Care Assessment for Residential Services Tool

Resident Name: _____ Date of Assessment: _____

Resident DOB: _____ Date of Admission: _____

Initial/Admission Assessment ☐ Six-Month Assessment ☐ After significant change Assessment ☐

INSTRUCTIONS:

- **Attach current list of diagnoses and medications.**
- **Each check mark in a shaded box must have a care plan or list A, B, C, or D why the need does not require a care plan. See acceptable reasons for not care planning below.**
- **All questions must be answered if prompted.**
- **Trained personnel may complete all sections of this assessment. Collaboration or consulting with health care professionals, their examinations or progress notes is essential to ensure the assessment is accurately completed.**
- **If any shaded box in Section I is checked, a nurse shall determine if a nursing assessment and care plan is required.**
- **One care plan may contain numerous needs that have a check mark in a shaded area.**

ACCEPTABLE REASONS FOR ABSENCE OF CARE PLAN FOR A NEED IN A SHADED BOX:

- **Reason A = This need is met for all residents as part of the basic services and all staff provide this need per their job description, responsibilities and / or facility policy.**
- **Reason B = This need is met by other health care professionals not employed by the facility but with oversight provided by facility staff.**
- **Reason C = The facility, and others, have exhausted all reasonable attempts to meet this need. The resident, legal agent and family are aware and agree this need will not have a care plan.**
- **Reason D = Other. Must provide explanation.**

Section I. MEDICAL/NURSING

If any shaded box in this section is checked, a nurse shall determine if a nursing assessment and care plan is required.

Nutritional Status	Yes	No	Care Plan?	Reason/Comments:	Nursing Assessment?
1. Special dietary need. If yes, specify.					
2. Requires adaptive eating utensils. If yes, specify.					
3. Weight change of 5% or more in the past 30 days. If yes, specify.					

Medication Administration	Yes	No	Care Plan?	Reason/Comments:	Nursing Assessment?
1. Resident self-administers medication without assistance(Must pass bi-annual evaluation and have annual order from licensed practitioner)					
2. Resident self-directs medication administration. (Must pass bi-annual evaluation and have annual order from licensed practitioner verifying their physical limitation)					
3. Resident self-administers medication with assistance					
4. Requires nurse or personnel to administer medications.					

5. Requires someone to order medications.					
6. Is resident receiving treatment/medication for pain?					

Health Maintenance	Yes	No	Care Plan?	Reason/Comments:	Nursing Assessment?
1. Frequent urinary tract infections.					
2. Chronic constipation					
3. Indwelling catheter					
4. Receives nutrition through feeding tube					
5. Ostomy – identify type					
6. Requires monitoring of new/changed/or deteriorating medical condition. If yes, specify					

Hospice Services	Yes	No	Care Plan?	Reason/Comments:	Nursing Assessment?
1. Currently receiving hospice services.					

Wound Care	Yes	No	Care Plan?	Reason/Comments:	Nursing Assessment?
1. Currently receiving wound care services.					

COGNITIVE, MENTAL AND BEHAVIORAL HEALTH STATUS	Yes	No	Care Plan?	Reason/Comments:	Nursing Assessment?
1. Active diagnosis of cognitive/memory impairment, including dementia. (If yes, list in comment section. Example: Early, Mid, Late)					
2. Displays exit-seeking behaviors.					
3. Active diagnosis of mental health condition, including depression, anxiety, schizophrenia, etc. (If yes, list)					
4. Actively pursuing or currently receiving mental health treatment or services. (If yes, list in comment section.)					
5. Has attempted suicide in the past six months.					
6. Has been verbally, physically or behaviorally aggressive in the past six months.					

Section II. ADL Functions

	Yes	No	Care Plan?	Reason/Comments:
1. Incontinence of bladder, bowel, or both. Please circle.				
2. Requires assistance with incontinence products. If yes, circle level of assistance required: SET UP or ONE/TWO PERSON				
3. Requires assistance with toileting. If yes, circle level of assistance required: SET UP or ONE/TWO PERSON				
4. Requires assistance with bathing. If yes, circle level of assistance required: SET UP or ONE/TWO PERSON				
5. Resistant to maintaining hygiene. If yes, circle bathing, grooming, dental care				
6. Requires assistance with dressing. If yes, circle level of assistance required: SET UP or ONE/TWO PERSON				
7. Requires assistance with dental care. If yes, circle level of assistance required: SET UP or ONE/TWO PERSON				

Section III. SAFETY

AMBULATION/TRANSFERS	Yes	No	Care Plan?	Reason/Comments:
1. Independent with ambulation. If no, circle level of assistance required: SUPERVISION or ONE/TWO PERSON				
2. Walks with assistive equipment. (If yes, list equipment.)				
3. Independent with stair navigation. If no, circle level of assistance required: SUPERVISION or ONE/TWO PERSON				
4. Needs physical assistance to transfer. If yes, circle level of assistance required: SUPERVISION or ONE/TWO PERSON				
5. Requires lift equipment to transfer. (If yes, list equipment.)				
6. Does resident require the use of a wheelchair?				

FALLS	Yes	No	Care Plan?	Reason/Comments:
1. Diagnosis of gait or balance impairment.				
2. Documented falls in last three months. (If yes, how many.)				

EVACUATION (Select level of assistance necessary for safe evacuation.)	Yes	No	Care Plan?	Reason/Comments:
1. Evacuates building independently.				
2. Evacuates building with verbal assist.				
3. Evacuates building with physical assist. If yes, circle level of assistance required: ONE PERSON or TWO PERSON				

Section IV. COMMUNICATION

COMMUNICATION	Yes	No	Will you Care Plan?	Reason/Comments:
1. Requires corrective lenses or reading glasses. **(Circle one: Daily Reading Both Refuses)**				
2. Requires hearing aids. **(Circle one: Right Left Both Refuses)**				
3. Effective verbal communication. (If no, list barriers. Example: Aphasia)				

Comments:

_____

_____

_____

Completed by: _____ _____ _____ _____

Name (printed) Signature Date Title

All assessments must be completed and reviewed in collaboration with resident or their guardian, agent, or personal representative, if any.

Reviewed by: _____ _____ _____ _____

Name (printed) Signature Date Relationship

Reviewed by: _____ _____ _____ _____

Name (printed) Signature Date Relationship