☐ **Pre-admission**
☐ **Comprehensive**

Touchmark at Meadow Lake Village
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RESIDENT HEALTH/NEEDS ASSESSMENT

RESIDENT NAME: _____

ASSESSMENT DATE: _____

MOVE IN DATE: _____ **APT #:**_____ **PROGRAM**: _____
(AL, Memory Care)

MOVE FROM:_____ **LIVED ALONE:** ☐**Yes** ☐**No**
(specify: home, hospital, nursing home, etc.)

REASON YOU ARE CONSIDERING MOVING: _____

_____

LIFE HISTORY:

Preferred Name: _____ Place/Year of Birth: _____

Other places you have lived: (if resident knows how long; during what part of his/her life, etc.)

_____

_____

List interests in broad categories: (religion, hobbies, social interests, and affiliations) _____

_____

Describe your current daily and evening schedule (mealtimes, sleeping hours, activities of interest & routine)

_____

_____

Describe your best time of day and your worst time of day: _____

_____

Other information that will help us provide person-centered care: _____

_____

CURRENT HEALTH CHALLENGES (Physical and/or Mental): _____

_____

_____

_____

CHRONIC HEALTH PROBLEMS/DIAGNOSES (e.g. high BP, skin, heart disease, diabetes, etc.):

_____

_____

_____

MEDICAL HISTORY: Has a doctor ever told you that you have any of the following?

☐	Age related dementia	☐	Clotting problems	☐	GERD	☐	Parkinson's Disease
☐	Allergies	☐	Cold Hands/Feet	☐	Heart Attack	☐	Peripheral Vascular Disease
☐	ALS	☐	Congenital Heart Disease	☐	Heart Murmurs	☐	Post Polio syndrome
☐	Alzheimer' disease	☐	Congestive Heart Failure	☐	Heart Valve Problems	☐	Rheumatic Fever
☐	Anemia	☐	COPD	☐	Hip Problems	☐	Prosthesis
☐	Angina	☐	Coronary Heart Disease	☐	Hypertension	☐	Rheumatic Heart Disease
☐	Arthritis (Osteo)	☐	Diabetes	☐	IBIS	☐	Seizure Disorder
☐	Arthritis (Rheumatoid)	☐	Dizziness/Fainting	☐	Irregular Heartbeats	☐	Shortness of Breath
☐	Asthma	☐	Edema/swelling	☐	Joint Replacement	☐	Shoulder Problems
☐	Back Pain	☐	Emphysema	☐	Joint, Tendon, or Muscular Pain	☐	Stroke
☐	Broken Bones	☐	Epilepsy	☐	Kidney problems	☐	Systemic Disease
☐	Cancer	☐	Falls	☐	Knee Problems	☐	Tuberculosis
☐	Cataracts/Glaucoma	☐	Foot Problems	☐	Multiple Sclerosis	☐	Other:
☐	Chest Discomfort	☐	Generalized Weakness	☐	Neck Problems	☐	Other:
Comments:							

Height _____ **Weight** _____ ☐ actual ☐ reported

BP _____ **Pulse** _____ **Resp** _____ **Temp** _____

END OF LIFE PREFERENCES: Who has the authority to make health decisions? _____

☐ Living will ☐ State specific DNR Consent Form ☐ Full Code _____
RN Signature

☐Durable POA _____ ☐POA for health care: _____
(name, phone) (name, phone)

NURSING NEEDS: Info provided by Physician's Orders, discharge planner, resident, family members, POA, etc.

	CBGs		IM injections		Coord. Comm. w/family		Dialysis
	Basic Wound Care		Quarterly Med Review		RN assess for health condition		Pacemaker
	Ostomy Care		Behavior plan for meds		Skin assessment		Other _____
	RN performs injections		Coord. Comm. w/health prof.		RN assess for pain management		Other _____
Comments:							
	RESPIRATION:						
	Oxygen Use (Independent)		Self Administered - LPM		Intermittent		Continuous
	Oxygen Use (Assisted))		LPM		Comments:		
	Oxygen Provider:		Comments:				
Comments:							

HOSPITALIZATIONS (facility & dates for the past 2 years): _____

_____

_____

PRESCRIPTION MEDICATIONS: *(include name, dose, route, frequency of administration of each medication)

***To be completed only at time of initial move-in or readmission**

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

OVER THE COUNTER MEDICATIONS: _____

_____

DRUG ALLERGIES: _____

NAME OF PHARMACY: _____

☐ Self-Administered ☐ Self-Administered w/staff assistance ☐ Staff Administered ☐ Family Assistance
(Use Self-Administered Form) (plan on file)

Resident understands and can explain the purpose of the medications ☐ **Yes** ☐ **No**

Resident understands and can explain the proper dosage for the medications ☐ **Yes** ☐ **No**

Resident understands and can explain the proper route (method) to take the medications ☐ **Yes** ☐ **No**

Resident understands and can explain the proper schedule for the medications ☐ **Yes** ☐ **No**

Resident understands and can explain the side effects that can occur with the medications ☐ **Yes** ☐ **No**

Resident demonstrates manual dexterity to open and measure dosage of medications ☐ **Yes** ☐ **No**

Resident demonstrates ability to safely store medications ☐ **Yes** ☐ **No**

Resident can accurately chart daily doses ☐ **Yes** ☐ **No**

Resident can correctly read the medication label on the container ☐ **Yes** ☐ **No**

Family/private caregiver manages medications (plan on file) ☐ **Yes** ☐ **No**

PERSONAL CARE INFORMATION/PREFERENCES/NEEDS:

SLEEPING HABITS:

☐ No routine supervision needed ☐ Nocturnal wandering ☐ Gets up during night and needs assistance (specify: how often, what kind of assistance): _____

_____

Usual Bedtime _____Usual Arising Time _____ Usual Nap Time _____

Any problems sleeping: ☐ Yes ☐ No If yes, Specify:_____

_____ _____

SENSORY NEEDS:

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

Speech: Ability to understand others:

☐ Understands others without difficulty or error

☐ Usually understands: occasionally misses part of a message

☐ Sometimes understands: responds appropriately to simple directions

☐ Rarely/never understands

☐ Relies on primary language - describe: _____

Speech: Ability to make self understood:

☐ Speech is easily understood by others

☐ Speech usually understood: has difficulty finishing thoughts, finding words

☐ Speech sometimes is understood: can make simple requests

☐ Speech is rarely understood

☐ Relies on primary language - describe:_____

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: can see only light, shadow, shapes, colors

☐ Peripheral vision problem: bumps into people/objects, leaves food on side of plate

ASSISTIVE DEVICES FOR SENSORY SUPPORT:

Hearing:		Hearing Aides		Left		Right		None		
Sight:		Glasses:		Yes		No				
Sight:		Contact Lenses								
Comments:										

EATING:

	Independent		Assistance Needed (Specify)
	Assist/eating		Assistance
	Food allergies		(Specify)
	Food intolerance		(Specify)
Comments:			

DIETARY NEEDS:

Dining Location:		Dining Room		Apartment (additional fee required)
Snack(s)		Bedtime		Between Meals
Snack Preference:				
Comments:				

Special Likes: _____

Particular Dislikes: _____

Do you have a good appetite: _____

Difficulty Chewing/Swallowing: ☐ Yes ☐ No

Special diet; if yes what: _____

Food Consistency Adjustment Required: ☐ Yes ☐ No Adaptive Eating Devices Required (cutlery, dishes, etc.):_____

Other Special Needs: (food positioning, lighting intensity, spoon only, etc.)

_____

PERSONAL HYGIENE:

Tub Bath		Independent		Assistance		Other:
Shower		Independent		Assistance		Other:
Spa Bath		Independent		Assistance		Other:
Oral Care		Independent		Assistance		Other:
Dentures		Independent		Assistance		Other
Shave		Independent		Assistance		Other:
Grooming:		Independent		Assistance		Other:
Dressing		Independent		Assistance		Other:

Hair		Independent		Assistance		Other:	
Nail Care		Independent		Assistance		Other:	
Make Up		Independent		Assistance		Other:	
Beauty Shop		Independent		Assistance		Other (Fee required):	
Comments:							

ELIMINATION:

Toilet:		Independent		Assistance:	
Bowels:		Continent		Self-Managed	Incontinent
Bladder:		Continent		Self-Managed	Incontinent
Catheter (Type/Size):		Self Care		Needs Assistance:	
Ostomy (Type of appliance)		Self Care		Needs Assistance:	
Incontinent products used:					
Comments:					

MOBILITY/STABILITY:

	Independent		Assistance:		Comment:				
	Wheelchair Independent		Manual		Motorized (Assessment required)				
	Wheelchair		Assistance:		Comment:				
	Other Auxiliary Aids		Walker		Cane		Crutch(s) (type):		
	Braces		Assistance:		Comment:				
	Other Safety Devices Mobility Aids Used:								
	Transfers:		Independent		Assistance		1 Person		2 Person
	Weight-Bearing:		Full weight		Partial		Left		Right
Comments:									
	Any Restricted Activity:		Yes		No	Note:			
	Joint Replacement		Yes		No	Site:			
Comments:									

Fall Risk Assessment Completed _____ _____

Date Score

HEALTH/SAFETY ISSUES:

☐ Smoker	Restrictions: NOTE: Not allowed in building
☐ Alcohol use	Restrictions/frequency/Dr. orders:
Other:	

LAUNDRY/HOUSEKEEPING:

☐ Able to manage own laundry	☐ Needs assistance with laundry
☐ Able to manage own housekeeping	☐ Needs additional housekeeping services
Other – bed-making preferences, etc.:	

OBSERVATION/INTERVIEW INFORMATION

MENTAL HEALTH HISTORY

☐ History of depression ☐ Behavior problems ☐ Mental illness ☐ Hallucinations ☐ Confusion

☐ Drug or alcohol dependency Comments:_____

Resident has a significant behavior or mental condition that may disrupt the peaceful living or care of other residents: ☐ Yes ☐ No If "yes", please explain:

_____ ____

_____ ____

Geriatric Depression Scale (GDS) (if available): _____

Has resident suffered any recent loss of any type (including loss of family member or friend, or loss of some functional ability): ☐ Yes ☐ No

If Yes, Explain _____ _____

_____

Has resident demonstrated any challenging behaviors related to mental health or dementia diagnosis:

☐ Yes ☐ No

If Yes, Explain _____ _____

_____

MMSE Score (as available/as reported): _____ Date: _____

Assessment Completed by: _____ Date: _____
(Signature)

Resident (signature) _____

Family Member / POA (signature) _____

Notes/Comments:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____
(RN)

Information for this assessment was obtained by: (check all that apply)

☐ personal interview with resident ☐ family or friends other than resident

☐ staff ☐ physician or other medical professional ☐ review of chart content

ADDENDUM: TO BE COMPLETED AFTER RESIDENT MOVES IN

STANDARD ASSESSMENT FOR COGNITIVE SAFETY *

Score answers either "1" for appropriate response of "0" for no response or an inappropriate response.

Score **Questions Asked of the Resident:**

_____1. How would you get out of the community?

_____2. What would you do if you noticed a fire in your room?

_____3. Is the resident oriented to ☐ Person ☐ Place ☐ Time (2 or more is appropriate)

_____4. If you needed help, what would you do?

Score answers either "1" for **Yes** or "0" for **No**.

Score **Questions Asked Of The Caregiver Familiar With The Resident:**

In your opinion:

_____1. Is the resident cognitively able to evacuate on his/her own?

_____2. Is the resident cognitively able to use the phone?

_____3. Can you leave the door of the community open without worry that the resident may wander?

_____4. Is the resident cognitively able to go on an outing on his/her own?

_____**Total Score** (add both columns: questions asked of the resident and questions asked of the staff)

If the total score is less than 4, the resident may be appropriate for residence in a Devonshire community. If the total score is 4 or 5, you should conduct the evacuation test below:

EVACUATION TEST

(To be conducted in the first 30 days of residence in the community)

Allow staff to prepare and cue the resident to evacuate when the alarm sounds. During a scheduled drill determine if the resident is able to evacuate within 4 minutes. ☐ Pass ☐ Fail

If the resident fails this test the plan for evacuation to the determined safe refuge area within the community must be detailed in the Service Plan. All emergency drills need to be conducted as written in the Service Plan and reviewed quarterly.

*** To be completed at the time of initial move-in, change-of-condition, or readmission only**

PARTICULAR CONCERNS DISCUSSED BY RESIDENT OR RESPONSIBLE PARTY:

_____

_____

* **REQUIRED**