add 2 _____</p> <p>Question 11 (b): If checked..... Add 1 _____</p> <p>Question 11 (c): If checked..... Add 2 _____</p> <p>Question 34 E: If marked as <i>anything</i> other than never..... Add 1 _____</p> <p>Question 34 F: If marked and <i>anything</i> other than never..... Add 1 _____</p> <p style="text-align: right;">Total score for this section</p>	
<p>5) Assistance with ADL's</p> <p>Question 21: Transfer total score on sum of questions 13 – 21</p> <p style="text-align: right;">Total score for this section</p>	

Resident name: _____

Date Completed: _____

Level of Care Scoring Tool - Page 2

6) Risk factor management (falls/skin breakdown/etc.)	Points score
Question 2: If past history of suicide attempts(s).....	Add 1 _____
Question 6: If any one item is marked.....	Add 1 _____
Question 6: If any two or more items are marked.....	Add 2 _____
Question 7: If any skin conditions are noted.....	Add 1 _____
Question 8 (a): If hearing is marked as poor or deaf.....	Add 1 _____
Question 8 (b): If vision is marked as poor or individual is blind.....	Add 1 _____
Question 8 (c): If any temperature deficits are noted.....	Add 1 _____
Question 9 (d): If marked as "Yes".....	Add 1 _____
Question 9 (e) or (f): If marked as "Yes".....	Add 2 _____
Question 10 (b): If any diagnoses of dementia checked as "Yes".....	Add 2 _____
Question 10 (e) (iii): If judgment moderately or severely impaired.....	Add 1 _____
Question 12 (a): If individual has 15 or more medications.....	Add 3 _____
Question 28: If any withdrawn behaviors (A &/or B) are noted.....	Add 1 _____
Question 29: If any wandering behaviors (A, D &/or E) are noted.....	Add 1 _____
Question 35: If 35 (b), (c), or (d) are marked as other than never.....	Add 1 _____
Total score for this section	
7) Management of problematic behavior	
Question 10 (e) (x): If frequency of dangerous behaviors is noted as Regular or Continuous.....	Add 10 _____
Question 10 (e) (ix): If the frequency of unsafe behaviors is noted as Regular or Continuous.....	Add 10 _____
Question 10 (e): If agitation is marked as Regular or Continuous.....	Add 2 _____
Question 29: If any wandering behaviors (C-E) are noted.....	Add 3 _____
Question 30: If any response is noted as Regular or Continuous.....	Add 1 _____
Question 31: If any response is noted as Regular or Continuous.....	Add 1 _____
Question 32: If any disruptive behaviors noted as Occasional.....	Add 1 _____
Question 32: If any disruptive behaviors noted as Regular or Continuous.....	Add 2 _____
Question 33: If any combative behaviors noted as Occasional.....	Add 1 _____
Question 33: If any combative behaviors noted as Regular or Continuous.....	Add 4 _____
Question 34: If any resistive behaviors noted as Occasional.....	Add 1 _____
Question 34: If any resistive behaviors noted as Regular or Continuous.....	Add 4 _____
Questions 28 – 34: If frequency for any of the questions is marked as Regular or Continuous.....	Add 4 _____
Questions 28 – 34: If frequency for 3 or more of the questions is marked as Regular or Continuous..	Add 4 _____
Total score for this section	
TOTAL SCORE FOR ALL 7 SECTIONS OF THE ASSESSMENT	
(add scores sections 1 – 7)	_____
Date _____	
Signature of person completing scoring	

If a score changes in any of the following areas, an evaluation of the resident by a health care practitioner is needed: Items 10 (e), 11 or 28 – 35

Key to Level of Care

Level 1 = 1 – 20 points Level 2 = 21 – 40 points Level 3 = 41 points or higher

When any of the following conditions or resident needs is noted, contact OHCQ, Assisted Living Division for guidance:

- | | |
|---|---|
| 1) More than intermittent nursing care | 5) Monitoring of chronic medical conditions that are not controllable through readily available medications or treatments |
| 2) Treatment for stage 3 or 4 skin ulcers | 6) Treatment for active reportable communicable disease |
| 3) Ventilator services | 7) Treatment for a disease or condition which requires more than contact isolation |
| 4) Skilled monitoring, testing and aggressive adjustment of medication & treatments where there is the presence of, or risk for a fluctuation acute condition | |

Exception: individuals who (a) are in a specialized program for HIV/AIDS, which the department has approved, or, (b) are under the care of a general hospice program

Appendix B. Meetings and Attendance.

May 15, 2006 – Orientation Session on the Resident Assessment Tool.

An orientation session was held for those individuals who were not familiar with the Resident Assessment Tool. Those in attendance included:

Kate Ricks, Voices for Quality Care; Clare Whitbeck, United Seniors of Maryland; Ted Meyerson, Howard County Commission on Aging; Kim Mayer, Office of Health Care Quality; Lynn Albizo, NAMI-Maryland; Paula Carder, UMBC – Erickson School of Aging Studies; Dorinda Adams, Office of Adult Services, DHR; Lynn Condon, Office of Health Care Quality; Dr. Georgia Stevens, mental health expert.

June 7, 2006 – HB 1322 Workgroup Meeting: Awake Overnight Staff.

Those in attendance included:

Michele Douglas, Alzheimer's Association; Stephaine Lyon, Consumer and Alzheimer's Association; Lynn Albizo, NAMI-MD; Dr. Steven Levenson, AMDA; Ted Meyerson, Howard County Commission on Aging; Wendy Kronmiller, OHCQ; William Vaughan, OHCQ; Sarah Collins, Health Facilities Association of Maryland; Wesley Malin, Health Facilities Association of Maryland - Hillhaven Assisted Living; Sheila Mackertich, Health Facilities Association of Maryland; Paul Carder, UMBC – Erickson School of Aging; Kim Mayer, OHCQ; Denise Adams, Maryland Department of Aging; Clare Whitbeck, United Seniors of Maryland; Kate Ricks, Voices for Quality Care; Lester Brown, Assisted Living Program Manger – Office of Health Care Quality; Karin Lakin, LifeSpan and an assisted living provider; Sushant Shidh – Life Span; Lisa Toland, Division of Waiver Programs – Maryland Medicaid; Barbara Resnick, RN, University of Maryland School of Nursing; Dr. Georgia Stevens, Mental Health Expert; and Beth Wiseman, BCASCO.

Those who were invited, but could not attend the meeting included: Dr. Adam Rosenblatt, Johns Hopkins University; Dennis Byrne, Small Assisted Living Alliance; Dorinda Adams, Department of Human Resources; Barbara Newman, Maryland Board of Nursing; and Kim Burton, Mental Health Association of Maryland.