Centers Health Care

POLICY:	EHR - DOWNTIME		**POLICY NO:**	**EHR-5**
Dept: Nsg	CLINICAL OPERATIONS	☐ **New** ☒ **Revised**	**Last Date Revised:**	8/2019
			Prev. Date Revised:	6/17, 11/17, 5/18
			Creation Date:	3/2014
RELATED FORMS:				

POLICY:

This facility follows current guidelines and recommendations for the procedure when there is a downtime of the Electronic Health Record (EHR).

There are 5 Different types of downtime and ways to prevent:

1. Loss of internet
2. Loss of power
   a. If downtime is related to a loss of facility power all necessary equipment will be plugged into the emergency outlets.
3. Unscheduled PCC maintenance outage
   a. If outage last greater than 60 minutes notify EHR support for guidance. (see below)
4. Scheduled PCC maintenance outage
   a. Lasts less than 2 hours, usually during the night, facility is notified in advance and can plan their documentation around the interruption.
5. Cyber-Security Attack
   a. Immediately notify HOSC IT support and HER Team from time of noted security breach.

PREVENTATIVE MEASURES

1. Quarterly check or more often as needed should be performed to desktops and/or laptops to ensure physical connectivity is maintained.
2. Facilities must maintain a backup or second internet source.
3. Facilities should have internet source plugged into emergency outlet so that internet is not lost.
4. Laptops should be charged nightly to ensure documentation is not delayed due to lack of power.

PROCEDURE

When an unscheduled downtime occurs, please contact the following in this order:

1. Contact and inform Administrator, DON, Supervisor and Maintenance Director
2. Contact IT provider if necessary for system restore
   a. HOCS – number is 718-377-0922 option #2
   b. Email support at: support@hocsinc.com
3. Contact Kodiak – 908-687-4101
4. Contact the EHR team via email or Hotline –
   a. 917-633-4854 (Mon – Fri 9am to 5pm)
   b. 866-294-0768 – All off hours

DOWNTIME DOCUMENTATION

1. If there is need to document an administration of medication or treatment during the outage print the appropriate administration record for that specific resident only or document on the blank Administration Record Blank Report during planned outage.

2. Do NOT administer medications/treatment etc. without printing the appropriate documentation from the back up.

3. If there is a change in a resident's orders during the outage the following process should be followed:

    a. Add the new order or the change to the blank administration record or printed back up and document on this record until the outage is resolved.
    b. After the outage, the order or update is entered into EHR and the original is kept with the filed administration records for not less than 30 days.

4. When EHR is available again, the licensed nurse that:
    a. Administered the medication/treatment and/or enteral feeding on the printout enters the medication and treatment administration documentation into PCC as a late entry.
    b. Received the physician order during the outage enters the order into PCC as a late entry.
    c. If there is a circumstance where the person that administers the medication or completed the documentation during the outage and cannot enter the documentation into the EHR, call facility DON/designee for further guidance.
    d. DON/designee will:
        i. Verify that all administration records were entered into EHR.
        ii. Keep the paper Administration record after the information has been entered into EHR for a period of not less than 30 days.
        iii. Administration shall keep a log of all outage periods in which paper documentation was required

PROGRESS NOTE

DATE	TIME	NARRATIVE
RESIDENT NAME		RM#

Resident ADL Sheet

Resident Name: _____ Room #: _____ Month/Year: _____

ACTIVITY Chart Self Performance in Top Box Support Given in Lower Box		DATE															
BED MOBILITY		How the resident moves to and from lying position, turns to side and positions body while in bed															
Self-Performance 1. Totally dependent 2. Extensive Assist 3. Limited Assist 4. Supervision 5. Independent 0. Did Not Occur	*Support Provided* 1. Two Person Assist 2. One Person Assist 3. Set-up 4. No Set Up 0. Did Not Occur	7-3															
		3-11															
		11-7															
TRANSFERS		How the resident moves to and from bed, chair, wheelchair, standing															
Self-Performance 1. Totally dependent 2. Extensive Assist 3. Limited Assist 4. Supervision 5. Independent 0. Did Not Occur	*Support Provided* 1. Two Person Assist 2. One Person Assist 3. Set-up 4. No Set Up 0. Did Not Occur	7-3															
		3-11															
		11-7															
TOILETING		How the resident uses the toilet room/commode/bedpan/urinal															
Self-Performance 1. Totally dependent 2. Extensive Assist 3. Limited Assist 4. Supervision 5. Independent 0. Did Not Occur	*Support Provided* 1. Two Person Assist 2. One Person Assist 3. Set-up 4. No Set Up 0. Did Not Occur	7-3															
		3-11															
		11-7															
EATING		How the resident eats/drinks (includes G-tube and TPN)															
Self-Performance 1. Totally dependent 2. Extensive Assist 3. Limited Assist 4. Supervision 5. Independent 0. Did Not Occur	*Support Provided* 1. Two Person Assist 2. One Person Assist 3. Set-up 4. No Set Up 0. Did Not Occur	7-3															
		3-11															
		11-7															

Resident ADL Sheet

Resident Name: _____ Room #: _____ Month/Year: _____

BLADDER																
1. CONTINENT 2. INCONTINENT 3. CATHETER	7-3															
	3-11															
	11-7															
URINARY OUTPUT																
1. YES 2. NO Report to your nurse if the resident urinary output has decreased or there is changes in color or smell	7-3															
	3-11															
	11-7															
BOWEL																
1. CONTINENT 2. INCONTINENT	7-3															
	3-11															
	11-7															
BOWEL MOVEMENT 1-4 TOP BOX 1-3 BOTTOM BOX																
1. NONE 2. SMALL 3. MEDIUM 4. LARGE	1. FORMED/NORMAL 2. LOOSE/DIARRHEA 3.CONSTIPATED/HARD	7-3														
		3-11														
		11-7														

Resident ADL Sheet

Resident Name: _____ Room #: _____ Month/Year: _____

% DIETARY INTAKE																	
Percentage of Meal Eaten 0. 0 % 1. 25% 2. 50% 3. 75% 4. 100%	7-3 Bkfs																
	3-11 Lun																
	11-7																
NOURISHMENT																	
Percentage of Meal Eaten 0. 0 % 1. 25% 2. 50% 3. 75% 4. 100%	7-3 Bkfs																
	3-11 Lun																
	11-7 Dinn																
COGNITIVE/MOOD/BEHAVIOR	CHART APPLICABLE #'s																
1. SAD/WORRIED EXPRESSION 2.CRYING/TEARFULNESS 3.DIFFICULTY SLEEPING 4.MEMORY PROBLEMS 5.DIFF. EXPRESSING OR UNDRSTNG 6. YELLS OUT/HITS @STAFF	7-3																
	3-11																
	11-7																
BATHING	How resident takes full body bath/shower and transfers in/out of tub/shower																
Self-Performance 1. Totally dependent 2. Extensive Assist 3. Limited Assist 4. Supervision 5. Independent 0. Did Not Occur	*Support Provided* 1. Two Person Assist 2. One Person Assist 3. Set-up 4. No Set Up 0. Did Not Occur	7-3															
		3-11															
		11-7															

Resident ADL Sheet

Resident Name: _____ Room #: _____ Month/Year: _____

DRESSING		How resident puts on, fastens and takes off all items of clothing, including donning/removing a rothesis or TED hose.																
Self-Performance 1. Totally dependent 2. Extensive Assist 3. Limited Assist 4. Supervision 5. Independent 0. Did Not Occur	*Support Provided* 1. Two Person Assist 2. One Person Assist 3. Set-up 4. No Set Up 0. Did Not Occur	7-3																
		3-11																
		11-7																
LOCOMOTION		How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair																
Self-Performance 1. Totally dependent 2. Extensive Assist 3. Limited Assist 4. Supervision 5. Independent 0. Did Not Occur	*Support Provided* 1. Two Person Assist 2. One Person Assist 3. Set-up 4. No Set Up 0. Did Not Occur	7-3																
		3-11																
		11-7																
PERSONAL HYGIENE		How resident maintains personal hygeine, including combing hair, brushing teeth, shaving, applying make up, washing drying face and hands																
Self-Performance 1. Totally dependent 2. Extensive Assist 3. Limited Assist 4. Supervision 5. Independent 0. Did Not Occur	*Support Provided* 1. Two Person Assist 2. One Person Assist 3. Set-up 4. No Set Up 0. Did Not Occur	7-3																
		3-11																
		11-7																

INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE	INITIALS	SIGNATURE

Client:	Effective Date:	Location:
Initial Admission:	Admission:	Date of Birth:
Physician:		

Eval. LN: Physical Evaluation

A. Admission Details

1.

Most Recent Admission:

2. Reason For Admission According To Resident/POA:

3. Did the resident have major surgery during the 100 days prior to admission?

- 0. No
- 1. Yes
- 8. Unknown

4. Recent Surgery Requiring Active SNF Care

- 0. No
- 1. Yes
- 8. Unknown

5. Is the resident currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition?

- 0. No
- 1. Yes
- 9. Not A Medicaid Certified Unit
- -. Not Assesses

6. Is active discharge planning already occurring for the resident to return to the community?

- 0. No
- 1. Yes
- -. Not assessed/no information

7. Admitted From:

8. Arrived Via:

- a. Ambulance/Ambulette
- b. Personal Vehicle
- c. Transportation Services
- d. Other

8-1. Specify other:

9. Accompanied by:

- [ ] a. Unaccompanied
- [ ] b. Spouse/Significant Other
- [ ] c. Child
- [ ] d. Parents
- [ ] e. Friend
- [ ] f. Other

9-1. Specify other:

Client:

10. Comments:

11. Allergies

12. Code Status

B. LOC/ Orientation

- [ ] Unrousable/Coma/Persistent Vegetative State

1. Orientation (check all that apply)
   - [ ] a. Resident not oriented to person, place, time or situation.
   - [ ] b. Person
   - [ ] c. Place
   - [ ] d. Time
   - [ ] e. Situation
2. Cognition (check all that apply)
   - [ ] a. Intact
   - [ ] b. Confused
   - [ ] c. Short-Term Memory Problem
   - [ ] d. Long-Term Memory Problem
3. Communication (check all that apply)
   - [ ] a. Speaks English
   - [ ] b. Does Not Speak English: Translator Required
   - [ ] c. Difficulty Understanding Others
   - [ ] d. Difficulty Being Understood
   - [ ] e. Non-Oral Communication Device (Communication Board, Sign Language, Computer/Tablet)
   - [ ] f. Preferred Language is not English

3a. If Non-English Speaker:
Language And Name Of Translator Used During Evaluation

3b. What is the residents preferred language?

4. Does the resident need or want an interpreter to communicate with a doctor or health care staff?
   - ( ) 0. No
   - ( ) 1. Yes
   - ( ) 9. Unable to determine
   - ( ) -. Not assessed/no information

5. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

5a. Health Literacy
   - ( ) 0. Never
   - ( ) 1. Rarely
   - ( ) 2. Sometimes

- 3. Often
- 4. Always
- 7. Resident declines to respond
- 8. Resident unable to respond
- -. Not assessed/no information

C. Psychiatric/Behavior(s)

1. Behavior and/or Psychiatric History

1a. Target Behavior History (If Known):

2. (Check all that apply)

- a. Hallucinations
- b. Delusions
- c. Delirium
- d. None of the above

2a. Signs and Symptoms of Delirium Exhibited:

- a. Inattention - Difficulty focusing attention, for example, being easily distractible or having difficulty keeping track of what was being said
- b. Disorganized Thinking - The resident
- c. Altered Level of Consciousness - The resident has an altered level of consciousness, as indicated by any of the following criteria:
  - vigilant - startled easily to any sound or touch
  - lethargic - repeatedly dozed off when being asked questions, but responded to voice or touch
  - stuporous - very difficult to arouse and keep aroused for the interview

3. Comments:

D. Vital Signs

1. Most Recent Weight

Weight: _____ Date: _____

Scale: _____

2. Most Recent Blood Pressure

Blood Pressure: _____ Date: _____

Position: _____

2-1. Refused Blood Pressure

3. Most Recent Temperature

Temperature: _____ Date: _____

Route: _____

3-1. Refused Temperature

4. Most Recent Pulse

Pulse: _____ Date: _____

Pulse Type: _____

4-1. Refused Pulse

5. Most Recent Respiration

Respiration: _____ Date: _____

5-1. Refused Respiration

6. Most Recent O2 sats

O2 sats: _____(%) Date: _____

Method: _____

6-1. ☐ Refused 02 sats

7. Most Recent Height

Height: _____ Date: _____

Method: _____

7-1. ☐ Refused Height

8. Most Recent Blood Sugar

Blood Glucose: _____ Date: _____

8-1. ☐ Refused Blood Glucose

E. General Appearance/ HEENT

1. ☐ Head: WNL (Normal Shape/Size, No Visible Trauma)

1-1. Comments:

2. Eyes

○ a. WNL- No Abnormalities Noted ○ b. Concerns Noted

2-1. Eye Concerns:

- ☐ a. Pupils uneven
- ☐ b. Pupils unreactive to light
- ☐ c. Wears Glasses
- ☐ d. Blind
- ☐ e. Cataracts
- ☐ f. Other eye abnormalities noted

2-1-1. Comments:

3. Ears

○ a. WNL - No Abnormalities Noted ○ b. Concerns Noted

3-1. Ear Evaluation Concerns:

- ☐ a. Hearing Aid(s) Used
- ☐ b. Deaf
- ☐ c. Large/excessive amounts of ear wax noted
- ☐ d. Other ear/auditory abnormalities

3-1-1. Comments:

4. ☐ Nose Unremarkable

4-1. Comments:

5. ☐ Throat: No Concerns Noted

5-1. Comments

6. Oral

○ a. WNL- No ○ b. Concerns Noted

Abnormalities Noted

b. Concerns Noted

6-1. Oral Evaluation Concerns:

- a. Oral Fungal Infection
- b. Dentures/Bridge Work
- c. No Teeth And No Dentures
- d. Obvious Dental Caries (Tooth Decay)
- e. Broken Teeth
- f. Oral Pain
- g. Other

6-2. Dentures/Bridgework if Applicable:

- a. Upper Dentures/Bridgework
- b. Lower Dentures/Bridgework

6-3. Comments:

F. Respiratory/ Cardiac

Respiratory

1. Respiratory Status

- a. WNL- No Abnormalities Noted
- b. Concerns Noted

1-1. Respiratory Evaluation Concerns:

- a. Respiratory Pattern Irregular
- b. Respiratory Infection/Antibiotics Ordered
- c. Breathing Treatments Per Orders
- d. Oxygen Per Orders
- e. Ventilator
- f. Tracheostomy
- g. Other

1-1-1. Specify other:

1-1-2. Trach Size/ Cannula Type:

2. **Evaluate for Shortness of Breath** (Check all that apply) (Example: Lay the HOB flat to evaluate for SO

- a. Shortness of breath or trouble breathing when sitting at rest
- b. Shortness of breath or trouble breathing with exertion (e.g., walking, bathing, transferring)
- c. Shortness of breath or trouble breathing when lying flat (Orthopnea)
- d. None of the Above

3. Lung Sounds

- a. WNL- No Abnormalities Noted
- b. Concerns Noted

3-1. Lung Sound Concerns:

- a. Crackles/Rales
- b. Rhonchi/Rubs
- c. Wheezes
- d. Diminishment
- e. Absent

4. Respiratory Comments:

Client:

Cardiac

5. Cardiac Status

- a. WNL- No Abnormalities Noted
- b. Concerns Noted

5-1. Cardiac Concerns:

- a. Pacemaker
- b. Internal Defibrillator
- c. Edema (Not Related To Trauma/Surgery)
- d. Other

5-1-2. Pacemaker/Internal Defibrillator Type:
Enter Type and Serial Number If Known

6. Heart Sounds

- a. WNL- No Abnormalities Noted
- b. Concerns Noted

6-1. Heart Sound Concerns

- a. Irregular
- b. Distant
- c. Murmur Noted
- d. Mechanical Click
- e. Other

7. Other Heart Sound Comments:

Pedal

8. Pedal Pulses

- a. WNL- No Abnormalities Noted
- b. Concerns Noted

8-1. Pedal Pulse Concerns:
Quality

- a. Right - Weak/Thready
- b. Right - Bounding
- c. Right - Absent
- d. Left - Weak/Thready
- e. Left - Bounding
- f. Left - Absent

9. Capillary Refill

- a. WNL- No Abnormalities Noted
- b. Concerns Noted

9-1. Capillary Refill Concerns:

- a. Right: Sluggish (< Or = 5 Seconds)
- b. Right: Abnormal (>5 Seconds)
- c. Right: N/A (Amputee)
- d. Left: Sluggish (< Or = 5 Seconds)
- e. Left: Abnormal (>5 Seconds)
- f. Left: N/A (Amputee)

Radial

10. Radial Pulses

- a. WNL- No Abnormalities Noted
- b. Concerns Noted

10-1. Radial Pulse Concerns:
Quality

- [ ] a. Right - Weak/Thready
- [ ] b. Right - Bounding
- [ ] c. Right - Absent
- [ ] d. Left - Weak/Thready
- [ ] e. Left - Bounding
- [ ] f. Left - Absent

11. Cardiac Comments:

G. Bladder/GU Bowel/GI

Bladder

1. Urinary Physical Evaluation

- ( ) a. WNL- No Abnormalities Noted
- ( ) b. Concerns Noted

1-1. Urinary Evaluation Concerns

- [ ] a. Urostomy/Nephrostomy
- [ ] b. Indwelling Catheter/Suprapubic Catheter
- [ ] c. Dysuria (Pain On Urination)
- [ ] d. Micturia (Frequency)
- [ ] e. Dribbling
- [ ] f. Incontinence
- [ ] g. Distended Bladder
- [ ] h. Other

1-2. Ostomy Size and Type

1-3. Urinary Catheter Type and Size:

1-4. Specify other:

Bowel

2. Bowel Physical Evaluation

- ( ) a. WNL- No Abnormalities Noted
- ( ) b. Concerns Noted

2-1. Bowel Evaluation Concerns:

- [ ] a. Bowel Sounds Absent/Abnormal
- [ ] b. Abdominal distention
- [ ] c. Abdominal pain/ cramping
- [ ] d. Tender upon Palpation
- [ ] e. Colostomy/Ileostomy/Jejunostomy
- [ ] f. Incontinent of Bowel
- [ ] g. Other

2-2. Colostomy/ileostomy/Jejunostomy (Specify Type and Size):

2-3. Specify other:

Menstrual Status

3. Menstrual Status

- [ ] A. Post-Menopausal
- [ ] B. Resident is male

C. Resident has active menstrual cycles

3-1. Last Menstrual Period If Not Post Menopausal

H. Musculoskeletal

Upper Extremities:

1a. Right Upper Extremity

a. Range Of Motion WNL | b. Contractures or restricted ROM

1b. Left Upper Extremity

a. Range Of Motion WNL | b. Contractures or restricted ROM

1c. Grasps Equal

a. Yes | b. No | c. Not Applicable

1d. Upper Extremity Comments:

Lower Extremities:

2a. Left Lower Extremity

a. Range Of Motion WNL | b. Contractures or restricted ROM

2b. Left Lower Extremity Weight Bearing Status:

a. Full Weight Bearing | b. Partial/Toe Tip Weight Bearing | c. Non-Weight Bearing | d. Not Applicable

2c. Right Lower Extremity

a. Range Of Motion WNL | b. Contractures or restricted ROM

2d. Right Lower Extremity Weight Bearing Status

a. Full Weight Bearing | b. Partial/Toe Tip Weight Bearing | c. Non-Weight Bearing | d. Not Applicable

2e. Lower Extremity Comments:

I. Skin Condition

General Observations

Skin Color/Turgor/Temperature

1a. Color

a. Skin Color Normal For Resident | b. Pale | c. Gray/Ashen | d. Cyanotic | e. Red

f. Jaundice | g. Unable to be determined due to refusal of skin evaluation

1b. Turgor

a. Normal | b. Tenting | c. Unable to be determined due to refusal of skin evaluation

1c. Temperature

a. Warm (Normal) | b. Hot | c. Cool | d. Cold | e. Dry

f. Moist | g. Diaphoretic | h. Unable to be determined due to refusal of skin

f. Moist g. Diaphoretic evaluation

Edema

2a. Right Lower Extremity Edema

a) No Edema
b) Trace (Non-Pitting)
c) 1+ (Mild Pitting)
d) 2+ (Moderate Pitting:Indentation Subsides Rapidly)
e) 3+ (Deep Pitting:Indentation Remains For A Short Time, Leg Visibly Edematous)
f) 4+ (Very Deep Pitting:Indentation Lasts A Long Time, Leg Very Edematous)
g) Unable to determine due to refusal of skin evaluation
h) N/A

2b. Left Lower Extremity Edema

a) No Edema
b) Trace (Non-Pitting)
c) 1+ (Mild Pitting)
d) 2+ (Moderate Pitting: Indentation Subsides Rapidly)
e) 3+ (Deep Pitting:Indentation Remains For A Short Time
f) 4+ (Very Deep Pitting:Indentation Lasts A Long Time)
g) Unable to determine due to refusal of skin evaluation
h) N/A

2c. Other areas of edema:

Document Location of Edema and Edema Scale

Skin2. LN & RN: Skin

A. Skin Condition

Skin Condition

1. Skin Condition<b< td=""></b<>

- ○ a. Skin is intact
- ○ b. Skin impairment(s) noted
- ○ c. Resident refused skin evaluation

2. Type of Skin Alteration

- ☐ a. Pressure Injury
- ☐ b. Vascular Wound
- ☐ c. Diabetic Ulcer
- ☐ d. Skin Tear
- ☐ e. Abrasion
- ☐ f. Rash
- ☐ g. Surgical Wound
- ☐ h. Blister (Non-Pressure)
- ☐ i. IV/Implanted Port
- ☐ j. Bruises/Scars
- ☐ k. Other skin alterations

2a. Other (specify)

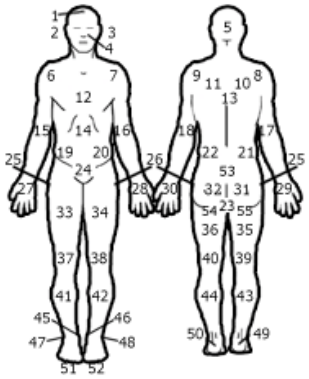
2b. Total number of Wounds not including bruises or scars:

One Wound	Two Wounds	Three Wounds	Four Wounds	Five Wounds	Six Wounds	Seven Wounds	Eight Wounds	Nine Wounds	Ten Wounds	More Than 10 Wounds

B. Bruises and Scars

Bruises and Scars

1. Site of Bruises and Scars



Suspected Deep Tissue Injury - Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Stage I - Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

Stage III - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Stage IV - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

N/A - Not Available

Units of measure : centimeters

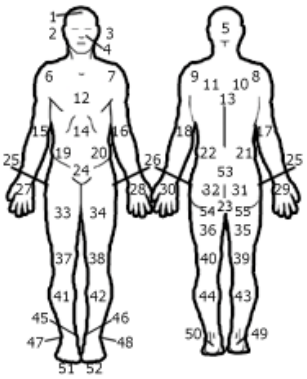
Site	Type	Length	Width	Depth	Stage

2. Additional Comments:

C. Wound One

Wound One Assessment

1. Wound 1 site



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N/A - Not Available

Units of measure : centimeters

Site	Type	Length	Width	Depth	Stage

1a. Undermining/Tunneling

- ☐ a. Undermining
- ☐ b. Tunneling

1b. Describe Undermining

1c. Describe tunneling

2. Exudate type

a) None
b) Serous
c) Serosanguineous
d) Purulent

2a. Exudate Amount

a) None
b) Scant
c) Small
d) Moderate
e) Large
f) Copious

3. Wound odor description

a) None
b) Slight
c) Moderate
d) Foul

4. Wound Bed

☐ a. Unable to Visualize ☐ b. Wound Closed or SDTI

4a. % Epithelial Tissue (new skin growing in superficial ulcer. it can be light pink and shiny, even in persons with darkly pigmented ski

4b. % Granulation Tissue (Pink or red tissue with shiny, moist, granular appearance)

4c. % Slough (Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous)

4d. % Black/Brown-eschar (Necrotic tissue-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin)

5. Surrounding Tissue

☐ a. Normal for Resident ☐ b. Pink ☐ c. Bright Red ☐ d. White/Gray Pallor ☐ e. Dark Red/Purple
☐ f. Black/Brown

6. Surrounding Tissue Wound Edges

☐ a. Normal for resident
☐ b. Peripheral Tissue Edema
☐ c. Maceration
☐ d. Hardness/Induration
☐ e. Rolled Edges

7. ☐ Treatment in Place

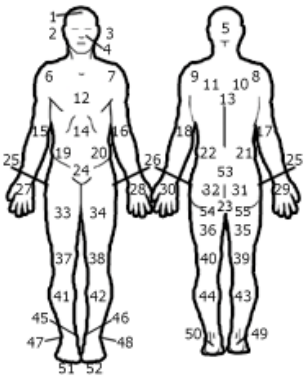
8. Additional Wound Assessment Comments

D. Wound Two

Wound Two Assessment

1. Wound 2 Site

Client:



Suspected Deep Tissue Injury - Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Stage I - Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

Stage III - Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

Stage IV - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

N/A - Not Available

Units of measure : centimeters

Site	Type	Length	Width	Depth	Stage

1a. Undermining/Tunneling

- ☐ a. Undermining
- ☐ b. Tunneling

1b. Describe Undermining

1c. Describe tunneling

2. Exudate type

a) None
b) Serous
c) Serosanguineous
d) Purulent

2a. Exudate Amount

a) None
b) Scant
c) Small
d) Moderate
e) Large
f) Copious

3. Wound odor description

a) None
b) Slight
c) Moderate
d) Foul

4. Wound Bed

- ☐ a. Unable to Visualize
- ☐ b. Wound Closed or SDTI

4a. % Epithelial Tissue (new skin growing in superficial ulcer. it can be light pink and shiny, even in persons with darkly pigmented ski

4b. % Granulation Tissue (Pink or red tissue with shiny, moist, granular appearance)

4c. % Slough (Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous)

4d. % Black/Brown-eschar (Necrotic tissue-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin)

5. Surrounding Tissue

- a. Normal for Resident
- b. Pink
- c. Bright Red
- d. White/Gray Pallor
- e. Dark Red/Purple
- f. Black/Brown

6. Surrounding Tissue Wound Edges

- a. Normal for resident
- b. Peripheral Tissue Edema
- c. Maceration
- d. Hardness/Induration
- e. Rolled Edges

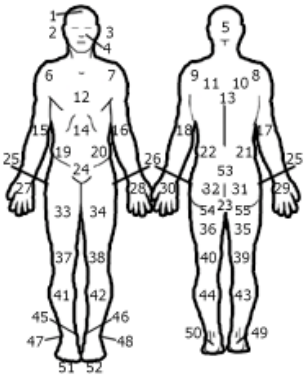
7. Treatment in Place

8. Additional Wound Assessment Comments

E. Wound Three

Wound Three Assessment

1. Wound 3 Site



Suspected Deep Tissue Injury - Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Stage I - Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

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Stage IV - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

N/A - Not Available

Units of measure : centimeters

Site	Type	Length	Width	Depth	Stage

1a. Undermining/Tunneling

- a. Undermining
- b. Tunneling

1b. Describe Undermining

1c. Describe tunneling

2. Exudate type

a) None
b) Serous
c) Serosanguineous
d) Purulent

2a. Exudate Amount

a) None
b) Scant
c) Small
d) Moderate
e) Large
f) Copious

3. Wound odor description

a) None
b) Slight
c) Moderate
d) Foul

4. Wound Bed

☐ a. Unable to Visualize ☐ b. Wound Closed or SDTI

4a. % Epithelial Tissue (new skin growing in superficial ulcer. it can be light pink and shiny, even in persons with darkly pigmented ski

4b. % Granulation Tissue (Pink or red tissue with shiny, moist, granular appearance)

4c. % Slough (Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous)

4d. % Black/Brown-eschar (Necrotic tissue-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin)

5. Surrounding Tissue

☐ a. Normal for Resident ☐ b. Pink ☐ c. Bright Red ☐ d. White/Gray Pallor ☐ e. Dark Red/Purple
☐ f. Black/Brown

6. Surrounding Tissue Wound Edges

☐ a. Normal for resident
☐ b. Peripheral Tissue Edema
☐ c. Maceration
☐ d. Hardness/Induration
☐ e. Rolled Edges

7. ☐ Treatment in Place

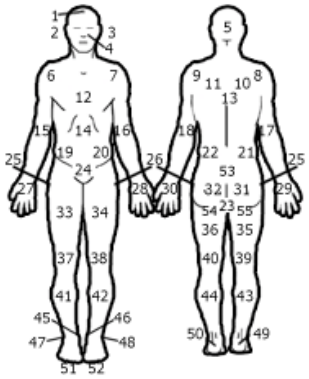
8. Additional Wound Assessment Comments

Client:

F. Wound Four

Wound Four Assessment

1. Wound 4 Site



Suspected Deep Tissue Injury - Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

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Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

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Stage IV - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

N/A - Not Available

Units of measure : centimeters

Site	Type	Length	Width	Depth	Stage

1a. Undermining/Tunneling

- ☐ a. Undermining
- ☐ b. Tunneling

1b. Describe Undermining

1c. Describe Tunneling

2. Exudate type

a) None
b) Serous
c) Serosanguineous
d) Purulent

2a. Exudate Amount

a) None
b) Scant
c) Small
d) Moderate
e) Large
f) Copious

3. Wound odor description

a) None
b) Slight
c) Moderate
d) Foul

4. Wound Bed

☐ a. Unable to Visualize ☐ b. Wound Closed or SDTI

4a. % Epithelial Tissue (new skin growing in superficial ulcer. it can be light pink and shiny, even in persons with darkly pigmented ski

4b. % Granulation Tissue (Pink or red tissue with shiny, moist, granular appearance)

4c. % Slough (Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous)

4d. % Black/Brown-eschar (Necrotic tissue-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin)

5. Surrounding Tissue

☐ a. Normal for Resident ☐ b. Pink ☐ c. Bright Red ☐ d. White/Gray Pallor ☐ e. Dark Red/Purple ☐ f. Black/Brown

6. Surrounding Tissue Wound Edges

☐ a. Normal for resident
☐ b. Peripheral Tissue Edema
☐ c. Maceration
☐ d. Hardness/Induration
☐ e. Rolled Edges

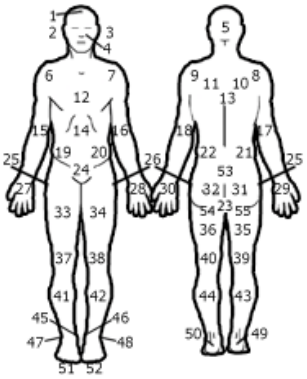
7. ☐ Treatment in Place

8. Additional Wound Assessment Comments

G. Wound Five

Wound Five Assessment

1. Wound 5 Site



Suspected Deep Tissue Injury - Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Stage I - Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

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Stage IV - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

N/A - Not Available

Units of measure : centimeters

Site	Type	Length	Width	Depth	Stage

Client:

1a. Undermining/Tunneling

- [ ] a. Undermining
- [ ] b. Tunneling

1b. Describe Undermining

1c. Describe Tunneling

2. Exudate type

a) None
b) Serous
c) Serosanguineous
d) Purulent

2a. Exudate Amount

a) None
b) Scant
c) Small
d) Moderate
e) Large
f) Copious

3. Wound odor description

a) None
b) Slight
c) Moderate
d) Foul

4. Wound Bed

- [ ] a. Unable to Visualize
- [ ] b. Wound Closed or SDTI

4a. % Epithelial Tissue (new skin growing in superficial ulcer. it can be light pink and shiny, even in persons with darkly pigmented ski

4b. % Granulation Tissue (Pink or red tissue with shiny, moist, granular appearance)

4c. % Slough (Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous)

4d. % Black/Brown-eschar (Necrotic tissue-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin)

5. Surrounding Tissue

- [ ] a. Normal for Resident
- [ ] b. Pink
- [ ] c. Bright Red
- [ ] d. White/Gray Pallor
- [ ] e. Dark Red/Purple
- [ ] f. Black/Brown

6. Surrounding Tissue Wound Edges

- [ ] a. Normal for resident
- [ ] b. Peripheral Tissue Edema
- [ ] c. Maceration
- [ ] d. Hardness/Induration
- [ ] e. Rolled Edges

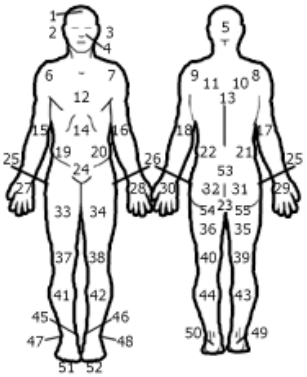
7. ☐ Treatment in Place

8. Additional Wound Assessment Comments

H. Wound Six

Wound Six Assessment

1. Wound 6 Site



Suspected Deep Tissue Injury - Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

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Stage IV - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

N/A - Not Available

Units of measure : centimeters

Site	Type	Length	Width	Depth	Stage

1a. Undermining/Tunneling

- ☐ a. Undermining
- ☐ b. Tunneling

1b. Describe Undermining

1c. Describe Tunneling

2. Exudate type

a) None
b) Serous
c) Serosanguineous
d) Purulent

2a. Exudate Amount

a) None
b) Scant
c) Small
d) Moderate
e) Large
f) Copious

3. Wound odor description

a) None

b) Slight
c) Moderate
d) Foul

4. Wound Bed

☐ a. Unable to Visualize ☐ b. Wound Closed or SDTI

4a. % Epithelial Tissue (new skin growing in superficial ulcer. it can be light pink and shiny, even in persons with darkly pigmented ski

4b. % Granulation Tissue (Pink or red tissue with shiny, moist, granular appearance)

4c. % Slough (Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous)

4d. % Black/Brown-eschar (Necrotic tissue-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin)

5. Surrounding Tissue

☐ a. Normal for Resident ☐ b. Pink ☐ c. Bright Red ☐ d. White/Gray Pallor ☐ e. Dark Red/Purple ☐ f. Black/Brown

6. Surrounding Tissue Wound Edges

☐ a. Normal for resident
☐ b. Peripheral Tissue Edema
☐ c. Maceration
☐ d. Hardness/Induration
☐ e. Rolled Edges

7. ☐ Treatment in Place

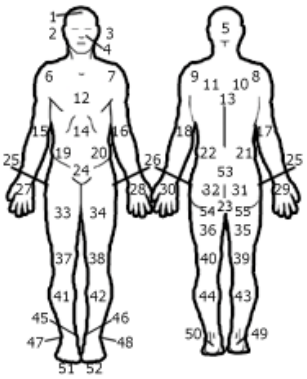
8. Additional Wound Assessment Comments

I. Wound Seven

Wound Seven Assessment

1. Wound 7 Site

Client:



Suspected Deep Tissue Injury - Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Stage I - Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

Stage II - Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

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Stage IV - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

N/A - Not Available

Units of measure : centimeters

Site	Type	Length	Width	Depth	Stage

1a. Undermining/Tunneling

- ☐ a. Undermining
- ☐ b. Tunneling

1b. Describe Undermining

1c. Describe Tunneling

2. Exudate type

a) None
b) Serous
c) Serosanguineous
d) Purulent

2a. Exudate Amount

a) None
b) Scant
c) Small
d) Moderate
e) Large
f) Copious

3. Wound odor description

a) None
b) Slight
c) Moderate
d) Foul

4. Wound Bed

- ☐ a. Unable to Visualize
- ☐ b. Wound Closed or SDTI

4a. % Epithelial Tissue (new skin growing in superficial ulcer. it can be light pink and shiny, even in persons with darkly pigmented ski

4b. % Granulation Tissue (Pink or red tissue with shiny, moist, granular appearance)

4c. % Slough (Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous)

4d. % Black/Brown-eschar (Necrotic tissue-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin)

5. Surrounding Tissue

- a. Normal for Resident
- b. Pink
- c. Bright Red
- d. White/Gray Pallor
- e. Dark Red/Purple
- f. Black/Brown

6. Surrounding Tissue Wound Edges

- a. Normal for resident
- b. Peripheral Tissue Edema
- c. Maceration
- d. Hardness/Induration
- e. Rolled Edges

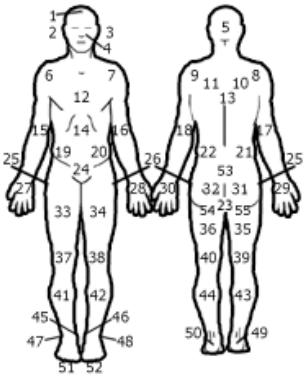
7. Treatment in Place

8. Additional Wound Assessment Comments

J. Wound Eight

Wound Eight Assessment

1. Wound 8 Site



Suspected Deep Tissue Injury - Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.

Stage I - Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.

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Stage IV - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

N/A - Not Available

Units of measure : centimeters

Site	Type	Length	Width	Depth	Stage

1a. Undermining/Tunneling

- a. Undermining
- b. Tunneling

1b. Describe Undermining

1c. Describe Tunneling

2. Exudate type

a) None
b) Serous
c) Serosanguineous
d) Purulent

2a. Exudate Amount

a) None
b) Scant
c) Small
d) Moderate
e) Large
f) Copious

3. Wound odor description

a) None
b) Slight
c) Moderate
d) Foul

4. Wound Bed

☐ a. Unable to Visualize ☐ b. Wound Closed or SDTI

4a. % Epithelial Tissue (new skin growing in superficial ulcer. it can be light pink and shiny, even in persons with darkly pigmented ski

4b. % Granulation Tissue (Pink or red tissue with shiny, moist, granular appearance)

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4d. % Black/Brown-eschar (Necrotic tissue-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin)

5. Surrounding Tissue

☐ a. Normal for Resident ☐ b. Pink ☐ c. Bright Red ☐ d. White/Gray Pallor ☐ e. Dark Red/Purple
☐ f. Black/Brown

6. Surrounding Tissue Wound Edges

☐ a. Normal for resident
☐ b. Peripheral Tissue Edema
☐ c. Maceration
☐ d. Hardness/Induration
☐ e. Rolled Edges

7. ☐ Treatment in Place

8. Additional Wound Assessment Comments

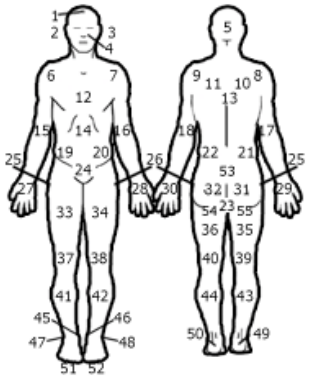
K. Wound Nine

Client:

K. Wound Nine

Wound Nine Assessment

1. Wound 9 Site



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Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

N/A - Not Available

Units of measure : centimeters

Site	Type	Length	Width	Depth	Stage

1a. Undermining/Tunneling

- ☐ a. Undermining
- ☐ b. Tunneling

1b. Describe Undermining

1c. Describe Tunneling

2. Exudate type

a) None
b) Serous
c) Serosanguineous
d) Purulent

2a. Exudate Amount

a) None
b) Scant
c) Small
d) Moderate
e) Large
f) Copious

3. Wound odor description

a) None
b) Slight
c) Moderate
d) Foul

4. Wound Bed

☐ a. Unable to Visualize ☐ b. Wound Closed or SDTI

4a. % Epithelial Tissue (new skin growing in superficial ulcer. it can be light pink and shiny, even in persons with darkly pigmented ski

4b. % Granulation Tissue (Pink or red tissue with shiny, moist, granular appearance)

4c. % Slough (Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous)

4d. % Black/Brown-eschar (Necrotic tissue- black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin)

5. Surrounding Tissue

☐ a. Normal for Resident ☐ b. Pink ☐ c. Bright Red ☐ d. White/Gray Pallor ☐ e. Dark Red/Purple ☐ f. Black/Brown

6. Surrounding Tissue Wound Edges

☐ a. Normal for resident
☐ b. Peripheral Tissue Edema
☐ c. Maceration
☐ d. Hardness/Induration
☐ e. Rolled Edges

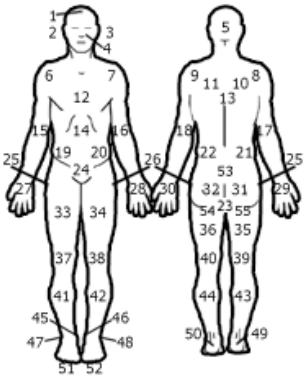
7. ☐ Treatment in Place

8. Additional Wound Assessment Comments

L. Wound Ten

Wound Ten Assessment

1. Wound 10 Site



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Stage IV - Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling.

Unstageable - Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.

N/A - Not Available

Units of measure : centimeters

Site	Type	Length	Width	Depth	Stage

Client:

1a. Undermining/Tunneling

- [ ] a. Undermining
- [ ] b. Tunneling

1b. Describe Undermining

1c. Describe Tunneling

2. Exudate type

a) None
b) Serous
c) Serosanguineous
d) Purulent

2a. Exudate Amount

a) None
b) Scant
c) Small
d) Moderate
e) Large
f) Copious

3. Wound odor description

a) None
b) Slight
c) Moderate
d) Foul

4. Wound Bed

- [ ] a. Unable to Visualize
- [ ] b. Wound Closed or SDTI

4a. % Epithelial Tissue (new skin growing in superficial ulcer. it can be light pink and shiny, even in persons with darkly pigmented ski

4b. % Granulation Tissue (Pink or red tissue with shiny, moist, granular appearance)

4c. % Slough (Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous)

4d. % Black/Brown-eschar (Necrotic tissue-black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin)

5. Surrounding Tissue

- [ ] a. Normal for Resident
- [ ] b. Pink
- [ ] c. Bright Red
- [ ] d. White/Gray Pallor
- [ ] e. Dark Red/Purple
- [ ] f. Black/Brown

6. Surrounding Tissue Wound Edges

- [ ] a. Normal for resident
- [ ] b. Peripheral Tissue Edema
- [ ] c. Maceration
- [ ] d. Hardness/Induration
- [ ] e. Rolled Edges

7. ☐ Treatment in Place

8. Additional Wound Assessment Comments

ADL. LN: Activities Of Daily Living

A. ADL's

1. How Much Assistance Does Resident Require With Bed Mobility?
   - 1. Independent And Requires No Assistance
   - 2. Set up help only (Staff provide items needed to complete task- like handing bar of trapeze, raises 1/4 rails, etc.)
   - 3. Supervision - No Setup Help (Staff provide one or many verbal prompts/cues to resident AND/OR observe durring task)
   - 4. Supervision And Setup Help (Staff provide one or many verbal prompts/cues to resident AND/OR observe some or all of task AND give, hand or adjust item needed to complete task like handing bar of trapeze, raises ½ rails, etc.)
   - 5. X1 Staff Limited Assist (Staff physically TOUCH the resident but do not bear wt., EX: guiding hand to rail)
   - 6. X1 Staff Extensive Assist (Staff physically LIFT, BEAR, HOLD or SUPPORT ANY amount of weight at any time while resident is turning, rolling, sitting, lying or positioning)
   - 7. X2 Staff Extensive Assist (Staff physically LIFT, BEAR, HOLD or SUPPORT ANY amount of weight at any time while resident is turning, rolling, sitting, lying or positioning)
   - 8. X1 Staff Total Dependence (Resident Does Not Participate In Activity At All)
   - 9. X2 Staff Total Dependence (Resident Does Not Participate In Activity At All)
2. How Much Assist Does The Resident Require To Transfer Safely?
   - 1. Independent And Requires No Assist
   - 2. Set up help only (Staff may give resident transfer board, walker, or other assistive device, lock the wheels on a wheelchair, etc.)
   - 3. Supervision No Set up help (Staff provide one or many verbal prompts/cues to resident AND/OR observe some or all of task)
   - 4. Supervision And Setup Help (Staff provide one or many verbal prompts/cues to resident AND/OR observe some or all of task AND give resident transfer board, walker, or other assistive device, locking the wheels on a wheelchair, etc.)
   - 5. X1 Staff Limited Assist (Staff physically TOUCH the resident but do not bear wt., EX: placing hand on residents back to provide comfort and/or guidance)
   - 6. X1 Staff Extensive Assist (Staff physically LIFT, BEAR, HOLD or SUPPORT ANY amount of weight at any time Ex: placing hand on residents back and lifting some trunk weight, hook arm under residents are to lift)
   - 7. X2 Staff Extensive Assist (Staff physically LIFT, BEAR, HOLD or SUPPORT ANY amount of weight at any time Ex: placing hand on residents back and lifting some trunk weight, hook arm under residents are to lift)
   - 8. Sit To Stand Mechanical Lift Required
   - 9. Totally Dependent; X1 Staff (Resident Does Not Participate In Activity At All)
   - 10. Totally Dependent; X2 Staff (Resident Does Not Participate In Activity At All)
   - 11. Total Mechanical Lift (Hoyer) Required - Resident Can Assist With Rolling On/Off Lift Sheet
   - 12. Total Mechanical Lift (Hoyer) Required - Resident Can **Not** Assist With Rolling On/Off Lift Sheet
3. How Much Assistance Does Resident Require To **Walk In Room?**
   - 1. Independent And Requires No Supervision
   - 2. Set up help only (Staff may provide walker/ cane, etc.)
   - 3. Supervision - No Setup Help Required (Staff provide one or many verbal prompts/cues to resident AND/OR observe some or all of task)
   - 4. Supervision AND Setup Help (Staff provide one or many verbal prompts/cues to resident AND/OR observe some or all of task AND provide walker/ cane, etc.)
   - 5. X1 Staff Limited Assist (Staff physically TOUCH the resident but do not bear wt., EX: placing hand on residents back to provide comfort and/or guidance, hold residents' hand)
   - 6. x1 Staff Extensive Assist (Staff physically LIFT, BEAR, HOLD or SUPPORT ANY of the resident's weight- Ex: resident

- may lean on staff, staff may lift or hold gait belt, staff may walk arm in arm to support trunk or extremity weakness.)
- 7. x2 Staff Extensive Assist (Staff physically LIFT, BEAR, HOLD or SUPPORT ANY of the resident's weight- Ex: resident may lean on staff, staff may lift or hold gait belt, staff may walk arm in arm to support trunk or extremity weakness.)
- 8. Activity Does Not Occur-Resident CANNOT Walk

4. How Much Assistance Does Resident Require To **Walk In The Corridor?**

- 1. Independent And Requires No Supervision
- 2. Set up help only (Staff may provide walker/ cane, etc.)
- 3. Supervision - No Setup Help Required (Staff provide one or many verbal prompts/cues to resident AND/OR observe some or all of task)
- 4. Supervision AND Setup Help (Staff provide one or many verbal prompts/cues to resident AND/OR observe some or all of task AND provide walker/ cane, etc.)
- 5. X1 Staff Limited Assist (Staff physically TOUCH the resident but do not bear wt., EX: placing hand on residents back to provide comfort and/or guidance, hold residents' hand)
- 6. x1 Staff Extensive Assist (Staff physically LIFT, BEAR, HOLD or SUPPORT ANY of the resident's weight- Ex: resident may lean on staff, staff may lift or hold gait belt, staff may walk arm in arm to support trunk or extremity weakness.)
- 7. x2 Staff Extensive Assist (Staff physically LIFT, BEAR, HOLD or SUPPORT ANY of the resident's weight- Ex: resident may lean on staff, staff may lift or hold gait belt, staff may walk arm in arm to support trunk or extremity weakness.)
- 8. Activity Does Not Occur-Resident CANNOT Walk

5. How Much Assist Does Resident Require With Dressing?

- 1. Independent And Requires No Assistance
- 2. Set up help only (Staff may retrieve, lay out or hand resident clothing)
- 3. Supervision - No Setup Help (Staff provide one or many verbal prompts/cues to resident AND/OR observe some or all of task)
- 4. Supervision And Setup Help (Staff provide one or many verbal prompts/cues to resident AND/OR observe some or all of task AND retrieving, laying out or hand resident clothing.)
- 5. X1 Staff Limited Assist (Staff physically TOUCH the resident but do not bear wt., EX: zipping or buttoning articles of clothing)
- 6. X1 Staff Extensive Assist (Staff physically LIFT, BEAR, HOLD or SUPPORT ANY of the resident's weight- Ex: lifting limbs to put on articles of clothing)
- 7. X2 Staff Extensive Assist (Staff physically LIFT, BEAR, HOLD or SUPPORT ANY of the resident's weight- Ex: lifting limbs to put on articles of clothing)
- 8. X1 Staff Total Dependence (Resident Does Not Participate In Activity At All)
- 9. X2 Staff Total Dependence (Resident Does Not Participate In Activity At All)

6. How Much Assist Does Resident Require With Eating?
(Includes tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration and ALL eating and drinking, not limited to meal time)

- 1. Independent
- 2. Set up help only (Staff provides set up assistance by cutting meat, opening containers at meals, giving one food item at a time)
- 3. Supervision - No Setup Help (Staff observe all of eating for safety (ex. Aspiration precautions) or provide one or many verbal prompts to resident while eating or drinking)
- 4. Supervision And Setup Help (Staff observe all of eating/drinking for safety (ex. Aspiration precautions) or provide one or many verbal prompts to resident while eating or drinking AND staff provides set up assistance by cutting meat and opening containers at meals, giving one food item at a time)
- 5. Limited Assist (Staff hand resident utensil, cup or push (guide) utensil or cup or finger food towards mouth (only needs to occur for one sip of liquid or one bite of food)
- 6. Extensive Assist Staff physically feed one or more bites of food to resident or hold cup and provide one or more sips of liquid at any time OR lift residents hand to mouth while resident is holding utensil or cup or finger food (only needs to occur for one sip of liquid or one bite of food) or if resident helps with tube feeding)
- 7. Total Dependence (Resident Does Not Assist With Feeding Themselves by any route (oral, IV, TPN, enteral))

- 8. Activity Does Not Occur - Resident is NPO or Tube Fed ONLY

7. How Much Assistance Does Resident Require With Toileting?
Including Transferring On/Off Toilet, Use of bed pan, urinal or pad; Cleansing/Wiping; Managing Clothing, Catheter, and Ostomy devices.

- 1. Independent And Requires No Assistance
- 2. Set up help only (Staff retrieve, lay out or hand resident clothing, incontinence products, or ostomy devices, etc.)
- 3. Supervision - No Setup Help (Staff provide one or many verbal prompts/cues to resident AND/OR observe some or all of task)
- 4. Supervision And Setup Help (Staff provide one or many verbal prompts/cues to resident AND/OR observe some or all of task AND retrieve, lay out or hand resident clothing, incontinence products, or ostomy devices, etc.)
- 5. X1 Staff Limited Assist (Staff physically TOUCH the resident but do not bear wt., EX: zipping or buttoning articles of clothing)
- 6. X1 Staff Extensive Assist (Staff physically LIFT, BEAR, HOLD or SUPPORT ANY of the resident's weight- Ex: cleaning perineal area, lifting brief/clothes, supporting weight while getting on/off toilet).taff Palms Up - Moving/Guiding Limbs, Staff Wt Bearing)
- 7. X2 Staff Extensive Assist (Staff physically LIFT, BEAR, HOLD or SUPPORT ANY of the resident's weight- Ex: cleaning perineal area, lifting brief/clothes, supporting weight while getting on/off toilet).
- 8. X1 Staff Total Dependence (Resident Does Not Participate In Activity At All EX: Staff manage ostomy or catheter)
- 9. X2 Staff Total Dependence (Resident Does Not Participate In Activity At All EX: Staff manage ostomy or catheter)

8. How Much Assistance Does Resident Require With Personal Hygiene?

- 1. Independent And Requires No Assistance
- 2. Set up help only (Staff provide wash cloth, toothbrush, comb, basin of water etc.)
- 3. Supervision - No Setup Help (Staff provide one or many verbal prompts/cues to resident AND/OR observe some or all of task)
- 4. Supervision And Setup Help (Staff provide one or many verbal prompts/cues to resident AND/OR observe some or all of task AND provide wash cloth, toothbrush, comb, basin of water etc.)
- 5. X1 Staff Limited Assist (Staff physically TOUCH the resident do not bear wt. Ex: Guiding residents' hand with wash cloth to face)
- 6. X1 Staff Extensive Assist (Staff physically LIFT, BEAR, HOLD or SUPPORT ANY of the resident's weight- Ex: Resident brushes own teeth or hair for some of task, staff provides this assistance for some of task, staff support residents arm while resident brushes hair)
- 7. X2 Staff Extensive Assist (Staff physically LIFT, BEAR, HOLD or SUPPORT ANY of the resident's weight- Ex: Resident brushes own teeth or hair for some of task, staff provides this assistance for some of task, staff support residents arm while resident brushes hair)
- 8. X1 Staff Total Dependence (Resident Does Not Participate In Activity At All)
- 9. X2 Staff Total Dependence (Resident Does Not Participate In Activity At All)

9. How Much Assistance Does Resident Require With Bathing?

- 1. Independent
- 2. Setup Help And/OR Supervision (Resident requires oversight or cueing help. Staff provides assistance by providing cleaning products, towels and adjusting water temperature for resident.)
- 3. X1 Staff Physical Help limited to transfer only
- 4. X2 Staff Physical Help limited to transfer only
- 5. X1 Staff Physical Help in part of bathing activity (Does not include washing back or hair)
- 6. X2 Staff Physical Help in part of bathing activity (Does not include washing back or hair)
- 7. X1 Staff Totally Dependent (Resident Does Not Participate In Activity At All)
- 8. X2 Staff Totally Dependent (Resident Does Not Participate In Activity At All)

10. How Much Assistance Does Resident Require With Locomotion off Unit?
Locomotion includes walking or wheeling from one area to another.

- 1. Independent

- 2. Set up help only (Staff may unlock brakes on the wheelchair, flip foots rests up/down, etc.)
- 3. Supervision Required (Staff provide one or many verbal prompts/cues to resident)
- 4. Supervision And/OR Setup (Staff provide one or many verbal prompts/cues to resident AND/OR provides set up assistance unlocking the brakes on the wheelchair or adjusting foot pedals to facilitate foot motion while wheeling or provides walker/ cane, etc.)
- 5. Limited Assist (Staff physically TOUCH the resident but does not bear wt., EX: placing hand on residents back to provide comfort and/or guidance while walking, placing hand over hand on walker, holding resident hand, etc.)
- 6. Extensive Assist (Staff physically LIFT, BEAR, HOLD or SUPPORT ANY of the residents weight- Ex: Staff push wheelchair for a portion of task, resident may lean on staff, staff may lift or hold gait belt, staff may walk arm in arm to support trunk or extremity weakness)
- 7. Total Dependent (Resident does not participate in activity at all)

11. How Much Assistance Does Resident Require With Locomotion on Unit?
Locomotion includes walking or wheeling from one area to another.

- 1. Independent
- 2. Set up help only (Staff may unlock brakes on the wheelchair, flip foots rests up/down, etc.)
- 3. Supervision Required (Staff provide one or many verbal prompts/cues to resident)
- 4. Supervision And/OR Setup (Staff provide one or many verbal prompts/cues to resident AND/OR provides set up assistance unlocking the brakes on the wheelchair or adjusting foot pedals to facilitate foot motion while wheeling or provides walker/ cane, etc.)
- 5. Limited Assist (Staff physically TOUCH the resident but do not bear wt., EX: placing hand on residents back to provide comfort and/or guidance while walking, placing hand over hand on walker, holding residents' hand)
- 6. Extensive Assist (Staff physically LIFT, BEAR, HOLD or SUPPORT ANY of the residents weight- Ex: Staff push wheelchair for a portion of task, resident may lean on staff, staff may lift or hold gait belt, staff may walk arm in arm to support trunk or extremity weakness)
- 7. Total Dependent (Resident does not participate in activity at all)

GG. LN:GG

A. Self Care

Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.

A. ADL Performance During Shift:

06) Independent
05) Setup or Clean-Up Assistance
04) Supervision or touching assist
03) Partial/Moderate Assistance
02) Substantial/Maximal Assistance
01) Dependent
07) Resident Refused
09) Not Applicable
10) Not attempted due to environmental limitations
88) Not attempted due to medical/safety concerns

A1. Is the resident Tube Fed or NPO?

a. Yes b. No

Oral hygiene: The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to insert and remove dentures into and from the mouth, and manage denture soaking and rinsing with use of equipment

B. ADL Performance During Shift:

06) Independent
05) Setup or Clean-Up Assistance
04) Supervision or touching assist

03) Partial/Moderate Assistance
02) Substantial/Maximal Assistance
01) Dependent
07) Resident Refused
09) Not Applicable
10) Not attempted due to environmental limitations
88) Not attempted due to medical/safety concerns

Toileting hygiene: The ability to maintain perineal Hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment

C. ADL Performance During Shift:

06) Independent
05) Setup or Clean-Up Assistance
04) Supervision or touching assist
03) Partial/Moderate Assistance
02) Substantial/Maximal Assistance
01) Dependent
07) Resident Refused
09) Not Applicable
10) Not attempted due to environmental limitations
88) Not attempted due to medical/safety concerns

C1. Care Givers Required:

a. One Person Physical Assist | b. Two Person Physical Assistance | c. Two Person Assistance (1 person hands on,1 person hands off)

C2. Care Givers Required:

a. One Person Physical Assist | b. Two Person Physical Assistance | c. Two Person Assistance (1 person hands on,1 person hands off)

Shower/bathe: The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower

D. ADL Performance During Shift:

06) Independent
05) Setup or clean-up assistance
04) Supervision or touching assistance
03) Partial/moderate assistance
02) Substantial/maximal assistance
01) Dependent
07) Resident refused
09) Not applicable
10) Not attempted due to environmental limitations
88) Not attempted due to medical condition or safety concerns

D1. Care Givers Required:

a. One Person Physical Assist | b. Two Person Physical Assistance | c. Two Person Assistance (1 person hands on,1 person hands off)

D2. Care Givers Required:

a.. One Person Physical Assist | b.. Two Person Physical Assistance | c.. Two Person Assistance (1 person hands on,1

a.. One Person Physical Assist | b.. Two Person Physical Assistance | person hands off)

Upper body dressing: The ability to dress and undress above the waist; including fasteners, if applicable.

E. ADL Performance During Shift:

06) Independent
05) Setup or clean-up assistance
04) Supervision or touching assistance
03) Partial/moderate assistance
02) Substantial/maximal assistance
01) Dependent
07) Resident refused
09) Not applicable
10) Not attempted due to environmental limitations
88) Not attempted due to medical condition or safety concerns

E1. Care Givers Required:

a. One Person Physical Assist | b. Two Person Physical Assistance | c. Two Person Assistance (1 person hands on,1 person hands off)

E2. Care Givers Required:

a. One Person Physical Assist | b. Two Person Physical Assistance | c. Two Person Assistance (1 person hands on,1 person hands off)

Lower body dressing: The ability to dress and undress below the waist, including fasteners; does not include footwear

F. ADL Performance During Shift:

06) Independent
05) Setup or clean-up assistance
04) Supervision or touching assistance
03) Partial/moderate assistance
02) Substantial/maximal assistance
01) Dependent
07) Resident refused
09) Not applicable
10) Not attempted due to environmental limitations
88) Not attempted due to medical condition or safety concerns

F1. Care Givers Required:

a. One Person Physical Assist | b. Two Person Physical Assistance | c. Two Person Assistance (1 person hands on,1 person hands off)

F2. Care Givers Required:

a. One Person Physical Assist | b. Two Person Physical Assistance | c. Two Person Assistance (1 person hands on,1 person hands off)

Putting on/taking off footwear: The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable

G. ADL Performance During Shift:

06) Independent
05) Setup or clean-up assistance

04) Supervision or touching assistance
03) Partial/moderate assistance
02) Substantial/maximal assistance
01) Dependent
07) Resident refused
09) Not applicable
10) Not attempted due to environmental limitations
88) Not attempted due to medical condition or safety concerns

G1. Care Givers Required:

a. One Person Physical Assist | b. Two Person Physical Assistance | c. Two Person Assistance (1 person hands on,1 person hands off)

G2. Care Givers Required:

a. One Person Physical Assist | b. Two Person Physical Assistance | c. Two Person Assistance (1 person hands on,1 person hands off)

Personal Hygiene: The abiltiy to combing hair, shave face, applying makeup, and wash/dry face and hands (excludes baths, showers, and oral hygiene).

H. ADL Performance During Shift:

06) Independent
05) Setup or clean-up assistance
04) Supervision or touching assistance
03) Partial/moderate assistance
02) Substantial/maximal assistance
01) Dependent
07) Resident refused
09) Not applicable
10) Not attempted due to environmental limitations
88) Not attempted due to medical condition or safety concerns

H1. Care Givers Required:

a. One Person Physical Assist | b. Two Person Physical Assistance | c. Two Person Assistance (1 person hands on,1 person hands off)

H2. Care Givers Required:

a. One Person Physical Assist | b. Two Person Physical Assistance | c. Two Person Assistance (1 person hands on,1 person hands off)

B. Mobility

Roll left and right: The ability to roll from lying on back to left and right side, and return to lying on back on the bed.

A. ADL Performance During Shift:

06) Independent
05) Setup or Clean-Up Assistance
04) Supervision or touching assist
03) Partial/Moderate Assistance
02) Substantial/Maximal Assistance
01) Dependent
07) Resident Refused

09) Not Applicable
10) Not attempted due to environmental limitations
88) Not attempted due to medical/safety concerns

A1. Care Givers Required:

- a. One Person Care Givers Required: Assist
- b. Two Person Physical Assistance
- c. Two Person Assistance (1 person hands on,1 person hands off)

A2. Care Givers Required:

- a. One Person Physical Assist
- b. Two Person Physical Assistance
- c. Two Person Assistance (1 person hands on,1 person hands off)

Sit to lying: The ability to move from sitting on side of bed to lying flat on the bed.

B. ADL Performance During Shift:

06) Independent
05) Setup or Clean-Up Assistance
04) Supervision or touching assist
03) Partial/Moderate Assistance
02) Substantial/Maximal Assistance
01) Dependent
07) Resident Refused
09) Not Applicable
10) Not attempted due to environmental limitations
88) Not attempted due to medical/safety concerns

B1. Care Givers Required:

- a. One Person Care Givers Required: Assist
- b. Two Person Physical Assistance
- c. Two Person Assistance (1 person hands on,1 person hands off)

B2. Care Givers Required:

- a. One Person Physical Assist
- b. Two Person Physical Assistance
- c. Two Person Assistance (1 person hands on,1 person hands off)

Lying to sitting on side of bed: The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor and with no back support.

C. ADL Performance During Shift:

06) Independent
05) Setup or Clean-Up Assistance
04) Supervision or touching assist
03) Partial/Moderate Assistance
02) Substantial/Maximal Assistance
01) Dependent
07) Resident Refused
09) Not Applicable
10) Not attempted due to environmental limitations
88) Not attempted due to medical/safety concerns

C1. Care Givers Required:

- a. One Person Care Givers Required: Assist
- b. Two Person Physical Assistance
- c. Two Person Assistance (1 person hands on,1 person hands off)

C2. Care Givers Required:

- a. One Person Physical Assist
- b. Two Person Physical Assistance
- c. Two Person Assistance (1 person hands on,1 person hands off)

Sit to stand: The ability to come to a standing position from sitting in a chair. wheelchair. or on the side of the bed.

D. ADL Performance During Shift:

- 06) Independent
- 05) Setup or Clean-Up Assistance
- 04) Supervision or touching assist
- 03) Partial/Moderate Assistance
- 02) Substantial/Maximal Assistance
- 01) Dependent
- 07) Resident Refused
- 09) Not Applicable
- 10) Not attempted due to environmental limitations
- 88) Not attempted due to medical/safety concerns

D1. Care Givers Required:

- a. One Person Physical Assist
- b. Two Person Physical Assistance
- c. Two Person Assistance (1 person hands on,1 person hands off)
- d. Sit To Stand Mechanical Lift Required

D2. Care Givers Required:

- a. One Person Physical Assist
- b. Two Person Physical Assistance
- c. Two Person Assistance (1 person hands on,1 person hands off)
- d. Sit To Stand Mechanical Lift Required

Chair/bed-to -Chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair)

E. ADL Performance During Shift:

- 06) Independent
- 05) Setup or Clean-Up Assistance
- 04) Supervision or touching assist
- 03) Partial/Moderate Assistance
- 02) Substantial/Maximal Assistance
- 01) Dependent
- 07) Resident Refused
- 09) Not Applicable
- 10) Not attempted due to environmental limitations
- 88) Not attempted due to medical/safety concerns

E1. Care Givers Required:

- a. One Person Physical Assist
- b. Two Person Physical Assistance
- c. Two Person Assistance (1 person hands on,1 person hands off)
- d. Two Person Mechanical Lift
- e. Sit To Stand Mechanical Lift Required

E2. Care Givers Required:

- a. One Person Physical Assist
- b. Two Person Physical Assistance
- c. Two Person Assistance (1 person hands on,1 person hands off)
- d. Two Person Mechanical Lift
- e. Sit To Stand Mechanical Lift Required

Toilet transfer: The ability to get on and off a toilet or commode.

F. ADL Performance During Shift:

06) Independent
05) Setup or Clean-Up Assistance
04) Supervision or touching assist
03) Partial/Moderate Assistance
02) Substantial/Maximal Assistance
01) Dependent
07) Resident Refused
09) Not Applicable
10) Not attempted due to environmental limitations
88) Not attempted due to medical/safety concerns

F1. Care Givers Required:

a. One Person Physical Assist | b. Two Person Physical Assistance | c. Two Person Assistance (1 person hands on,1 person hands off) | d. Two Person Mechanical Lift | e. Sit To Stand Mechanical Lift Required

F2. Care Givers Required:

a. One Person Physical Assist | b. Two Person Physical Assistance | c. Two Person Assistance (1 person hands on,1 person hands off) | d. Two Person Mechanical Lift | e. Sit To Stand Mechanical Lift Required

Shower/Tub Transfer: The ability to get into and out of the tub or shower. Do not include washing, rinsing, drying, or any other bathing

G. ADL Performance During Shift:

06) Independent
05) Setup or Clean-Up Assistance
04) Supervision or touching assist
03) Partial/Moderate Assistance
02) Substantial/Maximal Assistance
01) Dependent
07) Resident Refused
09) Not Applicable
10) Not attempted due to environmental limitations
88) Not attempted due to medical/safety concerns

G1. Care Givers Required:

a. One Person Physical Assist | b. Two Person Physical Assistance | c. Two Person Assistance (1 person hands on,1 person hands off) | d. Two Person Mechanical Lift | e. Sit To Stand Mechanical Lift Required

G2. Care Givers Required:

a. One Person Physical Assist | b. Two Person Physical Assistance | c. Two Person Assistance (1 person hands on,1 person hands off) | d. Two Person Mechanical Lift | e. Sit To Stand Mechanical Lift Required

Walking 10 Ft: Once standing, ability to walk 10 feet in corridor or similar space. Resident may take a brief standing rest break- if they sit activity is not completed. A helper cannot complete a walking activity for a resident

H. ADL Performance During Shift:

06) Independent

05) Setup or clean-up assistance
04) Supervision or touching assistance
03) Partial/moderate assistance
02) Substantial/maximal assistance
07) Resident refused
09) Not applicable
10) Not attempted due to environmental limitations
88) Not attempted due to medical condition or safety concerns

H1. Care Givers Required:

- a. One Person Physical Assist
- b. Two Person Physical Assistance
- c. Two Person Assistance (1 person hands on,1 person hands off)

Walking 50 Ft with 2 turns: Once standing, ability to walk 50 feet in corridor or similar space and do a 1/2 turn in one direction or 2 quarter turns. Turn to sit in chair, turn into a doorway, turn to face a helper Resident may take a brief standing rest break- if they sit activity is not completed. A helper cannot complete a walking activity for a resident

I. ADL Performance During Shift:

06) Independent
05) Setup or clean-up assistance
04) Supervision or touching assistance
03) Partial/moderate assistance
02) Substantial/maximal assistance
07) Resident refused
09) Not applicable
10) Not attempted due to environmental limitations
88) Not attempted due to medical condition or safety concerns

Walk 150 feet: Once standing, ability to walk 150 feet in corridor or similar space. Resident may take a brief standing rest break- if they sit- activity is not completed. A helper cannot complete a walking activity for a resident

J. ADL Performance During Shift:

06) Independent
05) Setup or clean-up assistance
04) Supervision or touching assistance
03) Partial/moderate assistance
02) Substantial/maximal assistance
07) Resident refused
09) Not applicable
10) Not attempted due to environmental limitations
88) Not attempted due to medical condition or safety concerns

Wheel 50 feet with two turns: The ability to wheel 50 feet in corridor or similar space and do a 1/2 turn in one direction or 2 quarter turns. Turn to sit at table, turn into a doorway, turn to face a helper. A helper CAN assist with completion of this activity

K. ADL Performance During Shift:

06) Independent
05) Setup or clean-up assistance
04) Supervision or touching assistance
03) Partial/moderate assistance
02) Substantial/maximal assistance
01) Dependent

07) Resident refused
09) Not applicable
10) Not attempted due to environmental limitations
88) Not attempted due to medical condition or safety concerns

K1. Care Givers Required:

- a. One Person Physical Assist
- b. Two Person Physical Assistance
- c. Two Person Assistance (1 person hands on,1 person hands off)

K2. Care Givers Required:

- a. One Person Physical Assist
- b. Two Person Physical Assistance
- c. Two Person Assistance (1 person hands on,1 person hands off)

Wheel 150 feet: Ability to wheel 150 feet in corridor or similar space. A helper CAN assist with completion of this activity

L. ADL Performance During Shift:

06) Independent
05) Setup or clean-up assistance
04) Supervision or touching assistance
03) Partial/moderate assistance
02) Substantial/maximal assistance
01) Dependent
07) Resident refused
09) Not applicable
10) Not attempted due to environmental limitations
88) Not attempted due to medical condition or safety concerns

Pain. LN: Pain

A. Pain Presence

1. Presence of Pain

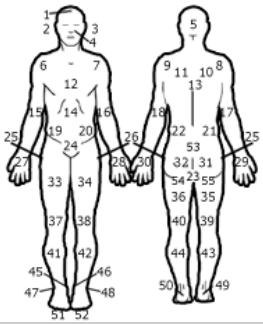
- a. Resident Is Unable To Discuss Pain
- b. Resident with no complaints of current or historical pain, no s/s of pain noted
- c. Resident has c/o of pain

1-1. Indicators of Pain or Possible Pain

- a. Non-verbal sounds (e.g., crying, whining, gasping, moaning, or groaning)
- b. Vocal complaints of pain (e.g., that hurts, ouch, stop)
- c. Facial expressions (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
- d. Protective body movements or postures (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
- e. None of these signs observed or documented

2. Pain Location and Description Instructions: Description should include the characteristics of the pain, including the intensity, pain rating, type (e.g., burning, stabbing, tingling, aching), patterns of pain (e.g., constant or intermittent), location, radiation of pain, and frequency, timing, and duration of pain

Client:



Site	Description

3. Most Recent Pain Level

Pain Level: _____ Date: _____

Pain Scale: _____

B. Pain Impact/What Helps Pain

1. Does Pain Impact any of the following? Check all that apply

- ☐ a. Ability to Sleep
- ☐ b. Appetite
- ☐ c. Desire to Participate in Activities
- ☐ d. Mobility
- ☐ e. None of the above

2. What Helps Pain?

- ☐ a. Quiet
- ☐ b. Dark Room
- ☐ c. Low Stimulation
- ☐ d. Independent Distractions (Reading A Book, Watcjing TV, Etc.)
- ☐ e. Group Distractions (Group Activities)
- ☐ f. Positiioning (Either Specific Positiond Or Repositioning)
- ☐ g. Massage
- ☐ h. Heat/Cold Application
- ☐ i. Scheduled Medications
- ☐ j. As Needed Medications
- ☐ k. Nothing Helps
- ☐ l. Other

2-1. Specify other:

C. Pain Scale For Resident and Pain Goals

1. Appropriate Pain Scale For Resident:

- a. 0-10 Verbal Pain Scale
- b. PAINAD (Pain Assessment in Advanced Dementia Scale)
- c. Faces Pain Scale

2. Pain Goals:

- a. No Pain
- b. Tolerable Level Of Pain While At Rest
- c. Tolerable Level Of Pain With Movement
- d. Resident Prefers To Be Awake/Alert And Recognizes That They Will Experience Pain With Movement/Activity
- e. Other

2-1. Specify other:

Fall. LN: Fall Risk

A. Fall Risk Evaluation

When Completing Evaluation Ask Resident/Family/Caregiver About Recent History To Gather Needed Data

1. History Of Falls Within Last 6 Months

- 0. No History
- 2. 1-2 Falls
- 4. Multiple Falls

2. Medication Use

Medication taken more than 3 x /week, including prn's

- a. Antihistamines
- b. Diuretics
- c. Hypoglycemic Agents
- d. Antiseizure/Antiepileptics
- e. Antihypertensives
- f. NSAID
- g. Benzodiazepine
- h. Narcotic
- i. Psychotropic
- j. Anti-Parkinson
- k. Cathartic
- l. Sedatives/Hypnotic
- m. If medication and/or dosage has changed in last 5 days

In The Last 7 Days: Recalls Three Out Of Four Of The Following: Current Season, That He/She Is In A Nursing Home, Location Of Room, Staff names/Faces

3. Memory and Recall Ability

- 0. Always
- 2. Sometimes
- 4. Never

4. Vision Pattern

- 0. Adequate-able to see in adequate light with glasses on
- 2. Inadequate- impaired vision in adequate light with glasses on
- 4. Severely Impaired- no vision or sees only light, color or shape

Continence in Last 14 Days

5. Continence

- 0. Continent: complete control
- 2. Occasional Incontinence: bladder 2 x/week, but not daily; bowel once a week
- 3. Frequently Incontinent: bladder incontinent daily, but some control present; bowel 2-3 x/week
- 4. Total Incontinence: daily episode of bladder incontinence; bowel always incontinent

Agitated Behavior in Last Seven Days

6. Wandering; verbally abusive; physically abusive; socially inappropriate, e.g. is noisy, screams, disrobes, self-abusive, rummages, hoards, etc

- 0. Behavior not exhibited in last 7 days
- 2. Behavior occurred less than daily
- 4. Behavior occurred daily or more

If resident cannot walk even when assisted by staff are they:

7. Confined To A Chair

- 2. Confined to a chair and oriented
- 3. Confined to a chair and disoriented
- 0. Not Applicable

Orthostatic Hypotension

8. Does the resident have a history of orthostatic hypotension?

- 4. Yes
- 0. No

Gait Analysis

9.

- a. Unable to independently come to a standing
- b. Exhibits loss of balance while standing
- c. Strays off the straight path of walking
- d. Requires hands-on assistance to move from place to place
- e. Uses short discontinuous steps and/or shuffling
- f. Changes gait pattern when walking through doorways
- g. Has lurching, swaying, or slapping gait
- h. Exhibits jerking or instability when making turns
- i. Uses an assistive device, e.g. cane, walker, etc.
- j. Wears poorly fitting shoes
- k. Decrease in muscle coordination

B. Interventions

1. Interventions initiated to decrease risk for falls:

- a. Floor Mats (next to bed)
- b. Positioning Device(s)
- c. Occupational Therapy Evaluation and tx as indicated
- d. Physical Therapy Evaluation and tx as indicated
- e. Non-Skid Socks
- f. Bed in lowest position
- g. Other

1-1. Please describe other interventions:
(These Interventions will not trigger to the care plan and must be manually added)

Elope. LN: Elopement Evaluation

A. Elopement Risk Evaluation

Upon admission and quarterly (at a minimum) thereafter, assess the resident status in seven clinical areas listed below (B-H) by assigning the corresponding score which best describes the resident in the appropriate assessment column. If the resident meets the criteria in section A (1 or 2) the score will be 0 and you do not need to complete sections (B-H). Add the column of numbers to obtain the total score.

A-1. Resident is comatose or in a vegetative state. If yes, no further assessment required.

A-2. ☐ Is resident totally dependent for mobility? If yes, no further assessment required .

B. Resident Mobility Status/Condition

- ○ 2. Propels self/some assist
- ○ 4. Fully ambulatory

C. History of Elopement Attempts Status

- ○ 0. No Attempt
- ○ 10. Prior elopement history or has made one + attempts or currently exit seeking

D. Out on Pass Compliance Status

- ○ 0. Understands Out-on-Pass protocol/ Not Applicable due to New Admission Status
- ○ 4. Homeless prior to admission or Unable to comprehend Out-on-Pass protocol
- ○ 10. Prior history of Out-on-Pass violation or previous AMA

E. Cognitive status

- ○ 0. Alert, Oriented x3
- ○ 2. Disoriented/no wandering
- ○ 4. Wanders aimlessly

F. Adjustment to Placement Status

- ○ 0. No concerns voiced with placement
- ○ 2. Exhibits distress due to recent changes in schedule or placement
- ○ 4. Insists on maintaining a pre-admission lifestyle/routine (e.g., daily outdoor walks) and does not exhibit safe decision making or willingness/ability to adhere to facility protocols
- ○ 10. Voices desire to leave or discontent with placement

G. Behavior Symptoms

- ○ 0. No current behavioral symptoms
- ○ 2. Looking for spouse / loved ones; behavior redirectable
- ○ 4. Agitation / Restlessness;/ Substance Abuse History with Substance seeking behavior

H. Major Psychiatric or Cognitive Impairment Diagnosis (i.e. Alzheimer's disease, Dementia, Paranoia, Bipolar, Schizophrenia, etc)

- ○ 0. No diagnosis
- ○ 2. Diagnosis on record, but no history exit seeking or elopement attempt
- ○ 4. Exhibits Hallucinations / Delusional thinking / Confusion / Paranoia/Unpredictable

B. Scoring/Interventions

Low Elopement Risk below 10
Elopement Risk- Score of 10 or greater
If the total score is 10 or greater, the resident should be considered to be at High risk for elopement. Prevention protocols should be followed and documented on the care plan.
Press save and view the score by clicking on the blue hyperlink to determine risk

1. Elopement Intervention(s)

- ☐ a. Wanderguard
- ☐ b. Identify triggers for wandering.
- ☐ c. Document behaviors. Attempt to identify pattern to target interventions
- ☐ d. Distract resident from wandering by offering pleasant diversions
- ☐ e. AMA Procedure has been explained to the resident/resident representative
- ☐ f. Resident is NOT a candidate for a Wanderguard
- ☐ g. Resident is NOT at risk for elopement

2. Comments

Client:

Med. LN: Medication Reconciliation/Drug Regime Review

1. Medication/Treatment/Oxygen Review

A. Do all records match?

If No, Complete section 2

a. Yes b. No

B. Source of Information (Check all that apply)

- a. Patient
- b. Family
- c. Community Physician
- d. Previous LTC Stay
- e. Hospital Discharge Records
- f. Other

B-1. Specify other:

C. Comments:

2. Order Discrepancies/ Outcome of Order Review

Only Transcribe Order Discrepancies
(Outcome from Medication/Treatment Review indicates the physician determination of discrepancies identified)

1 - 9 Order Reconciliation

1. Medication (Name, Dose, Freq, Route)/Treatment/Oxygen

1-1. Outcome from Medication/Treatment Review:

a) Continue Order
b) Discontinue Order
c) Modify Order

2. Medication (Name, Dose, Freq, Route)/Treatment/Oxygen

2-1. Outcome from Medication/Treatment Review:

a) Continue Order
b) Discontinue Order
c) Modify Order

3. Medication (Name, Dose, Freq, Route)/Treatment/Oxygen

3-1. Outcome from Medication/Treatment Review:

a) Continue Order
b) Discontinue Order
c) Modify Order

4. Medication (Name, Dose, Freq, Route)/Treatment/Oxygen

4-1. Outcome from Medication/Treatment Review:

a) Continue Order

b) Discontinue Order
c) Modify Order

5. Medication (Name, Dose, Freq, Route)/Treatment/Oxygen

5-1. Outcome from Medication/Treatment Review:
a) Continue Order
b) Discontinue Order
c) Modify Order

6. Medication (Name, Dose, Freq, Route)/Treatment/Oxygen

6-1. Outcome from Medication/Treatment Review:
a) Continue Order
b) Discontinue Order
c) Modify Order

7. Medication (Name, Dose, Freq, Route)/Treatment/Oxygen

7-1. Outcome from Medication/Treatment Review:
a) Continue Order
b) Discontinue Order
c) Modify Order

8. Medication (Name, Dose, Freq, Route)/Treatment/Oxygen

8-1. Outcome from Medication/Treatment Review:
a) Continue Order
b) Discontinue Order
c) Modify Order

9. Medication (Name, Dose, Freq, Route)/Treatment/Oxygen

9-1. Outcome from Medication/Treatment Review:
a) Continue Order
b) Discontinue Order
c) Modify Order

3. Outcome of Medication/ Treatment Review

A. Did a complete drug regimen review identify potential clinically significant medication issues?
- 0. No - No issues found during review
- 1. Yes - Issues found during review
- 9. NA - Resident is not taking any medications
- -. Not assessed/no information

B. Did the facility contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the admission?
- 0. No
- 1. Yes
- 9. NA - There were no potentially clinically significant medication issues identified since admission or patient is not taking any medications

-. Not assessed/no information

Smoke LN: Smoking

.

1. Smoking Evaluation

A. Is the resident a current/active smoker?

- 1. Yes
- 2. No

Cognition

B. Does the resident have cognitive loss?

1. Yes 2. No

Vision

C. Does the resident have a visual deficit?

1. Yes 2. No

Dexterity

D1. Is resident able to safely remove smoking materials?

1. Yes 2. No

D2. Is resident able to safely utilize lighter?

1. Yes 2. No

D3. Is resident able to safely handle lit cigarette?

1. Yes 2. No

D4. Does resident have a dexterity loss?

1. Yes 2. No

D4a. If yes, was rehab referral requested?

1. Yes 2. No

Safety

E. Can the resident light their own cigarette safely?

1. Yes 2. No

F. Resident need for adaptive equipment:

- 1. Smoking apron
- 2. Cigarette holder
- 3. Cigarette extender
- 4. One-on-One assistance
- 5. Other
- 6. None of the above

F1. Other:

G. Does resident need transport/escort to designated smoke area?

1. Yes 2. No

Signature **Date**

6 LN: Admission/Readmission Evaluation Part 2 - V 2

Client:	**Effective Date:**	**Location:**
Initial Admission:	**Admission:**	**Date of Birth:**
Physician:	**Braden Score Score:**	**Braden Score Category:**

Skin. LN: Braden

1. Sensory Perception

Ability to respond meaningfully to pressure-related discomfort

A.

- 1. **Completely Limited:** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level
- 2. **Very Limited:** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.
- 3. **Slightly Limited:** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.
- 4. **No Impairment:** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.

2. Moisture

Degree to which skin is exposed to moisture

B.

- 1. **Constantly Moist:** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.
- 2. **Very Moist:** Skin is often, but not always moist. Linen must be changed at least once a shift.
- 3. **Occasionally Moist:** Skin is occasionally moist, requiring an extra linen change approximately once a day.
- 4. **Rarely Moist:** Skin is usually dry, linen only requires changing at routine intervals.

3. Activity

Degree of physical activity

C. Activity

- 1. **Bedfast:** Confined to bed.
- 2. **Chairfast:** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.
- 3. **Walks Occasionally:** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair
- 4. **Walks Frequently:** Walks outside room at least twice a day and inside room at least once every two hours during waking hours

4. Mobility

Ability to change and control body position

D.

- 1. **Completely Immobile:** Does not make even slight changes in body or extremity position without assistance
- 2. **Very Limited:** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently
- 3. **Slightly Limited:** Makes frequent though slight changes in body or extremity position independently.
- 4. **No Limitation:** Makes major and frequent changes in position

5. Nutrition

Usual food intake pattern

E.

- 1. **Very Poor:** Never eats a complete meal. Rarely eats more than a of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** is NPO and/or maintained on clear liquids or IV?s for more than 5 days.

- 2. **Probably Inadequate:** Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. **OR** receives less than optimum amount of liquid diet or tube feeding
- 3. **Adequate:** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** is on a tube feeding or TPN regimen which probably meets most of nutritional needs
- 4. **Excellent:** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.

6. Friction & Shear

F.

- 1. **Problem:** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction
- 2. **Potential Problem:** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.
- 3. **No Apparent Problem:** Moves in bed and in chair independently and has sufficient muscle strength to lift up

Immun LN: Immunizations

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A. Immunizations

Influenza Vaccine

1. Is the information for this vaccine obtained from the documentation or resident/family verbal report?
   - a. Documentation provided
   - b. Resident/family reported

1a. Did the resident receive the influenza vaccine during this flu vaccination season?
   - a. Yes
   - b. Offered and consent received
   - c. Offered and declined

1a-1. Reason for declination:

1b. Influenza: (Must be manually entered into immunization tab)

Pneumonia Vaccines

2. Is the information for this vaccine obtained from the documentation or resident/family verbal report?
   - a. Documentation provided
   - b. Resident/family reported

2a. Has the resident received any Pneumovax 23 Vaccinations?
If yes, enter the dates of the vaccinations received for dose one and dose two of Pneumovax 23. If the resident has not received a Pneumovax 23 vaccination Review policy for eligibility requirements. If a resident is eligible and declines state reason for declination. If a resident is not eligible state reason for ineligibility.
   - a. Yes
   - b. Offered and consent received
   - c. Offered and declined
   - d. Not Eligible

2a-1. Reason for declination/ineligibility:

2a2. Pneumovax 23 Dose 1: (Must be manually entered into immunization tab)

2a3. Pneumovax 23 Dose 2: (Must be manually entered into immunization tab)

2b. Has the resident received the Prevnar 15 Vaccine?
If yes, enter the date of Prevnar 15 vaccination. If the resident has not received a Prevnar 15 vaccination Review policy for eligibility requirements. If a resident is eligible and declines vaccination state reason for declination. If a resident is not eligible state reason for ineligibility.

- a. Yes
- b. Offered on Admission
- c. Offered and declined
- d. Not Eligible

2b1. Reason for declination/ineligibility:

2b2. Prevnar 15: (Must be manually entered into immunization tab)

2c. Has the resident received the Prevnar 20 Vaccine?
If yes, enter the date of Prevnar 20 vaccination. If the resident has not received a Prevnar 20 vaccination Review policy for eligibility requirements. If a resident is eligible and declines vaccination state reason for declination. If a resident is not eligible state reason for ineligibility.

- a. Yes
- b. Offered on Admission
- c. Offered and declined
- d. Not Eligible

2c1. Reason for declination/ineligibility:

2c2. Prevnar 20: (Must be manually entered into immunization tab)

2d. Has the resident received the Prevnar 13 Vaccine?

- a. Yes
- b. No

2d1. Date of Prevnar 13 Vaccine: (Must be manually entered into immunization tab)

SARS-COV-2 (COVID-19) Vaccine(s)

3. Is the information for this vaccine obtained from the documentation or resident/family verbal report?

- a. Documentation provided
- b. Resident/family reported

3a. Has the resident received any SARS-COV-2 (COVID-19) Vaccinations? If yes, enter the dates of the vaccinations received for dose one, dose two and booster(s)(if applicable) of SARS-COV-2 (COVID-19) vaccine. If the resident has not received a SARS-COV-2 (COVID-19) vaccination Review policy for eligibility requirements. If a resident is eligible and declines state reason for declination. If a resident is not eligible state reason for ineligibility.

- a. Yes

- b. Offered and consent received
- c. Offered and declined
- d. Not Eligible

3a-1. Reason for declination/ineligibility:

3a2. SARS-COV-2 (COVID-19) Dose 1: (Must be manually entered into immunization tab)

3a3. SARS-COV-2 (COVID-19) Dose 2: (Must be manually entered into immunization tab)

3a4. SARS-COV-2 (COVID-19) Booster:

3a5. SARS-COV-2 (COVID-19) Booster:

3a6. SARS-COV-2 (COVID-19) Booster:

Other Vaccines

4. Has the resident received any other vaccinations?

- a. Yes
- b. No

4a. Is the information for this/these vaccine(s) obtained from the documentation or resident/family verbal report?

- a. Documentation provided
- b. Resident/family reported

4b. Name of Vaccines and Date of administration: (Must be manually entered into immunization tab)

TB. RN:Tuberculin Screening

A. TB Risk

Residents should be considered to be at increased risk for TB if they answer "yes" to any of the following statements:

Residence

1. Temporary or permanent residents (for greater than or equal to 1 month) in a country with a high TB rate (i.e. any country other than Australia, Canada, New Zealand, United States, and those in western or northern Europe)?

- a. Yes
- b. No

Immunosuppression

2. Immunosuppression, current or planned.
HIV infection, injection drug use, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

- a. Yes
- b. No

Close Contact

3. Close contact to someone with infectious TB disease at any time
   - a. Yes
   - b. No

TB History

4. History of TB, LTBI and treatment
   - a. Yes
   - b. No

B. Symptoms

Do you have:

1. Unexplained productive cough (e.g. bad cough greater than 3 weeks in duration)?
   - a. Yes
   - b. No
2. Coughing up blood or sputum?
   - a. Yes
   - b. No
3. Unexplained chills or fever (e.g. persistent temp elevations greater than one month)?
   - a. Yes
   - b. No

Night sweats (e.g. persistent sweating that leaves sheets and bedclothes wet)?

4. Night Sweats
   - a. Yes
   - b. No
6. Shortness of breath/chest pain (e.g. loss of appetite with unexplained weight loss)?
   - a. Yes
   - b. No

C. BCG Vaccination

1. Have you ever received a Bacille Calmette-Guerin (BCG Vaccination)?
   - a. Yes
   - b. No

Restr. RN:Restraint/Siderail Assessment

A. Potential Restraint Types

1. Potential Restraint(s):
   - [ ] 1. No Restraints
   - [ ] 2. Side Rail or Enabler Bar
   - [ ] 3. Wheelchair Seatbelt
   - [ ] 4. Specialty Wheelchair/Recliner
   - [ ] 5. Lap buddy/Wheel chair Tray
   - [ ] 6. Pummel Cushion
   - [ ] 7. Trunk Restraint
   - [ ] 8. Limb Restraint
   - [ ] 9. Concave, Scoop or Perimeter Mattress
   - [ ] 10. Positional Change Alarms (Bed/Chair/Clip etc.)
   - [ ] 11. Chair Preventing Rising
   - [ ] 12. Low Bed

- [ ] 13. Other

1a. Describe Other Potential Restraint:

B. Side Rail Assessment and Determination

Side Rail Assessment and Determination

1. Why is the side rail being considered?
   - [ ] a. Security
   - [ ] b. Safety
   - [ ] c. Resident Request
   - [ ] d. Family Request
   - [ ] e. Other

1a. Explain other reasons for side rail consideration:

2. Identify condition/symptoms that contribute to the resident's need to use side rail(s)
   - [ ] a. Weakness
   - [ ] b. Poor trunk control
   - [ ] c. Postural Hypotension
   - [ ] d. Resident leans
   - [ ] e. Leans to right
   - [ ] f. Leans to Left
   - [ ] g. Leans forward
   - [ ] h. Unable to sit upright
   - [ ] i. History of falling out of bed
   - [ ] j. Fear of rolling out of bed
   - [ ] k. History of sliding out of bed
   - [ ] l. Other

2a. If "Other" explain:

Please observe the resident, will the side rail(s) assist them in:

Bed Mobility

3. Turning from side to side?
   - ( ) a. Yes
   - ( ) b. No
4. Holding self to one side of bed?
   - ( ) a. Yes
   - ( ) b. No
5. Moving up and down in bed?
   - ( ) a. Yes
   - ( ) b. No
6. Pulling up from laying to sitting position?
   - ( ) a. Yes
   - ( ) b. No

Transfer

7. Supporting balance?
   - ( ) a. Yes

- b. No

8. Entering bed more safely?
   - a. Yes
   - b. No
9. Exiting bed more safely?
   - a. Yes
   - b. No

Other

10. Provides security for resident?
    - a. Yes
    - b. No
11. Avoiding rolling out of bed?
    - a. Yes
    - b. No
12. Will the side rail obstruct view?
    - a. Yes
    - b. No
13. Will the side rail impede freedom of movement?
    - a. Yes
    - b. No

Level of Consciousness

14. Does the resident's level of consciousness fluctuate?
    - a. Yes
    - b. No

14a. Specify cause for fluctuation of consciousness:

Cognition

15. Does the resident have a cognitive impairment?
    - a. Yes
    - b. No

15a. Specify Cognitive Status and ability to safely use side rails, if applicable:

Determination

16. Recommendations:
    - [ ] a. Side Rail(s) are not recommended at this time
    - [ ] b. Side Rail(s) are recommended at this time
    - [ ] c. Further evaluation by Rehab Department

16a. Additional Comments:

17. Side rail(s) recommended at this time due to:
    - [ ] a. Symptoms/Condition documented above
    - [ ] b. Resident Request
    - [ ] c. Other

17a. If "other" please explain:

Side Rail(s) type recommended:

18a. 1/4 partial rail/enabler

☐ a. Left upper ☐ b. Left Lower ☐ c. Right upper ☐ d. Right Lower

18b. 1/2 partial enabler

☐ a. Left upper ☐ b. Left lower ☐ c. Right upper ☐ d. Right lower

18c. 3/4 partial enabler

☐ a. Left upper ☐ b. Left lower ☐ c. Right upper ☐ d. Right lower

18d. Full side rail

☐ a. Right ☐ b. Left

Side rail(s) are recommended to use:

19.

- ☐ a. Only at night
- ☐ b. At all times, when resident is in bed
- ☐ c. When resident is ill
- ☐ d. Other

19a. If "other" please explain:

Risks/Benefits and Alternatives

20. The risks/benefits of side rail use have been discussed with:

☐ a. Resident ☐ b. Family/Resident Representative

21. Alternatives to side rail use have been discussed with:

☐ a. Resident ☐ b. Family/Resident Representative

22. Decision made as a result of discussion:

All steps below must be complete for use of side rail(s)
Check only when complete

23.

- ☐ a. Consent for side rail use
- ☐ b. Physician order for use of side rail, including symptoms/condition
- ☐ c. Care plan updated
- ☐ d. C.N.A Task Documented

24. Comments:

C. Restraint Assessment

Potential/Actual Restraint Assessment

1. ☐ Psychosocial Considerations

1a. Psychosocial Considerations Select all that apply

- ☐ a. Oriented to time and place
- ☐ b. Disoriented/confused
- ☐ c. Glasses are missing, broken, dirty
- ☐ d. Dentures/teeth uncomfortable
- ☐ e. Hearing is impaired
- ☐ f. Hunger/Thirst
- ☐ g. Wet or soiled clothes/bed linens
- ☐ h. Needs to go to the bathroom
- ☐ i. Needs to be repositioned
- ☐ j. Hot/cold

- [ ] k. Unable to understand what is being said
- [ ] l. Can not comprehend surroundings
- [ ] m. Affected by environmental noises
- [ ] n. Recent death of loved one
- [ ] o. Changed rooms recently
- [ ] p. Changed roommates recently
- [ ] q. Change in caregiver or staff
- [ ] r. Recent change in personal health status
- [ ] s. Recent change in personal financial status
- [ ] t. Loss of self-control
- [ ] u. Experiencing feelings of anger, fear, abandonment
- [ ] v. Experiencing feelings of loneliness or isolation
- [ ] w. Feels threatened by staff/residents
- [ ] x. Other

1b. Comments

2. ☐ Medical Considerations

2a. Medical Considerations Select all that apply

- [ ] a. Medication change, addition, deletion in past month
- [ ] b. Possible infection
- [ ] c. Possible electrolyte imbalance
- [ ] d. Possible dehydration
- [ ] e. History of vertigo, hypotension, seizures
- [ ] f. Recent significant weight loss
- [ ] g. Other

2b. Comments

3. ☐ Physical Considerations

3a. Ambulation:

- [ ] a. Gait - Steady
- [ ] b. Gait - Unsteady
- [ ] c. Balance - Stable
- [ ] d. Balance - Unstable
- [ ] e. Leans to a side, forward or backward
- [ ] f. Requires assistance of persons or devices
- [ ] g. Wheelchair mobility

3b. Sitting

- [ ] a. Stable, maintains upright position
- [ ] b. Unstable, slides down
- [ ] c. Leans to a side, forward or backward
- [ ] d. Can regain balance

3c. Transfers:

- ( ) a. Stable when making transfers
- ( ) b. Unstable when making transfers

3d. Other<b< td=""></b<>

- [ ] a. Foot Problems
- [ ] b. History of Falls
- [ ] c. Other

3e. Comments

4. ☐ Other Physical/Medical Issues

4a. Right Eye:

- ( ) a. None
- ( ) b. Poor
- ( ) c. Fair
- ( ) d. Good

4b. Left Eye

a. None b. Poor c. Fair d. Good

4c. Paralysis/Paresis:

- a. Right Arm
- b. Left Arm
- c. Right Hand
- d. Left Hand
- e. Right Leg
- f. Left Leg
- g. Right Foot
- h. Left Foot

4d. Muscle Control:

a. None b. Poor c. Fair d. Good

5. Restraint Alternatives

5a. Programs:

a. Activities b. Restorative Nursing c. Exercises for strengthening d. Scheduled toileting e. Other

5b. Devices

a. Low Bed b. Mattress near bed c. Walker d. Cane e. Non-slip Grips f. Wheelchair

5c. Environment:

a. Call system in reach b. Alarmed Doors c. Grab Bars d. Other

5d. Position Devices:

a. Cushion b. Pillows c. Wedges d. Other

5e. Describe Other:

6. Additional Comments:

AIMS. RN:AIMS

Medication Usage

1. Does the resident use antipsychotic medications or medications with known extrapyramidal effects such as Reglan/Tigan?

a. Yes b. No

A. Facial and Oral Movements

1. Muscles of Facial Expression: i.e. movement of forehead, eyebrows, periorbital area, cheeks; including frowning, blinking, smiling, grimacing

0. None 1. Minimal 2. Mild 3. Moderate 4. Severe

2. Lips and Perioral Area: i.e. puckering, pouting, smacking

0. None 1. Minimal 2. Mild 3. Moderate 4. Severe

3. Jaw: i.e. biting, clenching, chewing, mouth opening, lateral movement

0. None 1. Minimal 2. Mild 3. Moderate 4. Severe

4. Tongue: Rate only increases in movement both in and out of mouth. NOT inability to sustain movement.

Client:	Braden Score Score:	Braden Score Category:

0. None 1. Minimal 2. Mild 3. Moderate 4. Severe

B. Extremity Movements

5. Upper (arms, wrists, hands, fingers). Include choreic movements (i.e. rapid objectively purposeless, irregular, spontaneous) athetoid movements, DO NOT INCLUDE TREMOR (i.e. repetitive, regular, rhythmic).

0. None 1. minimal 2. mild 3. moderate 4. severe

6. Lower (legs, knees, ankles, toes) Lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot.

0. None 1. minimal 2. mild 3. moderate 4. severe

C. Trunk Movements

7. Neck, shoulders, hips, e.g. rocking, twisting, squirming, pelvic gyrations. Include diaphragmatic movements.

0. None 1. minimal 2. mild 3. moderate 4. severe

D. Global Judgements

8. Severity of abnormal movements overall.

0. None 1. minimal 2. mild 3. moderate 4. severe

9. Incapacitation due to abnormal movements.

0. None 1. minimal 2. mild 3. moderate 4. severe

10. Patients Awareness of Abnormal Movements:

0. No awareness 1. Aware, No Distress 2. Aware, Mild Distress 3. Aware, Moderate Distress 4. Aware, Severe Distress

E. Dental Status

11. ☐ Current problems with teeth and/or dentures?
12. ☐ Does patient usually wear dentures?

Signature **Date**

Team: IDT Baseline Care Plan - V 3

Client:	**Effective Date:**	**Location:**
Initial Admission:	**Admission:**	**Date of Birth:**
Score: NA	**Category:** NA	**Physician:**

A. Initial Goals

1. Admitted for:
   - ☐ a. Skilled Services
   - ☐ b. Long Term Care
   - ☐ c. Disease/Illness Management
   - ☐ d. Hospice/Respite
   - ☐ e. Other

2. Initial Goal:
   - ☐ a. Return to Community
   - ☐ b. Tranisition to long term placement
   - ☐ c. Participate in therapy
   - ☐ d. Participate in care
   - ☐ e. Display progress in overall well-being
   - ☐ f. Receive Hospice/Respite Care
   - ☐ g. Other

1-1. Specify other: **(S)**

2-1. Specify other:

B. Disease/Illness Management

3. Diagnosis:

4. Allergies

5. Disease/Illness Management

☐ 1. Diabetic	☐ 2. Hypertension	☐ 3. Post-Surgical Care	☐ 4. Seizure
☐ 5. COPD	☐ 6. Pain	☐ 7. Hemiplegia	☐ 8. GI Problem
☐ 9. Urinary Catheter	☐ 10. Unrousable/Coma/Persistent Vegetative State	☐ 11. Contractures	☐ 12. Quadriplegia
☐ 13. Pneumonia	☐ 14. O2 Therapy	☐ 15. Tube feeding	☐ 16. Vomiting
☐ 17. Weight Loss	☐ 18. Cerebral palsy	☐ 19. Multiple Sclerosis	☐ 20. Parkinson
☐ 21. Alzheimer/Dementia	☐ 22. On Psych Medication	☐ 23. Psychiatric Illness	☐ 24. Using Anticoagulant
☐ 25. Nutrition Concern	☐ 26. Weakness	☐ 27. Post CVA	☐ 28. Infection
☐ 29. On IV Medication/Fluid	☐ 30. End of life	☐ 31. Dialysis	☐ 32. Heart Failure
☐ 33. Substance Abuse Disorder	☐ 34. Liver Cirrhosis	☐ 35. Tracheostomy	☐ 36. Ventilator Dependent
☐ 37. Respiratory Treatments	☐ 38. SOB	☐ 39. Ostomy/Colostomy/Ileostomy	☐ 40. Urinary Incontinence
☐ 41. Bowel Incontinence	☐ 42. Anemia	☐ 43. Hypothyroidism	☐ 44. Hyperthyroidism
☐ 45. Cancer	☐ 46. other		

29a. Type of IV Access:
- ☐ a. Peripheral Line
- ☐ b. Central Line
- ☐ c. Mid-Line

- [ ] d. Implanted Port

5-1. Specify other:

6. Skin Conditions:

- [ ] a. Edema
- [ ] b. Rashes
- [ ] c. Wounds (Surgical/Arterial/Vascular/Diabetic)
- [ ] d. Pressure Injury
- [ ] e. Other
- [ ] f. None

6-1. Specify other:

Goal: Disease/Illness will be monitored and managed using standards of nursing practice until further instructions
Interventions:
1) Administer treatments as ordered
2) Monitor medications: side effects, effectiveness
3) Provide safety environment, properly use devices
4) Monitor for complications of illness
5) Monitor conditions, progress of illness. Report changes to Practitioner
6) Monitor lab values and report to Practitioner
7) Provide comfort and care

C. ADL

7. [ ] Requires assistance with ADL's

Goal: All ADL care will be assisted or encouraged for independence until re-evaluated upon comprehensive CP
Interventions:
1) Assist with ADL care
2) Encourage self-care/participation Set-up and Monitor
3) Maintain safety precautions
4) Provide supportive devices as needed
5) Toilet/ Check and Change as needed. Monitor for skin issues
6) Encourage and/or Assist with turning and repositioning every 2-4 hrs and as needed or requested

D. Diet

8. Problem:

- [ ] a. Tube Feeding
- [ ] b. Mechanically Altered Diet (Puree/Mechanical Soft/Chopped/etc.)
- [ ] c. Thickened Liquids
- [ ] d. Therapeutic Diet (CCHO/NSP/Renal /etc.)
- [ ] e. TPN
- [ ] f. NPO
- [ ] g. Religious/Cultural Preferences
- [ ] h. None
- [ ] i. Other

8-1. Specify other:

Goal: Follow dietician's recommendations & physicians orders for dietary care to assist with nutritional intake
Interventions:
1) Monitor for safety and assist with meals/food consumption
2) Monitor intake record and weight
3) Provide diet as ordered.
4) Monitor safety (swallowing)

5) Provide supportive devices as needed

E. Therapy

9. Therapy Services:

- [ ] a. Physical Therapy (PT)
- [ ] b. Occupational Therapy (OT)
- [ ] c. Speech Therapy (ST)
- [ ] d. Respiratory Therapy (RT)
- [ ] e. None

Goal: Resident will participate in therapeutic services
Interventions:
1) Therapy Services as ordered
2) Monitor status. Report to Practitioner as needed

F. Social Services

10. Code Status

11. Problem:

- [ ] a. PASRR Level II
- [ ] b. Indicators of Depression
- [ ] c. Behavioral Issues
- [ ] d. Mental Health Diagnosis/History
- [ ] e. None

Goal: Resident will receive appropriate services based upon resident conditions
Resident will discharge to community or transition to long term placement
Interventions:
1) Additional services will be arranged to meet resident needs
2) Facilitate discharge planning
3) Monitor conditions/behaviors, intervene as needed. Report changes/escalations to Practitioner

G. Safety

12. Problem:

- [ ] a. At Risk for Falls
- [ ] b. At Risk for Elopement
- [ ] c. At Risk for Pressure Injury
- [ ] d. Resident is a current smoker
- [ ] e. None
- [ ] f. Other

12-1. Specify other:

Goal: Safety will be maintained
Interventions:
1) Maintain safety precautions
2) Provide Supportive Devices as needed
3) Anticipate and meet resident needs
4) Monitor conditions. Report to Practitioner

H. Physician Orders/Baseline Summary

13. Physician Orders:

- ( ) a. Physician Orders reviewed with Resident/Resident Representative and a copy of Physician orders were offered and given. (ALL orders ie: Medication/Treatment/Ancillary/Labs/Therapy/Diet/etc.)
- ( ) b. Resident is Oriented but refuses to participate
- ( ) c. Resident has impaired cognition and does not have a resident representative or resident representative is unavailable

14. Baseline Care Plan:

- ( ) a. Baseline Care Plan reviewed with Resident/Resident Representative and a copy was offered and given .

Client:

- b. Resident is Oriented but refuses to participate
- c. Resident has impaired cognition and does not have a resident representative or resident representative is unavailable

Signature	Date

UM: Pain Interview (3.0) - V 5

Client:	**Effective Date:**	**Location:**
Admission:	**Date of Birth:**	**Score:** NA
Category: NA	**Physician:**	

Ins. Instructions

Complete Pain Assessment Interview (A-D) if resident is able to communicate appropriately. If the resident is rarely or never understood, skip to section E.

If resident is comatose or if A0310G = 2, skip to J1100, Shortness of Breath (dyspnea). Otherwise, attempt to conduct interview with all residents.

Should Pain Assessment Interview be Conducted?

- 0. No
- 1. Yes
- -. Not assessed

A. Pain Presence

Ask resident: "Have you had pain or hurting at any time in the last 5 days?"

- 0. No
- 1. Yes
- 9. Unable to answer
- -. Not assessed

B. Pain Frequency

Ask resident: "How much of the time have you experienced pain or hurting over the last 5 days?"

- 1. Almost constantly
- 2. Frequently
- 3. Occasionally
- 4. Rarely
- 9. Unable to answer
- -. Not assessed

C. Pain Effect on Function

1. Ask resident: Over the past 5 days, how much of the time has pain made it hard for you to sleep at night?

1a. Pain Effect on Sleep.

- 1. Rarely or not at all
- 2. Occasionally
- 3. Frequently
- 4. Almost Constantly
- 8. Unable to answer
- -. Not assessed/no information

2. Ask resident: Over the past 5 days, how often have you limited your participation in rehabilitation therapy sessions due to pain?

2a. Pain Interference with Therapy Activities

- 0. Does not apply - I have not received rehabilitation therapy in the past 5 days
- 1. Rarely or not at all
- 2. Occasionally

- 3. Frequently
- 4. Almost Constantly
- 8. Unable to answer
- -. Not assessed/no information

3. Over the past 5 days, how often have you limited your day-to-day activities (excluding rehabilitation therapy sessions) because of pain?

3a. Pain Interference with Day-to-Day Activities

- 1. Rarely or not at all
- 2. Occasionally
- 3. Frequently
- 4. Almost Constantly
- 8. Unable to answer
- -. Not assessed/no information

D. Pain Intensity

Administer ONLY ONE of the following pain intensity questions (1 or 2).

1. Numeric Rating Scale (00-10)

2. Verbal Descriptor Scale

- 1. Mild
- 2. Moderate
- 3. Severe
- 4. Very severe, horrible
- 9. Unable to answer
- -. Not assessed

E. Indicators of Pain or Possible Pain

Staff Assessment for Pain. Check all that apply.

1. Non-verbal sounds (e.g., crying, whining, gasping, moaning, or groaning)
2. Vocal complaints of pain (e.g., that hurts, ouch, stop)
3. Facial expressions (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
4. Protective body movements or postures (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
5. None of these signs observed or documented

F. Frequency of Indicator of Pain or Possible Pain

Frequency with which resident complains or shows evidence of pain or possible pain

- 1. Indicators of pain (1 to 2 days)
- 2. Indicators of pain (3 to 4 days)
- 3. Indicators of pain (daily)
- -. Not assessed

G. Pain Management

1. Been on a scheduled pain medication regimen?

1a. Describe treatment, any side effects and effectiveness.

Client:

2. ☐ Received PRN pain medications?

2a. Describe administration patterns, any side effects and effectiveness.

3. ☐ Received non-medication intervention for pain?

3a. Describe interventions and effectiveness.

4. Comments:

Signature	Date

LN: Fall Risk Evaluation - V 5

Client:	**Effective Date:**	**Location:**
Admission:	**Date of Birth:**	**Gender:**
Primary Language:	**Score:** NA	**Category:** NA
Physician:		
Allergies:		
Diagnoses:		

A. Fall Risk Evaluation

1. Reason for Evaluation Request

a) Recent Falls
b) Change in Functional Ability
c) New Admission
d) Physical Restraint Removal
e) Other

1-1. Specify other: **(S)**

2. Date of Admission

( ) a. Over 3 months ( ) b. Less than 3 months

3. History of Falls within last six months

( ) 0. No History ( ) 2. 1 - 2 times ( ) 4. Multiple Falls

4. Medication Use

Medication taken more than 3 x /week, including prn's

- [ ] a. Antihistamines
- [ ] b. Diuretics
- [ ] c. Hypoglycemic Agents
- [ ] d. Antiseizure/Antiepileptics
- [ ] e. Antihypertensives
- [ ] f. NSAID
- [ ] g. Benzodiazepine
- [ ] h. Narcotic
- [ ] i. Psychotropic
- [ ] j. Anti-Parkinson
- [ ] k. Cathartic
- [ ] l. Sedatives/Hypnotic
- [ ] m. If medication and/or dosage has changed in last 5 days

In The Last 7 Days: Recalls Three Out Of Four Of The Following: Current Season, That He/She Is In A Nursing Home, Location Of Room, Staff names/Faces

5. Memory and Recall Ability

( ) 0. Always ( ) 2. Sometimes ( ) 4. Never

6. Vision Pattern

( ) 0. Adequate-able to see in adequate light with glasses on
( ) 2. Inadequate- impaired vision in adequate light with glasses on
( ) 4. Severely Impaired- no vision or sees only light, color or shape

Continence in Last 14 Days

7. Continence

( ) 0. Continent: complete control
( ) 2. Occasional Incontinence: bladder 2 x/week, but not daily; bowel once a week
( ) 3. Frequently Incontinent: bladder incontinent daily, but some control present; bowel 2-3 x/week
( ) 4. Total Incontinence: daily episode of bladder incontinence; bowel always incontinent

Agitated Behavior in Last Seven Days

8. Wandering; verbally abusive; physically abusive; socially inappropriate, e.g. is noisy, screams, disrobes, self-abusive, rummages, hoards, etc

- ○ 0. Behavior not exhibited in last 7 days
- ○ 2. Behavior occurred less than daily
- ○ 4. Behavior occurred daily or more

If resident cannot walk even when assisted by staff are they:

9. Confined To A Chair

- ○ 2. Confined to a chair and oriented
- ○ 3. Confined to a chair and disoriented
- ○ 0. Not Applicable

10. Does the resident have a history of orthostatic hypotension?

- ○ 4. Yes
- ○ 0. No

Evaluate a resident's gait while: standing in one spot, walking straight forward and while making a turn

11. Gait Analysis

- ☐ a. Unable to independently come to a standing
- ☐ b. Exhibits loss of balance while standing
- ☐ c. Strays off the straight path of walking
- ☐ d. Requires hands-on assistance to move from place to place
- ☐ e. Uses short discontinuous steps and/or shuffling
- ☐ f. Changes gait pattern when walking through doorways
- ☐ g. Has lurching, swaying, or slapping gait
- ☐ h. Exhibits jerking or instability when making turns
- ☐ i. Uses an assistive device, e.g. cane, walker, etc.
- ☐ j. Wears poorly fitting shoes
- ☐ k. Decrease in muscle coordination

B. Interventions

1. Interventions initiated to decrease risk for falls:

- ☐ a. Fall Mat(s) next to bed
- ☐ b. Positioning Device(s)
- ☐ c. Occupational Therapy Evaluation and tx as indicated
- ☐ d. Physical Therapy Evaluation and tx as indicated
- ☐ e. Non-Skid Socks
- ☐ f. Bed in lowest position
- ☐ g. Other

1-1. Please describe other interventions:
(These Interventions will not trigger to the care plan and must be manually added)

Signature **Date**

LN: Braden Scale for Predicting Pressure Sore Risk

Client:	**Effective Date:**	**Location:**
Admission:	**Score:** NA	**Category:** NA
Physician:	**Type:**	**Facility:**
Facility Address:		

1. SENSORY PERCEPTION

Ability to respond meaningfully to pressure-related discomfort

- 1. **Completely Limited**: Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level
- 2. **Very Limited**: Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.
- 3. **Slightly Limited**: Responds to verbal commands, but cannot always communicate discomfort or the need to be turned. **OR** has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.
- 4. **No Impairment**: Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.

2. MOISTURE

Degree to which skin is exposed to moisture

- 1. **Constantly Moist**: Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.
- 2. **Very Moist** : Skin is often, but not always moist. Linen must be changed at least once a shift.
- 3. **Occasionally Moist** : Skin is occasionally moist, requiring an extra linen change approximately once a day.
- 4. **Rarely Moist**: Skin is usually dry, linen only requires changing at routine intervals.

3. ACTIVITY

degree of physical activity

- 1. **Bedfast**: Confined to bed.
- 2. **Chairfast**: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.
- 3. **Walks Occasionally**: Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair
- 4. **Walks Frequently**: Walks outside room at least twice a day and inside room at least once every two hours during waking hours

4. MOBILITY

ability to change and control body position

- 1. **Completely Immobile**: Does not make even slight changes in body or extremity position without assistance
- 2. **Very Limited**: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.
- 3. **Slightly Limited**: Makes frequent though slight changes in body or extremity position independently.
- 4. **No Limitation**: Makes major and frequent changes in position

5. NUTRITION

usual food intake pattern

- 1. **Very Poor**: Never eats a complete meal. Rarely eats more than a of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** is NPO and/or maintained on clear liquids or IV?s for more than 5 days.
- 2. **Probably Inadequate**: Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement. **OR** receives less than optimum amount of liquid diet or tube feeding
- 3. **Adequate**: Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** is on a tube feeding or TPN regimen which probably meets most of nutritional needs

Client:	**Effective Date:**	**Location:**
Admission:	**Score:** NA	**Category:** NA
Physician:	**Type:**	**Facility:**
Facility Address:		

- 4. **Excellent**: Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.

6. FRICTION & SHEAR

- 1. **Problem**: Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction
- 2. **Potential Problem**: Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.
- 3. **No Apparent Problem**: Moves in bed and in chair independently and has sufficient muscle strength to lift up

Signature	Date
_____	_____

RN: Side Rail/Restraint Assessment

Client:	**Effective Date:**	**Location:**
Initial Admission:	**Admission:**	**Date of Birth:**
Score: NA	**Category:** NA	**Physician:**

A. Reason for Assessment

1. Reason for conducting Assessment

- ○ a. Admission/Readmission
- ○ b. Quarterly
- ○ c. Annual
- ○ d. Significant change in status
- ○ e. Other

1a. Describe Other:

2. Potential Restraint(s):

- ☐ a. Side Rail or Enabler Bar
- ☐ b. Wheelchair Seatbelt
- ☐ c. Specialty Wheelchair/Recliner
- ☐ d. Lap buddy/Wheel chair Tray
- ☐ e. Pummel Cushion
- ☐ f. Trunk Restraint
- ☐ g. Limb Restraint
- ☐ h. Concave, Scoop or Perimeter Mattress
- ☐ i. Positional Change Alarms (Bed/Chair/Clip etc.)
- ☐ j. Chair Preventing Rising
- ☐ k. Other

2a. Describe Other Potential Restraint:

B. Side Rail Assessment and Determination

Side Rail Assessment and Determination

1. Why is the side rail being considered?

- ☐ a. Safety
- ☐ b. Security
- ☐ c. Resident Requested
- ☐ d. Family requested
- ☐ e. Other

1a. Explain other reasons for side rail consideration:

2. Identify condition/symptoms that contribute to the resident's need to use side rail(s)

- ☐ a. Weakness
- ☐ b. Poor trunk control
- ☐ c. Postural Hypotension
- ☐ d. Resident leans
- ☐ e. Leans to right
- ☐ f. Leans to Left
- ☐ g. Leans forward
- ☐ h. Unable to sit upright
- ☐ i. History of falling out of bed
- ☐ j. Fear of rolling out of bed
- ☐ k. History of sliding out of bed

☐ l. Other

2a. Specify Other:

Bed Mobility

3. Turning from side to side?

○ a. Yes ○ b. No

4. Holding self to one side of bed?

○ a. Yes ○ b. No

5. Moving up and down in bed?

○ a. Yes ○ b. No

6. Pulling up from laying to sitting position?

○ a. Yes ○ b. No

Transfer

7. Supporting balance?

○ a. Yes ○ b. No

8. Entering bed more safely?

○ a. Yes ○ b. No

9. Exiting bed more safely?

○ a. Yes ○ b. No

Other

10. Provides security for resident?

○ a. Yes ○ b. No

11. Avoiding rolling out of bed?

○ a. Yes ○ b. No

12. Will the side rail obstruct view?

○ a. Yes ○ b. No

13. Will the side rail impede freedom of movement?

○ a. Yes ○ b. No

Level of Consciousness

14. Does the resident's level of consciousness fluctuate?

○ a. Yes ○ b. No

14a. Specify cause for fluctuation of consciousness:

Cognition

15. Does the resident have a cognitive impairment?

○ a. Yes ○ b. No

15a. Specify Cognitive Status and ability to safely use side rails, if applicable:

Side Rail or Enabler Bar

16. Recommendations:

☐ a. Side rails are not recommended at this time.
☐ b. Side Rail(s) are recommended at this time
☐ c. Further evaluation by Rehab Department

16a. Additional Comments:

Side rail(s) recommended at this time due to:

17.

- [ ] a. Symptoms/Condition documented above
- [ ] b. Resident request
- [ ] c. Other:

17a. If "other" please explain:

Side Rail(s) Type Recommended:

18a. 1/4 partial rail/enabler

- [ ] a. Left Upper
- [ ] b. Left Lower
- [ ] c. Right Upper
- [ ] d. Right Lower

18b. 1/2 partial enabler

- [ ] a. Left Upper
- [ ] b. Left Lower
- [ ] c. Right Upper
- [ ] d. Right Lower

18c. 3/4 partial enabler

- [ ] a. Left Upper
- [ ] b. Left Lower
- [ ] c. Right Upper
- [ ] d. Right Lower

18d. Full side rail

- [ ] a. Right Side
- [ ] b. Left Side

Side Rail(s) are recommended for use:

19.

- [ ] a. Only at night
- [ ] b. At all times, when the resident is in bed
- [ ] c. When the resident is ill
- [ ] d. Other

19a. If "Other" selected above:

Risks/Benefits and Alternatives

20. The risks/benefits of side rail use have been discussed with:

- [ ] a. Resident
- [ ] b. Family/Resident Representative

21. Alternatives to side rail use have been discussed with:

- [ ] a. Resident
- [ ] b. Family/Resident Representative

22. Decision made as a result of discussion:

All steps below must be complete for use of side rail(s), check only when complete

23.

- [ ] a. Consent for side rail Use
- [ ] b. Physician order for use of side rail, including symptom/condition
- [ ] c. Care Plan updated
- [ ] d. C.N.A. Task Documented

24. Comments:

C. Potential/Actual Restraint Assessment

Potential/Actual Restraint Assessment

1. [ ] Psychosocial Considerations

1a. Psychosocial Considerations Select all that apply

- [ ] a. Oriented to time and place
- [ ] b. Disoriented/confused

- [ ] c. Glasses are missing, broken, dirty
- [ ] d. Dentures/teeth uncomfortable
- [ ] e. Hearing is impaired
- [ ] f. Hunger/Thirst
- [ ] g. Wet or soiled clothes/bed linens
- [ ] h. Needs to go to the bathroom
- [ ] i. Needs to be repositioned
- [ ] j. Hot/cold
- [ ] k. Unable to understand what is being said
- [ ] l. Can not comprehend surroundings
- [ ] m. Affected by environmental noises
- [ ] n. Recent death of loved one
- [ ] o. Changed rooms recently
- [ ] p. Changed roommates recently
- [ ] q. Change in caregiver or staff
- [ ] r. Recent change in personal health status
- [ ] s. Recent change in personal financial status
- [ ] t. Loss of self-control
- [ ] u. Experiencing feelings of anger, fear, abandonment
- [ ] v. Experiencing feelings of loneliness or isolation
- [ ] w. Feels threatened by staff/residents
- [ ] x. Other

Psychosocial Consideration

1b. Comments

2. [ ] Medical Considerations

2a. Medical Considerations Select all that apply

- [ ] a. Medication change, addition, deletion in past month
- [ ] b. Possible infection
- [ ] c. Possible electrolyte imbalance
- [ ] d. Possible dehydration
- [ ] e. History of vertigo, hypotension, seizures
- [ ] f. Recent significant weight loss
- [ ] g. Other

Medical Consideration:

2b. Comments

3. [ ] Physical Considerations

3a. Ambulation:

- [ ] a. Gait - Steady
- [ ] b. Gait - Unsteady
- [ ] c. Balance - Stable
- [ ] d. Balance - Unstable
- [ ] e. Leans to a side, forward or backward
- [ ] f. Requires assistance of persons or devices
- [ ] g. Wheelchair mobility

3b. Sitting

- [ ] a. Stable, maintains upright position
- [ ] b. Unstable, slides down
- [ ] c. Leans to a side, forward or backward
- [ ] d. Can regain balance

3c. Transfers:

- ( ) a. Stable when making transfers
- ( ) b. Unstable when making transfers

Client:

3d. Other

- ☐ a. Foot Problems
- ☐ b. History of Falls
- ☐ c. Other

Physical Consideration:

3e. Comments:

4. ☐ Other Physical/Medical Issues

4a. Right Eye:

- ○ a. None ○ b. Poor ○ c. Fair ○ d. Good

4b. Left Eye

- ○ a. None ○ b. Poor ○ c. Fair ○ d. Good

4c. Paralysis/Paresis:

- ☐ a. Right Arm
- ☐ b. Left Arm
- ☐ c. Right Hand
- ☐ d. Left Hand
- ☐ e. Right Leg
- ☐ f. Left Leg
- ☐ g. Right Foot
- ☐ h. Left Foot

4d. Muscle Control:

- ○ a. None ○ b. Poor ○ c. Fair ○ d. Good

5. ☐ Restraint Alternatives

5a. Programs:

- ☐ a. Activities ☐ b. Restorative Nursing ☐ c. Exercises for strengthening ☐ d. Scheduled toileting ☐ e. Other

5b. Devices

- ☐ a. Low Bed ☐ b. Mattress near bed ☐ c. Walker ☐ d. Cane ☐ e. Non-slip Grips ☐ f. Wheelchair

5c. Environment:

- ☐ a. Call system in reach ☐ b. Alarmed Doors ☐ c. Grab Bars ☐ d. Other

5d. Position Devices:

- ☐ a. Cushion ☐ b. Pillows ☐ c. Wedges ☐ d. Other

5e. Describe Other:

6. Additional Comments:

Signature **Date**

LN: Elopement risk evaluation V2 - V 7

Client:	**Effective Date:**	**Location:**
Initial Admission:	**Admission:**	**Date of Birth:**
Physician:		

A. Elopement Risk Evaluation

Upon admission and quarterly (at a minimum) thereafter, assess the resident status in seven clinical areas listed below (B-H) by assigning the corresponding score which best describes the resident in the appropriate assessment column. If the resident meets the criteria in section A (1 or 2) the score will be 0 and you do not need to complete sections (B-H). Add the column of numbers to obtain the total score.

A-1. ☐ Resident is comatose or in a vegetative state. If yes, no further assessment required.

A-2. ☐ Is resident totally dependent for mobility? If yes, no further assessment required.

B. Resident Mobility Status/Condition

- ○ 2. Propels self/some assist
- ○ 4. Fully ambulatory

C. History of Elopement Attempts Status

- ○ 0. No Attempt
- ○ 10. Prior elopement history or has made one + attempts or currently exit seeking

D. Out on Pass Compliance Status

- ○ 0. Understands Out-on-Pass protocol/ Not Applicable due to New Admission Status
- ○ 4. Homeless prior to admission or Unable to comprehend Out-on-Pass protocol
- ○ 10. Prior history of Out-on-Pass violation or previous AMA

E. Cognitive status

- ○ 0. Alert, Oriented x3
- ○ 2. Disoriented/no wandering
- ○ 4. Wanders aimlessly

F. Adjustment to Placement Status

- ○ 0. No concerns voiced with placement
- ○ 2. Exhibits distress due to recent changes in schedule or placement
- ○ 4. Insists on maintaining a pre-admission lifestyle/routine (e.g., daily outdoor walks) and does not exhibit safe decision making or willingness/ability to adhere to facility protocols
- ○ 10. Voices desire to leave or discontent with placement

G. Behavior Symptoms

- ○ 0. No current behavioral symptoms
- ○ 2. Looking for spouse / loved ones; behavior redirectable
- ○ 4. Agitation / Restlessness;/ Substance Abuse History with Substance seeking behavior

H. Major Psychiatric or Cognitive Impairment Diagnosis (i.e. Alzheimer's disease, Dementia, Paranoia, Bipolar, Schizophrenia, etc)

- ○ 0. No diagnosis
- ○ 2. Diagnosis on record, but no history exit seeking or elopement attempt
- ○ 4. Exhibits Hallucinations / Delusional thinking / Confusion / Paranoia/Unpredictable

B. Scoring/Interventions

Low Elopement Risk below 10
Elopement Risk- Score of 10 or greater
If the total score is 10 or greater, the resident should be considered to be at High risk for elopement. Prevention protocols should be followed and documented on the care plan.

1. Elopement Intervention(s)

Client:

- [ ] a. Wanderguard
- [ ] b. Identify triggers for wandering.
- [ ] c. Document behaviors. Attempt to identify pattern to target interventions
- [ ] d. Distract resident from wandering by offering pleasant diversions
- [ ] e. AMA Procedure has been explained to the resident/resident representative
- [ ] f. Resident is NOT a candidate for a Wanderguard
- [ ] g. Resident is NOT at risk for elopement

2. Comments:

Signature	Date