Assisted Living Resident Needs Assessment (with application information)

Pre Move-In ☐ ***Change in Condition*** ☐ ***Annual Category A*** ☐ ***Quarterly B*** ☐ ***Quarterly C*** ☐

Resident's Name: _____ ***Address:*** _____

Resident's Age: _____ ***Date of Birth:*** _____ ***Gender:*** _____

Marital Status: _____ ***Religious Affiliation (if offered):*** _____

Completed By: _____ ***Title:*** _____

Date _____

SECTION I. COGNITIVE PATTERNS

Short-term Memory
☐ 0. Resident can recall items after 5 minutes.
☐ 1. Resident cannot recall items after 5 minutes.

Long-term Memory
☐ 0. Resident can recall events long past
☐ 1. Resident cannot recall events long past.

Memory recall: Check all that resident is **able** to recall.
☐ Current season
☐ Location of room
☐ Awareness of home
☐ Caregivers names/faces

Decision Making
☐ 0. Independent: makes consistent, independent decisions
☐ 1. Modified independence: difficulty in new situations.
☐ 2. Moderately impaired: needs cueing for directions.
☐ 3. Severely impaired: rarely/never makes decisions.

Change in cognitive status/awareness or thinking disorders
☐ 0. No change in cognitive status.
☐ 1. Less alert, easily distracted, lethargic.
☐ 2. New episodes of incoherent speech.
☐ 3. Restless, agitated, pacing.

******A resident that has a cognitive impairment that renders them:***
a) incapable of expressing needs or of making basic care decisions; and
b) at risk for wandering from the facility without regard for personal safety;
is considered a Category C resident per MCA.
*****Please note that, with the exception of b) above, no resident may be a danger to themselves or others.***

SECTION II. SENSORY PATTERNS

Hearing

☐ 0. Hears adequately: normal talk, TV, phone without difficulty
☐ 1. Minimal loss: difficulty only with noisy backgrounds.
☐ 2. Moderate loss: cannot hear unless spoken to distinctly and directly.
☐ 3. Severe loss: total loss of useful hearing.
- ☐ Hearing aid: present and used
- ☐ Hearing aid: present but not used
- ☐ Hearing aid: not present

Speech: Ability to understand others

☐ 0. Understands others without difficulty or error.
☐ 1. Usually understands: occasionally misses part of message.
☐ 2. Sometimes understands: responds appropriately to simple direction.
☐ 3. Rarely/Never understands.

Speech: Ability to make self understood

☐ 0. Speech is easily understood by others.
☐ 1. Speech usually understood: has difficulty finishing thought, finding words.
☐ 2. Speech sometimes is understood: can make simple requests.
☐ 3. Speech is rarely/Never understood.

Vision: Ability to see in adequate light (with glasses, contacts, etc.)

☐ 0. Sees fine detail: can read regular print.
☐ 1. Mildly Impaired: requires large print, uses magnifying glass.
☐ 2. Moderately Impaired: cannot read newspaper headlines.
☐ 3. Severely Impaired: sees only light/shadow/shapes/colors.
☐ 4. Peripheral vision problem
(bumps into people, objects, leaves food on side of tray).

SECTION III. CONTINENCE

Bladder continence:

☐ 0. Continent: resident has complete control over bladder function.
☐ 1. Usually continent: 1 episode/week or less of incontinence.
☐ 2. Occasionally incontinent: 2 or more episodes/week (not daily)
☐ 3. Frequently incontinent: some control present, but has some episodes daily.
☐ 4. Incontinent: multiple daily episodes, no control present.
☐ 5. Urinary tract infection.
- ☐ Resident has not been treated for urinary tract infections
- ☐ Resident has been treated for urinary tract infections.

Bowel continence: (control of bowel movement)

☐ 0. Continent: resident has complete control over bowel function.
☐ 1. Usually continent: less than 1 episode of incontinence/week.

☐ 2. Occasionally incontinent: 1 episodes/week.
☐ 3. Frequently incontinent: 2-3 episodes of incontinence/week.
☐ 4. Incontinent: inadequate control most or all of the time.

Continent appliance/programs (Check all that apply)
☐ Scheduled toileting plan
☐ External catheter (condom)
☐ Pads/Briefs used
☐ Intermittent catheter
☐ Indwelling catheter

SECTION IV. ACTIVITIES OF DAILY LIVING (ADL) FUNCTIONAL PERFORMANCE (*TOTAL DEPENDANCE IN FOUR OR MORE ADLS REQUIRES CATEGORY B STATUS*)

Eating: (how resident eats and drinks)
☐ **1**. Independent: needs no help or supervision.
☐ **2.** Limited assistance: needs some physical help and support.
☐ **3. Total dependence:** resident needs to be fed.

Walking (Check all that apply)
☐ 0. None.
☐ 1. Cane/Walker.
☐ 2. Braces/Prosthesis.
☐ 3. Wheels self.
☐ **4. Total dependence:** Wheeled by others.

Mobility: (how resident moves within room and home, includes self-sufficient use of mobility devices)
☐ **1.** Independent: needs no help or supervision.
☐ **2.** Limited assistance: needs some physical help and support.
☐ **3. Total dependence:** always needs staff to perform locomotion.

Dressing: (how resident puts on, fastens, takes off clothing; includes applying/removing prosthesis)
☐ **1.** Independent: needs no help or supervision.
☐ **2.** Limited assistance: needs some physical help and support.
☐ **3. Total dependence:** staff needs to dress resident.

Grooming: (how resident combs hair, brushes teeth, shaves, cleans & cares for finger and toe nails, etc.)
☐ **1.** Independent: needs no help or supervision.
☐ **2.** Limited assistance: needs some physical help and support.
☐ **3. Total dependence:** staff needs to groom resident.

Bathing: (how resident takes a full body bath/shower)
☐ **1.** Independent: no help provided.
☐ **2.** Limited assistance: needs some physical help and support.

☐ **3. Total dependence:** staff must bathe resident.

Use of toilet: (how resident cleanses self, changes protective garments/pads, adjusts own clothes)
☐ **1.** Independent: needs no help or supervision.
☐ **2.** Limited assistance: needs some physical help and support.
☐ **3. Total dependence:** staff fully toilets resident.

Ability to transfer (to and from bed / chair / wheelchair / toilet, etc.)
☐ **1.** Independent: needs no help or supervision.
☐ **2.** Limited assistance: needs some physical help in maneuvering, minimal support.
☐ **3. Total dependence:** always needs staff to perform transfer.

THE RESIDENT IS TOTALLY AND CONSISTENTLY DEPENDENT IN:

☐ ***Eating***	☐ ***Walking***	☐ ***Mobility***	☐ ***Dressing***
☐***Grooming***	☐ ***Bathing***	☐ ***Toileting***	☐ ***Transferring***

******Total dependence in four or more of these ADLs requires category B status******

SECTION V. MOOD AND BEHAVIORAL PATTERNS

Sadness or Anxiety Displayed by Resident: (Check all that apply)
☐ None: resident does not display or verbalize sadness or anxiety.
☐ Resident does display sadness or anxiety.
Describe:

Wandering: no rational purpose to movement; occurs without regard to personal safety.
☐ 0. Behavior not exhibited recently or ever.
☐ 1. Behavior does occur.
Describe:

Verbally abusive: screaming, cursing, threatening others
☐ 0. Behavior not exhibited recently or ever.
☐ 1. Behavior does occurs.
Describe:

Physically abusive: hitting, shoving, scratching others
☐ 0. Behavior not exhibited recently or ever.
☐ 1. Behavior does occurs.
Describe:

Socially inappropriate/Disruptive behavior: self-abusive acts, disrobing in public, throwing food, smearing feces, sexual behavior, etc.

☐ 0. Behavior not exhibited recently or ever.
☐ 1. Behavior does occur.
Describe:

Resistant behavior:
☐ 0. No resistant behavior displayed.
☐ 1. Behavior does occur.
Describe:

******If a resident has a cognitive impairment that renders them:***
a) incapable of expressing needs or of making basic care decisions; and
b) at risk for wandering from the facility without regard for personal safety;
then the resident is considered Category C per MCA.
*****Please note that, with the exception of b) above, no resident may be a danger to themselves or others.***

SECTION VI. HEALTH PROBLEMS/ACCIDENTS:

☐ Constipation	☐ Pain	☐ Falls with injury
☐ Dizziness	☐ Nausea	☐ Others:
☐ Hallucinations	☐ Falls without injury	☐
☐ Shortness of breath	☐ Fecal impaction	☐
☐ Aspiration/Choking	☐ Fever	☐
☐ Diarrhea	☐ Joint aches	
☐ Fainting	☐ Vomiting	

SECTION VII. WEIGHT/NUTRITIONAL STATUS

Move-in date: _____Weight upon move-in: **_____Weight at last assessment: _____**

Current weight in pounds:_____Scale used:_____

☐ 0. No significant weight change since last assessment.
☐ 1. Significant weight change since last assessment.
Describe and document action taken:

Nutritional complaints (Check all that apply)
☐ Resident has no nutritional complaints.
☐ Resident does have nutritional complaints (dislikes, difficulties, dental issues, food allergies, etc.)
Describe:

SECTION VIII. SKIN PROBLEMS (Check all that apply)

☐ No history of skin problems/no current problems

☐ Resident has history of healed skin lesions/pressure sores
☐ Resident currently has open skin lesion or pressure sore.
50-5-226. Placement in assisted living facilities. *(2) An assisted living facility licensed as* ***a category A facility*** *under* ***50-5-227*** *may not admit or retain a category A resident unless each of the following conditions is met: (b)* ***The resident may not have a stage 3 or stage 4 pressure ulcer****.*

SECTION IX. MEDICATION USE (Check all that apply, may make notes/comments)

☐ Takes no prescription medicine.
☐ Takes prescription and OTC (over-the-counter) medication.
☐ Medications have changed/added in 30 days.
☐ Currently taking an antibiotic.
☐ Unable to self-administer medications (if unable to self-administer, medications must be administered by a Licensed Health Care professional – RN or higher).
☐ Unable to ask for PRN (as needed) medications.

Antipsychotic use
☐ None.
☐ Takes on scheduled basis.
☐ Has PRN (as needed) ordered for behavioral control.

Antianxiety/Hypnotic use
☐ None.
☐ Takes on scheduled basis.
☐ Has PRN (as needed) ordered for behavioral control.

Antidepressant use
☐ None.
☐ Takes on scheduled basis.

SECTION X. SAFETY/ASSISTIVE DEVICES USED (Check all that apply)
☐ None.
☐ Resident uses **assistive device:** Device is used *only* for the assistance of the resident. Identify device and usage in Service / Care Plan.
☐ Resident uses **safety device**: Used for the *safety* of the resident. If a safety device is utilized, the requirements of **Safety Devices in Long-Term Care Facilities (§MCA 50-5-1201 through 50-5-1204)** must be met and documented in the resident's record.

SECTION XI. **Assisted Living Resident Needs Assessment Summary**

Based upon this assessment, the Category for this resident's level of care is:

☐ **A** ☐ **B** ☐ **C**

(For Category C residents, also identify the level of health care needs as A or B)

Is there a Category Change: ☐ **YES** ☐ **NO**

If a Category change or significant change in condition, can the facility meet the needs of the resident?
☐ **YES** ☐ **NO**

If yes, is an Involuntary Discharge/Move out required? ☐ **YES** ☐ **NO**

If yes, Involuntary Discharge 30 day or emergent notice written: ☐ **YES** ☐ **NO**

Is there a change to the Resident's Service Plan Recommended: ☐ **YES** ☐ **NO**

Is there a change to Health Care / Service Plan Recommended: ☐ **YES** ☐ **NO**

☐ Resident is a Hospice Patient: ☐ Care needs can be met ☐ Care needs cannot be met

Signature of assessor: _____ Date: _____

Category B & C Requirements

1. Practitioner's written order for admission received and in file: ☐ **YES** ☐ **NO**

2. Signed quarterly health care assessment by a licensed health care professional: ☐ **YES** ☐ **NO**

3. Health Care / Service Plan developed (within 21 days of admission to category B and / or C status), then reviewed and/or revised quarterly and upon change of condition by a licensed health care professional: ☐ **YES** ☐ **NO**

Category B and C Certification by Licensed Health Care Professional (RN or higher)

I (printed name, title),_____hereby certify that the care needs of this resident can be adequately met by the facility, and that there have been no significant changes to the resident's needs that would require a transfer to higher level of care facility.

Signature of above Licensed Health Care Professional: _____ Date: _____

SECTION XII: AREAS OF CHANGE AND/OR COMMENTS:

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SECTION XIII: ANNUAL OR QUARTERLY NO CHANGE ASSESSMENT DOCUMENTATION: If there has been no change in the resident since the last required assessment, this section may be used to document the assessment, the date of the assessment, current category status, and signature of person performing the assessment:

Date: _____ **Category Status and weight:** _____ **Signature:** _____
Date: _____ **Category Status and weight:** _____ **Signature:** _____
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Date: _____ **Category Status and weight:** _____ **Signature:** _____
Date: _____ **Category Status and weight:** _____ **Signature:** _____

***SECTION XIV*. 50-5-226 MCA. Placement in assisted living facilities.**

(3) An assisted living facility licensed as a category B facility under **50-5-227** **may not admit or retain** a category B resident unless each of the following conditions is met:

(a) The resident may require skilled nursing care or other services for more than 30 days for an incident, for more than 120 days a year that may be provided or arranged for by either the facility or the resident, and as provided for in the facility agreement.

(PLEASE DOCUMENT INCIDENTS FOR ONE YEAR BELOW)

Starting Date of Record _____ ***Year ending on:*** _____

Resident required_____care beginning on:_____Ended on:_____Total Days:
(date) (date)

Resident required_____care beginning on:_____Ended on:_____Total Days:
(date) (date)

Resident required_____care beginning on:_____Ended on:_____Total Days:
(date) (date)