NEW HAVEN
MEMORY CARE
Serving TX Since 2013

New Haven Memory Care Kerrville

Level of Care Assessment

Resident Name:_____ Date of Birth: _____

Evaluation Completed By: _____ Score:_____

Effective Date: _____ Move In Date:_____

Physician:_____

Level 1 ($300)

0-25.9 Points

Level 2 ($600)

26-40.9 Points

Level 3 ($900)

41+ Points

	Points
1. Cognition	
a. Is this a memory care resident?	
❑ Yes	1000
❑ No	0
1. Orientation	
❑ Resident is oriented to person, place and time.	0
❑ Resident is not always oriented to person.	0.5
❑ Resident is not always oriented to place.	0.5
❑ Resident is not always oriented to time	0.5
2. Does the resident require assistance with re-direction and orientation?	
❑ Yes ❑ No	0
3. Cognitive needs:	
❑ **Focus:** COGNITION	
❑ **Goal:** I will be supported to make appropriate decisions about my care and environment.	
❑ **Goal:** Other: Please specify individual goals.	
❑ **Goal:** Resident directed goal:(specify)	
❑ **Intervention:** I Displays deficits in judgment.	
❑ **Intervention:** I am an elopement Risk: (Specify strategy and FREQ)	
❑ **Intervention:** I am oriented and able to recall or retain information (i.e. recent events, directions, time, and place of situation).	
❑ **Intervention:** I demonstrate inappropriate judgment related to safety.	
❑ **Intervention:** I demonstrate inappropriate judgment, behavior and ability to function in social settings.	
❑ **Intervention:** I have mild/moderate/severe memory loss (Specify).	
❑ **Intervention:** I have no apparent memory loss.	
❑ **Intervention:** I live with mild to moderate disorientation or difficulty recalling /retaining information. I need cueing.	
❑ **Intervention:** I live with moderate dementia with significant short-term memory and possibly long-term memory loss.	
❑ **Intervention:** I respond well/I do not respond well to prompts and cueing.	
❑ **Intervention:** I will make safe judgments and function appropriately in social situations.	
2. Medical Diagnosis Review	
1. Available Medical Diagnosis and Treatments have been reviewed.	
❑ Yes ❑ No	0
3. History and Physical	
1. Most recent H&P has been reviewed	
❑ Yes ❑ No	0
4. Behavioral Tendencies Management	
1. Is resident capable of independent decision making?	
❑ Yes ❑ No	0
2. Does resident dress in excessive layers of clothing?	
Yes No	0
	Page Total

4. Behavioral Tendencies Management (continued)

3. Does the resident demonstrate sexually inappropriate tendencies?
   ❑ Yes ❑ No — 0

4. Does the resident have a known history or current history of suicidal ideations?
   ❑ Yes ❑ No — 0

5. Does the resident have a diagnosis of depression or mental health history?
   ❑ Yes ❑ No — 0

6. Does the resident require interventions to manage verbal tendencies?
   ❑ Yes ❑ No — 4 / 0

7. Does the resident require interventions to manage physical/intrusive tendencies?
   ❑ Yes ❑ No — 4 / 0

8. Does the resident urinate in inappropriate places?
   ❑ Yes ❑ No — 8 / 0

9. Does the resident undress or disrobe in public areas?
   ❑ Yes ❑ No — 4 / 0

10. Is the resident experiencing hallucinations or delusion?
    ❑ Yes ❑ No — 4 / 0

11. Does the resident demonstrate obsessive/repetitive tendencies?
    ❑ Yes ❑ No — 4 / 0

12. Does the resident demonstrate anxious/paranoid or suspicious tendencies?
    ❑ Yes ❑ No — 4 / 0

13. Behavioral Tendencies
    - ❑ **Focus:** BEHAVIORAL TENDENCIES
    - ❑ **Goal:** I will be able to identify factors/interventions that help to prevent/minimize inappropriate tendencies.
    - ❑ **Goal:** I will not act out in a way that is harmful to self or others.
    - ❑ **Intervention:** Care partners will report changes from baseline to Nurse.
    - ❑ **Intervention:** I am unable to follow directions.
    - ❑ **Intervention:** I exhibit normal, functional behavioral patterns.
    - ❑ **Intervention:** I exhibit inappropriate tendencies: (Specify) disrobing, taking things belonging to others, wandering aimlessly, showing anger, provocation, verbal abuse or other extreme tendencies.
    - ❑ **Intervention:** I have a history of harming self/others/property. (Specify)
    - ❑ **Intervention:** I move about with purposeful direction.
    - ❑ **Intervention:** I prefer naps (Specify frequency)
    - ❑ **Intervention:** I respond to reorientation and redirection when wandering.
    - ❑ **Intervention:** I wander without a definable or obtainable purpose, i.e. looking for visitors who are not coming, or relatives who may be deceased. I am not a disturbance to others.

5. Medication & Treatment

1. Does the resident manage his/her own medications?
   ❑ Yes: Full ❑ Yes: Partial ❑ No ❑ No, Memory Care Resident — 0/100/100/0

2. Do care partners order medications for the resident?
   ❑ Yes: Full ❑ Yes: Partial ❑ No — 0

Page Total

5. Medication & Treatment – (continued)

3. Is the resident taking a medication that places his/her at risk for bleeding or bruising easily?
   - ❑ Yes ❑ No — 0

4. Do any of the following apply:
   - ❑ Narcotics — 2
   - ❑ Self-Administer — 0
   - ❑ N/A — 0

5. Does the resident require any special preparation of medications?
   - ❑ Yes — 2
   - ❑ No — 0

5a. Describe the Preparation of Medications

6. Care partners dispense scheduled medications & documents in MAR:
   - ❑ No — 0
   - ❑ 1X daily — 1
   - ❑ 2X daily — 1
   - ❑ 3X daily — 1
   - ❑ 4X daily — 4
   - ❑ Greater than 4X daily — 6

7. Care partners perform scheduled treatments i.e. (nebulizers, lotions, eye drops):
   - ❑ No — 0
   - ❑ 1X daily — 1
   - ❑ 2X daily — 2
   - ❑ 3X daily — 3
   - ❑ 4X daily — 4
   - ❑ Greater than 4X daily. — 5

8. If care partners are responsible for ordering and/or dispensing medications, does the resident use an outside pharmacy?
   - ❑ Yes ❑ No ❑ Self-Administer — 0

9. Does the resident receive medications in non-bubble format if we are responsible for dispensing?
   - ❑ Yes ❑ No ❑ Both — 0

10. Does this resident have any known drug allergies?
    - ❑ Yes ❑ No — 0

6. Health Monitoring

1. Does the resident receive any delegated services by a RN?
   - ❑ Yes ❑ No — 0

1a. Services received by RN:

Page Total

6. Health Monitoring (continued)

2. Care partners check blood pressure in addition to monthly vitals:

❑ No	0
❑ 1X Daily	1
❑ 2X Daily	2
❑ 1X Weekly	.5
❑ 2X Weekly	1
❑ 3X Weekly	1.5
❑ 2X Monthly	0

3. Care partners weigh resident in addition to monthly vitals:

❑ No	0
❑ 1X Daily	1
❑ 2X Daily	2
❑ 1X Weekly	.5
❑ 2X Weekly	1
❑ 3X Weekly	1.5
❑ 2X Monthly	0

4. Care partners check pulse / pulse O2 in addition to monthly vitals:

❑ No	0
❑ 1X Daily	1
❑ 2X Daily	2
❑ 1X Weekly	.5
❑ 2X Weekly	1
❑ 3X Weekly	1.5
❑ 2X Monthly	0

5. Care partners perform Blood Sugar Checks:

❑ No	0
❑ 1X Daily	4
❑ 2X Daily	6
❑ 3X Daily	8
❑ 4X Daily	10
❑ 1X Weekly	1
❑ 2X Weekly	2
❑ 3X Weekly	3
❑ 1X Monthly	.5
❑ 2X Monthly	.75
❑ PRN checks	0

6. Nurse performs an injection other than insulin.

❑ No	0
❑ 1X Daily	50
❑ 2X Daily	50
❑ 1X Weekly	8
❑ 1X Monthly	2
❑ 2X Monthly	2

7. Does the resident require portable oxygen therapy?

❑ Resident is independent with portable oxygen therapy.	0
❑ Resident requires assistance with oxygen therapy.	3
❑ Resident does not require portable oxygen.	0

Page Total

6. Health Monitoring (continued)	0
8. Does the resident use an oxygen concentrator?	
❑ Resident is independent with oxygen concentrator.	0
❑ Resident requires assistance with oxygen concentrator.	3
❑ Resident does not require an oxygen concentrator.	0
9. Does the resident have an oxygen sign on their suite door?	
❑ Yes ❑ No	0
10. Does the resident require the use of CPAP or BPAP?	
❑ Resident is independent with CPAP or BPAP needs.	0
❑ Resident requires assistance with CPAP or BPAP equipment.	10
❑ N/A	0
7. Pain Management	
1. Does the resident report unmanaged pain?	
❑ Yes ❑ No	0
2. Has the resident utilized 8 or more PRN medications for pain in the last 30 days?	
❑ Yes ❑ No ❑ Unknown	0
3. Is the resident showing signs of pain?	
❑ Yes ❑ No	0
4. Is the resident able to verbalize pain?	
❑ Yes ❑ No	0
5. Does the resident have any supporting diagnosis that may contribute to pain?	
❑ Yes ❑ No	0
8. Skin Integrity	
1. Does the resident have any present edema/swelling in lower extremities, upper extremities, or abdomen?	
❑ Yes ❑ No	0
2. Does the resident have any skin impairments?	
❑ Yes ❑ No	0
2a. Impairment location	
3. Skin Care Needs	
❑ **Focus:** SKIN CONDITION	
❑ **Goal:** Other: please specify individual goals.	
❑ **Goal:** My Care Partners and/or I will notify nurse of any new skin conditions as they occur.	
❑ **Intervention**: Special skin issues. Interventions are: (Specify)	
❑ **Intervention:** Care Partners or I will report new or changed skin conditions to Nurse.	
	Page Total

9. <u>Sleep Pattern/Night Time Care/Wake Up</u>	
1. Does the resident require/request a wakeup call?	
❑ Yes ❑ No	0
2. Does the resident require night time safety checks/comfort checks?	
❑ Yes, Twice nightly	0
❑ Yes. More than twice nightly	8
❑ No.	0
3. Does the resident demonstrate or verbalize a sleep cycle disturbance/ insomnia?	
❑ Yes ❑ No	0
10. <u>Dietary & Nutrition Management</u>	
1. List food allergies	
2. Diet order	
3. Does the resident require special textural modifications?	
❑ Yes	6
❑ No	0
3a. Describe the special textural modifications.	
4. Is the resident at risk for dehydration or have a known history?	
❑ Yes ❑ No	0
5. Does the resident require an adaptive device i.e. (utensils/dishes) to assist w/dining?	
❑ Yes ❑ No	0
6. Does the resident require assistance with dining?	
❑ Yes (hands on assistance)	6
❑ Cueing & Encouragement	3
❑ No	0
7. Does the resident require meal reminders?	
❑ Yes	6
❑ No	0
8. Does the resident prefer In-Apartment Dining?	
❑ No	0
❑ In-apartment dining 1x daily	6
❑ In-apartment dining 2x daily	8
❑ In-apartment dining 3x daily	10
9. Does the resident require escorts to and from the dining room and/or to activities not related to memory impairment?	
❑ No	0
❑ Yes	8
10. Dietary/ Nutritional Needs	
❑ **Focus:** EATING/MEALS	
❑ **Goal:** I will maintain appropriate weight and nutritional status.	
❑ **Goal:** I will participate in meals.	
❑ **Goal:** Other: please specify individual goals.	
❑ **Goal:** Resident directed goal:(specify)	
	Page Total

10. Dietary & Nutrition Management – (continued)

- ❑ **Intervention:** Care Partners will report to the nurse if resident has changes in ability to eat or drink.
- ❑ **Intervention:** Care partners will encourage fluids.
- ❑ **Intervention:** I am independent with meals, eating and drinking.
- ❑ **Intervention:** I have swallowing difficulties.
- ❑ **Intervention:** I need all of my meals prepared.
- ❑ **Intervention:** I need reminders to go to meals.
- ❑ **Intervention:** I prefer finger foods and like to move about safely while eating.
- ❑ **Intervention:** I prefer to eat in apartment.
- ❑ **Intervention:** I prefer to eat in the dining room.
- ❑ **Intervention:** I prepare or obtain meals independently.
- ❑ **Intervention:** I require assistance to eat: (Specify - hand over hand, verbal/non-verbal cueing, encouragement, total feed)

11. Bathing Services

1. Does the resident require assistance with bathing?
   - ❑ Resident is independent and does not require assistance with bathing. 0
   - ❑ Resident receives outside service for bathing (complete section 24). 0
   - ❑ Care partners to provide set-up and cueing assistance with bathing. 4
   - ❑ Care partners to provide hands on assistance for all bathing. 6
2. What is the bathing frequency?
   - ❑ 1X Weekly 0
   - ❑ 2X Weekly 0
   - ❑ 3X Weekly 4
   - ❑ 4X Weekly 8
   - ❑ Greater than 4X Weekly 12
3. Does the resident prefer Day or Evening bath / shower?
   - ❑ Day 0
   - ❑ Evening 0
4. Does the resident require a safety device during bathing/showers?
   - ❑ Resident does not have any safety device in place. 0
   - ❑ Resident uses a shower/bath chair. 0
   - ❑ Resident uses a shower/bath bench. 0
5. Bathing Needs
   - ❑ **Focus:** BATHING
   - ❑ **Goal:** I will maintain independence for bathing.
   - ❑ **Goal:** I will be able to meet my bathing needs with assistance (specify).
   - ❑ **Goal:** Other: Please specify individual goals.
   - ❑ **Goal:** Resident directed goal:(specify)
   - ❑ **Intervention:** I may bathe or may take a sponge bath without assistance.
   - ❑ **Intervention:** I prefer showers/baths?
   - ❑ **Intervention:** I require assistance- specify: transfers in/out; steadying; cueing to wash self; cueing to dry self; shampooing/rinsing/drying hair; applying lotion).
   - ❑ **Intervention:** I use a hand held shower device.
   - ❑ **Intervention:** I use a shower chair.
   - ❑ **Intervention:** I will check skin with bath/shower and I will report any reddened/open areas to a care partner.
   - ❑ **Intervention:** I will report any changes in ability to bathe to a care partner.

Page Total

12. Dressing Assistance

1. Does the resident require assistance with dressing?
   - ❑ Resident is Independent with dressing and does not require assistance. 0
   - ❑ Care partners to provide assistance w selection and laying out of clothes. 3
   - ❑ Care partners to provide physical assistance with AM/PM dressing. 6
2. Does the resident wear TED hose?
   - ❑ Resident does not wear TED hose. 0
   - ❑ Resident requires assistance in the AM/PM with knee high TED hose. 4
   - ❑ Resident requires assistance in the AM/PM with thigh high TED hose. 4
   - ❑ Resident requires assistance in the AM/PM with pantyhose style support hose. 4
   - ❑ Resident wears TED hose, but does not require assistance. 0
3. Does the resident wear an adaptive device such as contracture brace, leg/eye prosthesis, mastectomy support bra, etc.?
   - ❑ Yes ❑ No ❑ If yes, describe 0
4. Dressing Assistance Needs
   - ❑ **Focus:** DRESSING/UNDRESSING
   - ❑ **Goal:** I will be dressed with assistance (specify)
   - ❑ **Goal:** I will maintain independence with dressing.
   - ❑ **Goal:** Other: Please specify individual goals.
   - ❑ **Goal:** Resident directed goal:(specify)
   - ❑ **Intervention:** I am able to apply adaptive devices (Specify) without assistance.
   - ❑ **Intervention:** I am not able to dress/undress self if I am not assisted.
   - ❑ **Intervention:** I attempt to dress self but need assistance.
   - ❑ **Intervention:** I have a prosthesis (specify)
   - ❑ **Intervention:** I may need assistance or repetitive verbal cues to complete dressing.
   - ❑ **Intervention:** I may need minimal physical assistance (i.e. tying shoes, obtaining clothes from closet, putting on coat)
   - ❑ **Intervention:** I require an adaptive device (specify) to dress/undress.
   - ❑ **Intervention:** I require assistance applying/removing prosthesis.
   - ❑ **Intervention:** I require assistance with putting on and removing ted hose
   - ❑ **Intervention:** I take initiative and responsibility for dressing and undressing self without assistance.
   - ❑ **Intervention:** I will report any changes in ability to dress/undress to a care partner.

13. Grooming Services

1. Does the resident require assistance with grooming?
   - ❑ Resident is independent and does not require assistance w/grooming task 0
   - ❑ Care partners to provide set-up and cueing assistance w/grooming tasks 3
   - ❑ Care partners to provide hands on assistance for all grooming tasks. 6
2. Does the resident wear dentures or partials?
   - ❑ Yes ❑ No 0

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13. <u>Grooming Services – (continued)</u>	
3. Does the resident require assistance with nail care?	
❑ Resident is independent and/or arranges for nails to be done with an outside service.	0
❑ Resident requires care partner assistance with nail care.	0
4. Does the resident require assistance with foot care?	
❑ Resident is independent and/or arranges for nails to be done with an outside service.	0
❑ Resident requires care partner assistance with foot care.	0
5. Grooming Needs	
❑ **Focus:** GROOMING/ORAL HYGIENE	
❑ **Goal:** Resident directed goal:(specify)	
❑ **Goal:** Other: Please specify individual goals.	
❑ **Goal:** I will be able to maintain grooming and hygiene with/without (specify) assistance.	
❑ **Intervention:** I may need assistance with grooming/personal hygiene on short term basis.	
❑ **Intervention:** I will report any changes in ability to maintain grooming and hygiene to a care partner.	
❑ **Intervention:** I require assistance with grooming needs	
❑ **Intervention:** I require minimal supervision with grooming.	
❑ **Intervention:** I am independent with personal hygiene with/without use of assistive devices.	
❑ **Intervention:** I require no assistance with grooming (i.e. combing hair, washing face, shaving, brushing teeth).	
14. <u>Bowel and Bladder</u>	
1. Is the resident incontinent of either bowel or bladder?	
❑ Resident is continent of both bowel and bladder.	0
❑ Resident is incontinent of bowel or bladder, but can self-manage.	0
❑ Resident is incontinent of bladder only (even if occasionally incontinent).	0
❑ Resident is incontinent of bowel only (even if occasionally incontinent).	0
❑ Resident is incontinent of both bowel and/or bladder and needs assistance	0
2. Does the resident require assistance with toileting?	
❑ Resident is independent with toileting.	0
❑ Care partners to provide the resident with verbal reminders or occasional assistance to use the restroom.	3
❑ Care partners to provide limited toileting (1-2Xs daily) assistance.	6
❑ Care partners to provide toileting assistance greater than 2Xs daily.	8
❑ Care partners to provide full assistance with incontinence care.	10
3. Does the resident need assistance with catheter care?	
❑ Resident does not have a catheter.	0
❑ Resident has a catheter and is independent with care.	0
❑ Resident has a catheter and requires staff assistance.	10
	Page Total

14. Bowel and Bladder - Continued

4. Does the resident need assistance with an ostomy product?

- ❑ Resident does not have an ostomy. 0
- ❑ Resident has an ostomy and is independent with care 0
- ❑ Resident has an ostomy and requires minimal assistance from care partners. Change ostomy bag 1x weekly. 4
- ❑ Resident has an ostomy and requires care partner assistance with changing ostomy bag >than 1x weekly and PRN 6
- ❑ Resident has an ostomy and requires care partner assistance with changing ostomy bag and emptying. 10

5. Does the community order incontinence supplies?

- ❑ Yes ❑ No 0

6. Bowel and Bladder Needs

- ❑ **Focus:** TOILETING
- ❑ **Goal:** I will be able maintain/improve bladder function with/without assistance. (Specify)
- ❑ **Goal:** I will be able maintain/improve bowel function with/without assistance. (Specify)
- ❑ **Goal:** Other: please specify individual goals.
- ❑ **Intervention:** I am independent with toileting.
- ❑ **Intervention:** I do not use incontinence products of any kind.
- ❑ **Intervention:** I may experience leaking of urine during the day.
- ❑ **Intervention:** I may need assistance to use toilet and maintain bladder continence.
- ❑ **Intervention:** I need (Specify) assistance to change my incontinence product.
- ❑ **Intervention:** I need assistance with my clothing after toileting.
- ❑ **Intervention:** I need minimal (Specify) assistance with toileting.
- ❑ **Intervention:** I need regular or frequent assistance to/from bathroom.
- ❑ **Intervention:** I prefer to use a commode at night.
- ❑ **Intervention:** I prefer to use a urinal at night.
- ❑ **Intervention:** I require assistance with incontinence care.
- ❑ **Intervention:** I require assistance with peri-care.
- ❑ **Intervention:** I use incontinence products (pull-up, liner, brief).
- ❑ **Intervention:** I will report any changes in my toileting ability to a care partner.
- ❑ **Intervention:** My bathroom is equipped with adaptive devices for toileting activities (i.e. grab bars, raised toilet, etc.)

15. Mobility Needs

1. Does the resident require assistance with transferring?

- ❑ Resident is ambulatory or uses an ambulatory device independently. 0
- ❑ Resident requires staff to stand by during transfers. 3
- ❑ Resident requires a ONE person assist with transfers prior to ambulating. 3

Page Total

15. Mobility Needs - Continued

2. Does the resident use an ambulatory device?

❑ Yes ❑ No ❑ If yes, describe — 0

3. Does the resident require an assistive device to transfer to bed, chair, or toilet?

- ❑ Resident does not require an assistive device. — 0
- ❑ Resident uses a bedside assistive device to assist with transfers. — 0
- ❑ Resident uses a transfer pole to assist with transfers. — 0
- ❑ Resident uses a slide board to assist with transfers. — 3

4. Bed Mobility: How does the resident move to and from a lying position, side to side and/or position body while in bed?

- ❑ Resident is independent in bed or uses an assistive device to reposition. — 0
- ❑ Resident requires reminders using cueing and coaching. — 0
- ❑ Resident requires a one-person physical assistance. — 3
- ❑ Resident requires a two-person physical assist or needs complete assist. — 6

5. Mobility Needs

- ❑ **Focus:** MOBILITY
- ❑ **Goal:** I will be able to move about the community with/without assistance.
- ❑ **Goal:** Resident directed goal: please specify individual goals.
- ❑ **Intervention:** AMBULATION: I am not able to ambulate long distances without guidance or assistance.
- ❑ **Intervention:** AMBULATION: I have a history of falls which puts the resident at risk if she/he ambulates unassisted.
- ❑ **Intervention:** AMBULATION: I use (Specify assistive device: straight cane, quad cane, braces, walker) for ambulation.
- ❑ **Intervention:** ASSISTIVE DEVICE: I need to be reminded to use assistive device if seen without it.
- ❑ **Intervention:** ASSISTIVE DEVICE: I need occasional assistance with assistive device (Specify device and assistance: wheelchair, straight cane, quad cane, crutches, walker, or braces).
- ❑ **Intervention:** I am able to use stairs without assistance.
- ❑ **Intervention:** I am independent with ambulation.
- ❑ **Intervention:** I am unable to exit building without total assistance.
- ❑ **Intervention:** I am unable to use stairs without assistance.
- ❑ **Intervention:** I need escorts to/from activities and or dining room
- ❑ **Intervention:** I use a wheelchair all the time.
- ❑ **Intervention:** Is able to use stairs with assistance and/or assistive device.
- ❑ **Intervention:** MOBILITY: I am mobile with assistive device (Specify: wheelchair, scooter)
- ❑ **Intervention:** MOBILITY: I require assistance with wheelchair for long distances.

Page Total

16. Hearing & Speech (Communication)

1. Does the resident require assistance with hearing?

- ❑ Resident does not wear hearing devices. 0
- ❑ Resident uses a hearing device and is independent. 0
- ❑ Resident uses a personal amplification device and is independent. 0
- ❑ Resident uses hearing device and requires assistance with placing, cleaning, and removing/changing batteries. 1
- ❑ Resident uses hearing device in right ear only and requires assistance with placing, cleaning, and removing/changing batteries. 1
- ❑ Resident uses hearing device in left ear only and requires assistance with placing, cleaning, and removing/changing batteries. 1
- ❑ Resident does not use a hearing device, but is hard of hearing. 0

1a. Hearing

- ❑ **Focus:** HEARING
- ❑ **Goal:** I will be supported to use appropriate assistive devices for hearing.
- ❑ **Goal:** Resident directed goal: please specify individual goals.
- ❑ **Intervention:** I have hearing loss (specify: right, left, bilateral).
- ❑ **Intervention:** I wear hearing aids (specify: right, left, bilateral).
- ❑ **Intervention:** Please remind me to wear my hearing aid(s)
- ❑ **Intervention:** Please speak slowly and clearly when communicating with me.

2. Does the resident require any additional devices/approaches to support communication?

- ❑ Resident does not require any additional measures to understand or be understood. 0
- ❑ Resident uses an amplified telephone. 0
- ❑ Resident uses sign language. 0
- ❑ Resident uses a communication board. 0
- ❑ Resident reads Braille. 0
- ❑ Resident requires that care partners speak slowly and clearly to help facilitate communication. Care partners should give resident adequate time to respond to questions. 0
- ❑ Resident's primary language is NOT English. 0
- ❑ Other(specify)_____

_____

2b. COMMUNICATION

- ❑ **Focus:** COMMUNICATION
- ❑ **Goal:** Resident will be able to communicate and make his/her needs known.
- ❑ **Goal:** Other: please specify individual goals.
- ❑ **Intervention:** Word seeking - allow time to respond.
- ❑ **Intervention:** Language spoken is:
- ❑ **Intervention:** Is able to make self-understood.
- ❑ **Intervention:** Is unable to make needs understood.
- ❑ **Intervention:** Mode of expression is speech.
- ❑ **Intervention:** Mode of expression is writing.

Page Total

16. Hearing & Speech Communication) – Continued	
3. Does the resident require assistance with vision?	
❑ Resident does not use a vision aide at this time and is independent.	0
❑ Resident wears glasses and is independent.	0
❑ Resident wears contact lenses and is independent.	0
❑ Resident wears glasses and requires assistance with placing, cleaning, and removing at night.	0
❑ Resident wears contact lenses and requires assistance with placing, cleaning, and removing at night.	0
❑ Resident is blind.	0
❑ Other	0
4. VISION	
❑ **Focus:** VISION	
❑ **Goal:** I will be supported to maintain appropriate devices of vision.	
❑ **Goal:** Resident directed goal: please specify individual goals.	
❑ **Intervention:** Ensure glasses are on and that the glasses are clean.	
❑ **Intervention:** Has vision loss (Specify right/left/bilateral).	
❑ **Intervention:** Needs assistance cleaning glasses.	
❑ **Intervention:** Wears glasses (specify: for reading, for seeing, both)	
17. Evacuation	
1. Does the resident require assistance to evacuate?	
❑ Yes ❑ No	0
2. Does the resident have a pet that would require assistance to evacuate?	
❑ Yes ❑ No	0
18. Safety and Risk	
1. Does the resident have the ability to utilize the call system?	
❑ Yes ❑ No	0
2. Does the resident move or walk about an area without a known purpose?	
❑ Yes ❑ No	0
3. Does the resident look for people, places, or things (former house/apartment/bus)?	
❑ Yes ❑ No	0
4. Is the resident at risk for elopement/require a wander guard?	
❑ Yes	50
❑ No	0
5. Does the resident have a known recent history of falling (3 months) and/or is the resident at risk for falls?	
❑ Yes ❑ No	0
6. Does the resident currently use tobacco products?	
❑ Resident does not smoke. ❑ Resident is independent with smoking.	0/0
7. Does the resident have a known history of tobacco use?	
❑ Yes ❑ No	0
	Page Total

18. Safety and Risk (continued)

8. Does the resident currently use alcohol excessively or have a known history of alcohol abuse?

❑ Yes ❑ No — 0

9. Does the resident currently use illegal drugs or have a known history i.e. marijuana, heroin, methamphetamines, cocaine, other?

❑ Yes ❑ No — 0

10. Safety and Risk Needs

- ❑ **Focus:** FALLS
- ❑ **Goal:** Other: please specify individual goals.
- ❑ **Goal:** I will be encouraged to call for assistance when needed.
- ❑ **Goal:** I will remain free of injury
- ❑ **Intervention:** Fall interventions are: (specify)
- ❑ **Intervention:** Safety Checks for Falls: (Specify Frequency)
- ❑ **Intervention:** Care partners will remind me to call for assistance.
- ❑ **Intervention:** I am at risk for falls due to (specify)

19. Reluctance to Accept Care

1. Does resident exhibit reluctance to accept care?

❑ Yes ❑ No

Select all that apply

❑ Resident is reluctant to taking medications consistently	2
❑ Resident is reluctant to eat	0
❑ Resident is reluctant to dress and groom	2
❑ Resident is reluctant to shower or bathe	2
❑ Resident is reluctant to care which may contribute to falls	2
❑ Resident is reluctant to go to the dining room for meals	2
❑ Resident is reluctant to get out of bed consistently	2
❑ Resident is reluctant to allow care partners to change incontinent products or assist with toileting constantly.	2

20. Home Management

1. Does the resident require/prefer spot cleaning in addition to basic housekeeping package daily?

❑ Yes ❑ No — 0

2. Housekeeping Needs

- ❑ **Focus:** HOME MANAGEMENT
- ❑ **Goal:** Other: please specify individual goals.
- ❑ **Goal:** Resident directed goal:(specify)
- ❑ **Goal:** Will receive encouragement/assistance with housekeeping chores as needed.
- ❑ **Goal:** My housekeeping needs will be met
- ❑ **Intervention:** PERSONAL SHOPPING: assistance with personal shopping provided by: (specify)
- ❑ **Intervention:** LINENS: I require assistance with bed making daily.
- ❑ **Intervention:** HOUSEKEEPING: My housekeeping is provided on scheduled days.
- ❑ **Intervention:** HOUSEKEEPING: My garbage will be emptied on scheduled days.
- ❑ **Intervention:** LINENS: I require bed linen changes per schedule

Page Total

21. Laundry

1. Does the resident request laundry services?
   - ❑ Resident or family manages laundry independently. — 0
   - ❑ 1X Weekly — 0
   - ❑ 2X Weekly — 2
   - ❑ 3X Weekly — 3
   - ❑ Daily — 4
2. Does the resident require the use of a special laundry detergent?
   - ❑ Yes — 2
   - ❑ No — 0
3. Laundry Needs
   - ❑ **Focus:** HOME MANAGEMENT
   - ❑ **Goal:** Laundry services will be met
   - ❑ **Intervention:** LAUNDRY: I need assistance to put away clean clothes.
   - ❑ **Intervention:** LAUNDRY: I do not require assistance.
   - ❑ **Intervention:** LAUNDRY: I require assistance to place dirty laundry in appropriate place
   - ❑ **Intervention:** LAUNDRY: I require assistance with laundry on scheduled days
   - ❑ **Intervention:** LAUNDRY: I prefer laundry soap that is either provided by me or my family will provide.

22. Transportation

1. Does the resident require/request assistance arranging transportation?
   - ❑ Resident does not require/request assistance arranging transportation to medical and non-medical appointments. — 0
   - ❑ Resident requires/requests assistance arranging medical appointments. — 2
2. Transportation Needs
   - ❑ **Focus:** Needs help with managing transportation/appointments
   - ❑ **Goal:** I will receive necessary assistance with transportation and appointments
   - ❑ **Intervention:** I will require transportation assistance and/or appointment reminders as needed.

23. Pet Care

1. Does the resident have a pet?
   - ❑ Yes, the resident has a pet and the pet policy has been reviewed and agreement has been signed. — 0
   - ❑ No — 0

1a. Name and type of Pet?

2. Does the resident require assistance to care for pet?
   - ❑ Resident does not have a pet and or is independent in caring for pet.
   - ❑ Resident has pet and requires outside services for care of pet.
   - ❑ Resident has pet and requires services for care of pet.

Page Total

23. Pet Care (continued) 3. Pet Care Needs ❑ **Focus:** Has a pet (specify) ❑ **Goal:** I will abide by community pet policy. ❑ **Intervention:** Requires staff to assist with feeding, walking, and/or clean up (specify frequency) ❑ **Intervention:** Staff will assist out of the building in the event of an evacuation ❑ **Intervention:** I have reviewed the pet policy and agree to the terms. ❑ **Intervention:** My pet will be escorted out by resident in the event of an emergency and evacuation is necessary.	
24. Outside Agencies and Support Services 1. Does the resident require support services from and outside provider? ❑ Yes ❑ No 1a. If yes, name of outside provider and service provided 2. Outside Agency and Support Services Needs ❑ **Focus:** Occupational Therapy ❑ **Goal:** Will maximize self-care potential ❑ **Intervention:** OT Services (Specify Frequency), by (Specify Provider) ❑ **Focus:** Physical Therapy ❑ **Goal:** Will maximize self-care potential ❑ Intervention: PT Services (Specify Frequency), by (Specify Provider) ❑ **Focus:** Speech Therapy ❑ **Goal:** Will maximize communication potential ❑ **Goal:** Will maximize swallow potential and decrease risk of aspiration ❑ **Intervention:** ST Services (Specify Frequency), by (Specify Provider)	0
25. Appliance Usage 1. Has resident demonstrated competence properly and safely using approved small Appliances? ❑ Yes ❑ No ❑ N/A Memory Support Resident	0
Communication ❑ Has the resident changed from the last functional assessment? ❑ No change in function ❑ Comments ❑ Decline in functional status: Requires more assistance ❑ Improved functional status: Requires less assistance	

Signature: _____ Date: _____

Signature: _____ Date: _____