RESIDENT ASSESSMENT TOOL

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

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

An assisted living program may not provide services to an individual who at the time of initial admission requires: (1) More than intermittent nursing care; (2) Treatment of stage three or stage four skin ulcers; (3) Ventilator services; (4) Skilled monitoring, testing, & aggressive adjustment of medications & treatments where there is the presence of, or risk for, a fluctuating acute condition; (5) Monitoring for a chronic medical condition that is not controllable through readily available medications & treatments; or (6) Treatment for a disease or condition which requires more than contact isolation. An exception is provided for residents who are under the care of a licensed general hospice program.

Resident:	DOB: 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: _____

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.					
11.					
12.					
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: - -