

***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***

- Resident can recall items after 5 minutes.
- Resident cannot recall items after 5 minutes.

***Long-term Memory***

- Resident can recall events long past
- 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***

- Independent: makes consistent, independent decisions
- Modified independence: difficulty in new situations.
- Moderately impaired: needs cueing for directions.
- Severely impaired: rarely/never makes decisions.

***Change in cognitive status/awareness or thinking disorders***

- No change in cognitive status.
- Less alert, easily distracted, lethargic.
- New episodes of incoherent speech.
- 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**

- Hears adequately: normal talk, TV, phone without difficulty
- Minimal loss: difficulty only with noisy backgrounds.
- Moderate loss: cannot hear unless spoken to distinctly and directly.
- 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**

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

### **Speech: Ability to make self understood**

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

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

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

## **SECTION III. CONTINENCE**

### **Bladder continence:**

- Continent: resident has complete control over bladder function.
- Usually continent: 1 episode/week or less of incontinence.
- Occasionally incontinent: 2 or more episodes/week (not daily)
- Frequently incontinent: some control present but has some episodes daily.
- Incontinent: multiple daily episodes, no control present.

### **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)

- Continent: resident has complete control over bowel function.
- Usually continent: less than 1 episode of incontinence/week.
- Occasionally incontinent: 1 episodes/week.

- Frequently incontinent: 2-3 episodes of incontinence/week.
- 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**

**Eating:** (how resident eats and drinks)

- Independent: needs no help or supervision.
- Supervision: needs cueing, monitoring  1-Person Assist
- Limited assistance: needs some physical help and support.  2-Person Assist
- Extensive assistance: needs assistance to be able to complete task
- Total dependence:** fully reliant on staff for eating.

**Walking** (Check all that apply)

- Independent: needs no help or supervision
- Supervision: needs cueing, monitoring  1-Person Assist
- Limited assistance: needs some physical help and support  2-Person Assist
- Extensive assistance: needs physical support most of the time
- Total dependence:** fully reliant on staff for walking.

**Mobility:** (how resident moves within room and home, includes self-sufficient use of mobility devices)

- Independent: needs no help or supervision.
- Supervision: needs cueing, monitoring  1-Person Assist
- Limited assistance: needs some physical help and support.  2-Person Assist
- Extensive assistance: needs physical help most of the time.
- Total dependence:** fully reliant on staff for locomotion

**Dressing:** (how resident puts on, fastens, takes off clothing; includes applying/removing prosthesis)

- Independent: needs no help or supervision.
- Supervision: needs some cueing, monitoring  1-Person Assist
- Limited assistance: needs some physical help and support.  2-Person Assist
- Extensive assistance: needs assistance with all of dressing
- Total dependence:** fully reliant on staff for all dressing needs

**Grooming:** (how resident combs hair, brushes teeth, shaves, cleans & cares for finger and toe nails, etc.)

- Independent: needs no help or supervision.
- Supervision: needs cueing, monitoring  1-Person Assist
- Limited assistance: needs some physical help and support.  2-Person Assist
- Extensive assistance: needs physical help with all of grooming
- Total dependence:** fully reliant on staff for all grooming needs

**Bathing:** (how resident takes a full body bath/shower)

- Independent: no help provided.
- Supervision: needs supervision, monitoring  1-Person Assist
- Limited assistance: needs some physical help and support  2-Person Assist
- Extensive assistance: needs physical help with most of bathing
- Total dependence:** fully reliant on staff for bathing

**Use of toilet:** (how resident cleanses self, changes protective garments/pads, adjusts own clothes)

- Independent: needs no help or supervision.
- Supervision: needs cueing, monitoring  1-Person Assist
- Limited assistance: needs some physical help and support.  2-Person Assist
- Extensive assistance: needs physical help with most of toileting
- Total dependence:** fully reliant on staff for toileting

**Ability to transfer** (to and from bed / chair / wheelchair / toilet, etc.)

- Independent: needs no help or supervision.  1-Person Assist
- Supervision: needs cueing, monitoring  2-Person Assist
- Limited assistance: needs some physical help in maneuvering, minimal support.
- Extensive assistance: needs physical help with most of transferring
- Total dependence:** fully reliant on staff for transferring

**THE RESIDENT IS TOTALLY AND CONSISTENTLY DEPENDENT IN:**

- |                                |                               |                                 |                                    |
|--------------------------------|-------------------------------|---------------------------------|------------------------------------|
| <input type="radio"/> Eating   | <input type="radio"/> Walking | <input type="radio"/> Mobility  | <input type="radio"/> Dressing     |
| <input type="radio"/> Grooming | <input type="radio"/> Bathing | <input type="radio"/> Toileting | <input type="radio"/> Transferring |

**\*\*\* Total dependence in four or more of these ADLs indicates 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.

- Behavior not exhibited recently or ever.
- Behavior does occur.

Describe:

**Verbally abusive:** screaming, cursing, threatening others

- Behavior not exhibited recently or ever.
- Behavior does occur.

Describe:

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

- Behavior not exhibited recently or ever.
- Behavior does occur.

Describe:

***Resistant behavior:***

- No resistant behavior displayed.
- 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:**

- |   |  |   |
|---|--|---|
| <input type="radio"/> Constipation        | <input type="radio"/> Pain                 | <input type="radio"/> Falls with Injury |
| <input type="radio"/> Dizziness           | <input type="radio"/> Nausea               | <input type="radio"/> Diabetes          |
| <input type="radio"/> Hallucinations      | <input type="radio"/> Falls without injury | <input type="radio"/> Others:           |
| <input type="radio"/> Shortness of Breath | <input type="radio"/> Fecal impaction      | <input type="radio"/> _____             |
| <input type="radio"/> Aspiration/Choking  | <input type="radio"/> Fever                | <input type="radio"/> _____             |
| <input type="radio"/> Diarrhea            | <input type="radio"/> Joint Aches          | <input type="radio"/> _____             |
| <input type="radio"/> Fainting            | <input type="radio"/> Vomiting             | <input type="radio"/> _____             |

**SECTION VII. WEIGHT/NUTRITIONAL STATUS**

Move-in date: \_\_\_\_\_ Weight upon move-in: \_\_\_\_\_ Weight at last assessment: \_\_\_\_\_

Current weight in pounds: \_\_\_\_\_ Scale used: \_\_\_\_\_

- No significant weight change since last assessment.
- 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 Nurse).
- 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) and **Administrative Rules of Montana regarding the use of devices** (ARM 37.106.2901 through 37.106.2908) must be met and documented in the resident's record.  
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**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: \_\_\_\_\_

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)