

North Carolina Department of Health and Human Services
Division of Health Service Regulation – Adult Care Licensure Section
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RESIDENT ASSESSMENT SELF-INSTRUCTIONAL MANUAL FOR ADULT CARE HOMES

This self- instructional manual is based on the Division of Medical Assistance (DMA) 3050R, **THE PERSONAL CARE PHYSICIAN AUTHORIZATION AND CARE PLAN FORM**, the resident assessment instrument established and accepted by the Department as the assessment tool for residents of adult care homes, including family care home. Staff authorized to complete the Resident Assessment shall document on the DMA 3050R information obtained on the FL2, any hospital records that accompany the resident, or any documents from prescribing practitioner or Licensed Health Professional Support, resident observations, and interviews with family and the resident. Residents are to be assessed within 30 days following admission and reassessed at least annually thereafter or after a significant change in condition as specified in Rule **10A NCAC 13F .0801** for Adult Care Homes (7+ beds) and Rule **10A NCAC 13G. 0801** for Family Care Homes.

The care plan is to be developed within 30 days of admission based on the Resident Assessment. The facility shall assure the resident's physician authorizes personal care services and certifies by signing and dating the care plan within 15 *calendar* days of completion of the assessment as specified in Rule **10A NCAC 13 F. 0802** for Adult Care Homes (7+ beds) and Rule **10A NCAC 13G. 0802** for Family Care Homes.

As required by Rules **10A NCAC 13F .0508** and **13G .0508**, this self-instructional manual is to be completed by staff responsible for completing the Resident Assessment prior to performing the assessment. Upon completion of the self-instructional manual, staff shall date and sign the last page, **which shall be maintained in the facility files for review by State and County monitors.**

This manual may be reproduced and is also available on the DFS website at <http://facility-services.state.nc.us/gcpage.htm>.

NOTE: The information is presented in the order as it is shown on the DMA 3050R.

DATES OF ASSESSMENTS

The block in the upper right hand corner of the form denotes the type of assessment and date the assessment was completed. Document only one of the following three options:

ASSESSMENT DATE

At the top of page 1, the assessment date should be the date of the resident's initial 30-day assessment.

REASSESSMENT DATE

At the top of page 1, the reassessment date should be the date annual reassessment was completed.

SIGNIFICANT CHANGE

At the top of page 1, the significant change date, should be the reassessment after a significant change in condition as described in **10A NCAC 13 G. 0801 for Family Care Homes** and **10A NCAC 13F. 0801 for Adult Care Homes**.

RESIDENT INFORMATION

Complete all identified areas under resident information.

Line 1. Resident name, sex (Male or Female), date of birth, and Medicaid identification number if applicable.

Line 2. Facility Name

Line 3. Facility Address

Line 4. Telephone number and Medicaid Provider Number if applicable.

Line 5. Date of most recent examination by the resident’s primary care physician. **NOTE: This means most recent physical exam- not necessarily hospitalization.**

1. MEDICATIONS

List the name of each medication; include non-prescription medications that the resident will continue upon admission. Document the dose, frequency, the route and if the resident will self-administer the medication. Obtain the medications from the physician or prescribing practitioner orders. A copy of the current physician orders or Medication Administration Record (MAR) may be attached instead of recopying the orders. The documentation in this section should read “See Attachments.” Keep the attachments with the Resident Assessment DMA Form 3050R.

2. MENTAL HEALTH AND SOCIAL HISTORY

INTENT

To identify past or present behavior symptoms that cause distress to the resident, or is distressing or disruptive to facility residents and staff members. Such behaviors include those that are potentially harmful to the resident or disruptive in the environment. Acknowledging and documenting the resident’s behavioral symptom patterns on the resident assessment form provide a basis for further evaluation, care planning, and delivery of consistent, appropriate care towards improving the behavior.

If any of the areas in the first column are checked, explain or document in “Social/Mental Health History Section. Review all records (FL2, records from discharging facility, etc.) to determine if there was any indication about history of injury to self, others or property.

Example: 1. Wandering is identified problem. Document wandering i.e. the resident frequently attempts to leave the facility. Has wandered away from home prior to admission. 2. Suicidal is identified. Document recent or past behavior i.e. resident attempted suicide 20 years ago. 3. Assaultive behavior is

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identified. Document what behavior was i.e. resident became combative at the last facility and was in psychiatric hospital where medications were adjusted. Sexual assault occurred at previous facility. 4. Resists care is identified. Document how the resident has resisted care and if family, responsible person or health care professional is available to help staff or give information that will help staff assist the resident with care needs. What information or tools is available to help resident be less resistive, i.e. resists taking a bath and will fight staff. Family states the resident will bathe if cigarettes are given prior to bath and after.

Definition

- a. **Wandering-** Ambulation or locomotion with no recognizable, rational purpose. A wandering resident may not be aware of his or her physical or safety needs. Wandering behavior may be shown by walking or by wheeling aimlessly in a wheelchair. Do not automatically include pacing as wandering behavior. Pacing back and forth may not be wandering but repetitive movements.
- b. **Verbally Abusive-**Other residents or staff were threatened, screamed at or cursed at, etc.
- c. **Physically Abusive-** Other residents or staff were hit, shoved, scratched or sexually abused etc.
- d. **Resists Care-** Resists or has resisted taking medications/injections or assistance with one or more activities of daily living (eating, toileting, ambulating, bathing, dressing, grooming/personal hygiene, or transferring).
- e. **Suicidal-** Demonstrates or has demonstrated verbally or non-verbally the intent/ to harm/kill oneself.
- f. **Homicidal-** Demonstrates or has demonstrated or expresses verbally or non-verbally the intent to kill another person.
- g. **Disruptive Behavior/Socially Inappropriate-** Includes sounds, excessive noise, screams, self-abusive acts, sexual behavior or disrobing in public, smearing or throwing food or feces, hoarding, rummaging through others' belongings, etc.
- h. **Injurious to Self, Others, or Property-** The resident has harmed him/herself including cutting, burning, scratching or injured other residents' including hit, shoved, scratched, sexually abused. Property has been damaged including, burning, breaking, cutting, etc.

Is the resident currently receiving medication(s) for mental illness/behavior?

Mark yes or no on the DMA 3050R. Refer to medications ordered for the resident.

Is there a history of: Substance Abuse?

Check on the DMA 3050R if there is a history. This includes excessive use of addictive substances especially alcohol and narcotic drugs such as marijuana, cocaine, heroin, crack, as well as prescription narcotic medications such a morphine, oxycodone, codeine, valium, librium, etc.

Is there a history of Developmental Disabilities? (DD)?

Check on the DMA 3050R if there is a professional diagnosis of developmental disability or mental retardation and a documented history. Use the FL2/MR2 or hospital discharge summary to identify developmental disabilities.

Is there a history of Mental Illness?

Check on the DMA 3050R if there is a documented history. Use the FL2/MR2 or hospital discharge summary to identify a history of mental illness.

Mental illness includes such disorders as schizophrenia, schizoaffective disorder, major depressive disorder, obsessive-compulsive disorder, panic and other severe anxiety disorders, autism and pervasive developmental disorders, attention deficit/hyperactivity disorder, borderline personality disorder, and other severe and persistent mental illnesses that affect the brain.”

Is the resident currently receiving Mental Health, DD (Developmental Disabilities), or Substance Abuse Services (SAS)?

Mark yes or no on the DMA 3050R.

Example: Services are: Private psychiatrist or psychologist, Area Mental Health Clinic services, Day Hospital Program, Alcoholic Anonymous (AA) meetings etc.

Has a referral been made?

Mark yes or no on the DMA 3050R.

Example: Has a referral been made to private psychiatrist or psychologist, Area Mental Health Clinic, Day Hospital Program, Alcoholic Anonymous (AA) meetings, etc?

If yes:

Date of referral

Name of the contact person (name of the individual you spoke with to arrange the referral)

Agency (name of the clinic, psychiatrist, or psychologist or service)

3. AMBULATION/LOCOMOTION

Intent

To record how the resident moves (walking or wheeling a wheelchair) in and out of the facility or how limited the resident is in walking, moving or propelling a wheelchair around in and out of the facility.

Definition:

A limitation in how the resident moves (walking or wheeling a wheelchair) that interferes with daily functioning particularly with activities of daily living, eating, toileting, bathing, dressing, grooming/personal hygiene, or transferring or places the resident at risk of injury.

a. No problems

Document here if the resident can move (walking or wheeling a wheelchair) about the facility on his/her own without need of any assistance from another person or devices/aides.

Example: 1. The resident walks in and out of the facility without need of assistance. 2. The resident self propels the wheelchair in and out of the facility.

b. Limited Ability

Document here if the resident can move (walking or wheeling a wheelchair) about the facility with some limitations such as walks only short distances alone. This may interfere with daily functioning particularly with activities of daily living, (eating, toileting, bathing, dressing, grooming/personal hygiene, or transferring) or place the resident at risk of injury.

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Example: 1. The resident is able to walk from bed to bathroom, bed to chair or short distance in hallway.
2. The resident moves about the facility in a wheelchair without the need of staff assistance for short distances.

c. Ambulatory w/aide or Devices

Document here if the resident is able to move (walking or wheeling a wheelchair) about the facility with the assistance of some equipment such as a cane, quad cane, crutch, wheel chair, prosthesis (artificial leg) splint, brace etc. This may interfere with daily functioning particularly with activities of daily living, (eating, toileting, bathing, dressing, or grooming/personal hygiene) or place the resident at risk of injury.

Example: 1. Resident uses a wheel chair to move about the Home. 2. The resident uses a walker with wheels to move about the Home. 3. The resident walks only with staff assistance.

NOTE: Prior to staff assisting with ambulation, Licensed Health Professional Support must complete the training and competency validation of the staff. Licensed Health Professional Support must evaluate the resident within 30 days of admission or within 30 days of developing the need for ambulating with assistive devices and staff assistance and reevaluate the resident at least quarterly thereafter.

d. Non-Ambulatory

Document here if the resident is not able to move (walking or wheeling a wheelchair) about in the facility. This may interfere with daily functioning particularly with activities of daily living, (eating, toileting, bathing, dressing, or grooming/personal hygiene) or place the resident at risk of injury.

Example: 1. The resident remains in bed or remains seated after staff has placed the resident in a bed, chair, wheel chair, geri chair or another person must push the resident in wheel chair.

NOTE: Prior to staff completing transfer of a non-ambulatory resident Licensed Health Professional Support must complete the training and competency evaluation of the staff, within 30 days evaluate the resident and reevaluate the resident at least quarterly thereafter.

e. Device(s) Needed

Document all devices the resident needs or uses to move (walking or wheeling a wheelchair) around in the facility.

Examples: Wheelchair, electric wheel chair, scooter, walker, cane, quad cane, crutches, prosthesis, brace, splint, Hoyer lift etc.

Has Device(s) Document if applicable Does not use

Example: 1. The resident has a cane/quad cane but does not use it. 2. The resident has a walker but does not use it. 3. The resident has a wheel chair but does not use it.

or

Needs repair or replacement

Example: 1. Resident has a walker but it needs repair/replacement wheel missing. 2. The wheelchair has broken seat/back/armrests, needs to be repaired. 3. The electric wheelchair does not run. 4. The resident has wheelchair but size not appropriate for resident; feet do not touch floor. The resident needs leg extensions for support due to feet/legs swelling.

4. UPPER EXTREMITIES

Intent

To record how the presence of functional limitation in range of joint motion or loss of voluntary movement of arms, wrists, hands fingers affects the resident. Can the resident comb his hair, remove clothing, brush teeth, shave, pick up spoon, button or zip clothing?

Definition:

A limitation in arms, wrists, hands and fingers that interferes with daily functioning particularly with activities of daily living, (eating, toileting, bathing, dressing, grooming/personal hygiene, or transferring) or place the resident at risk of injury.

a. No problems

Document here if the resident has full use/movement of arms, wrists, and hands and fingers on his/her own without need of any assistance from another person or devices/aides.

Example: 1. The resident has full use of upper body, arms and hands.

b. Limited Range of Motion

Document here if the resident has a limitation of movement of arms, wrists, or hands and fingers. This interferes with daily functioning particularly with activities of daily living, (eating, toileting, bathing, dressing, grooming/personal hygiene, or transferring) or place the resident at risk of injury.

Example: The resident has a history of a stroke with paralysis on one side of the body. The resident has diagnosis of arthritis and pain in wrist and hand joints. As a result the resident has limited movement or use of hands.

c. Limited Strength

Document here if the resident can use the upper extremities but is not strong in the arms, wrists, hands or fingers. This interferes with daily functioning particularly with activities of daily living, (eating, toileting, bathing, dressing, grooming/personal hygiene, or transferring) or place the resident at risk of injury.

Example: 1. The resident has diagnosis of arthritis and can bathe but cannot dress self due to pain and/or loss of movement in the hands and fingers. The resident requires assistance with buttons, zippers.
2. The resident has to use both hands to hold a cup of liquids.

d. Limited Eye-hand Coordination

Document here if the resident has combined visual and muscle coordination problems to complete tasks. This interferes with daily functioning particularly with activities of daily living, (eating, toileting, bathing, dressing, grooming/personal hygiene, or transferring) or place the resident at risk of injury.

Example: 1. The resident is unable to feed self, misses the mouth.

e. Specify affected joint(s)

Document which joint of the arm, wrist, hand or fingers the resident has decreased range of motion or strength.

Example: Fingers on right hand are swollen due to diagnosis of arthritis and the resident cannot grasp objects such as spoon, toothbrush, or razor.

Right or Left or Bilateral (both) Document the appropriate side(s) where the resident has the limited range of motion or strength that interferes with daily functioning particularly with activities of daily living, (eating, toileting, bathing, dressing, grooming/personal hygiene, or transferring) or place the resident at risk of injury.

f. Other Impairment, Specify

Document any other area of limited function or range of motion that interferes with daily functioning particularly with activities of daily living, (eating, toileting, bathing, dressing, grooming/personal hygiene, or transferring) or place the resident at risk of injury.

Example: The resident can only turn head to left side due to arthritis or injury.

g. Device(s) Needed

Document all devices needed or used by the resident to maintain function, range of motion or strength of upper extremities such as ace wraps, splints, braces etc.

Example: 1. The resident has a hand splint/brace, built up spoon, ace wrap, arm sling.

NOTE: Prior to staff completing task of application of ace wraps, splints, braces, the Licensed Health Professional Support must complete the training and competency validation of staff prior to performing the task, within 30 days evaluate the resident and reevaluate the resident at least quarterly thereafter.

Has Device(s)

Does Not Use Document if applicable.

Example: The resident has a splint for the left hand to prevent contractures after stroke but does not wear it.

Or

Needs Repair or Replacement Document if device needs to be repaired or replaced.

Example: 1. The resident has brace for the left arm but the Velcro straps are missing.

5. NUTRITION

Intent

To record how the resident consumes food and fluids to maintain adequate nutrition and hydration and identify any problems that would interfere with nutrition and hydration. Early problem recognition can help to ensure appropriate and timely nutritional interventions.

Definition

How the resident uses food and fluids for maintenance of a healthy body.

a. Oral

Document if the resident takes the food and liquids by mouth.

b. Tube (Type)

Document the use of the gastrostomy tube (feeding tube placed into the stomach through which the resident receives liquid feedings and medications).

Example: The resident has a gastrostomy tube (G- tube) and staff administers feedings every 4 hours as ordered by the physician.

NOTE: The Licensed Health Professional Support must complete the training and competency evaluation of the staff prior to the staff feeding the resident with tube feedings, evaluate the resident within 30 days, and at least quarterly thereafter.

c. Height

Document how tall the resident is. **Example:** 5'6" (five feet 6 inches)

d. Weight

Document how much the resident weighs in order to monitor nutrition and hydration over time. If the last recorded weight was more than one month ago or previous weight is not available, it is best to weigh in the facility during the 30 -day assessment period to obtain an initial weight. If the resident has been hospitalized the resident could have weight loss during the hospitalization from the “usual weight”. The resident could be receiving a diuretic (fluid pill) and weight could be different.

Example: The resident weighs 178 pounds.

Note: Abstracts of Interpretations of Adult Care Home Rules and Residents’ Rights, 1998, reads: “There should be at least an annually documented ‘baseline’ weight from which to determine weight loss or gain. Weight is to be recorded on the FL2 and will therefore provide the annual weight documentation. The administrator needs to assure that this information is on the FL2 or that a weight measurement and date is documented in the resident’s record at least annually.

On observation of unplanned weight loss or gain, or of conditions that would cause loss or gain such as a noticeable change in appetite/food consumption that continues for several days, a resident’s weight should be determined and recorded. There should be follow-up measurements and documentation within at least 30 days thereafter if an observable or measured decline or gain in weight continues.”

e. Dietary Restrictions

Document any dietary restrictions including a modified diet that is prepared to alter the consistency of food in order to help the resident eat the diet.

Example: Resident needs soft solids, pureed foods, ground meat, thickened liquids, limited fluid intake, document any food allergies such as no peanuts or peanut butter, has swallowing problem and needs to be fed by staff, etc.

NOTE: If resident has a swallowing problem and is fed by staff, the Licensed Health Professional Support must complete the training and competency evaluation of the staff prior to the staff assisting with feeding the resident, evaluate the resident within 30 days and at least quarterly thereafter.

f. Device(s) Needed

Document any type of specialized, altered or adaptive equipment to help resident to feed him/herself. Document any devices to assist the resident with eating. Document any specialized or altered feeding techniques, including positioning to prevent choking at meals, i.e. resident sitting upright facing forward. Any orders or feeding recommendations such as chin tucks, food placed on only one side of mouth etc.

Example: The resident uses a built up spoon, divided plate, plate guard, chin tuck to help with swallowing; resident is to be seated upright in geri chair facing forward for all meals.

NOTE: If resident has any assessed swallowing difficulties, the Licensed Health Professional Support must complete the training and competency validation of staff prior to performing the task, within 30 days evaluate the resident, and reevaluate the resident at least quarterly thereafter.

Has Device(s) Document if applicable Does not use

Example: 1. The resident has a built up spoon but does not use it. 2. The resident has a divided plate and a plate guard but does not use it.

or

Needs repair or replacement

Example: The built up spoon needs handle to be re-padded. The resident has used a built up spoon, plate guard/divided plate, but the built up spoon, plate guard/divided plate needs to be replaced.

6. RESPIRATION

Intent

To record how the resident breathes and to identify any problems the resident may have with breathing.

Definition

The act of breathing.

a. Normal

Document if the resident breathes without any difficulties or devices such as oxygen.

b. Well Established Tracheostomy

Document if the resident has a tracheostomy (an operation of cutting into the trachea or windpipe and inserting a tube to assist the resident to breathe). Well established means that the surgical opening has healed and there is only minimal cleaning of secretions around the area. The resident may complete self-care or require staff to complete the care.

Example: The resident has a tracheotomy since surgery 10 years ago. The resident cleans skin around the tracheostomy 2 to 3 times daily.

NOTE: The Licensed Health Professional Support must complete the training and competency validation of staff prior to performing the task, within 30 days evaluate the resident and reevaluate the resident at least quarterly thereafter.

c. Oxygen

Document if the resident uses continuous oxygen or intermittent oxygen by nasal cannula. Document if the resident uses an oxygen concentrator or tanks of oxygen. Does Home Health or respiratory therapist visit regularly to clean, change or adjust equipment?

Example: 1. The resident has oxygen concentrator and uses oxygen just at night due to shortness of breath when lying down. 2. The resident uses oxygen continuously. Oxygen concentrator in room and also uses portable oxygen when leaving the room. Respiratory therapy comes in monthly to assess the resident and the oxygen equipment.

NOTE: The Licensed Health Professional Support must complete the training and competency validation of staff prior to performing the task, within 30 days evaluate the resident and reevaluate the resident at least quarterly thereafter.

d. Shortness of Breath

Document if the resident has difficulty breathing. There may be many causes of the shortness of breath. This difficulty may be slight or severe. More effort is required for breathing, and the resident is more aware of the difficulty in breathing. This is a tiring and unpleasant sensation for the resident. With the increased difficulty in breathing the resident may become apprehensive and panicky.

Example: The resident has shortness of breath with any exertion, and cannot walk further than to the bedside commode.

e. Device(s) needed

Document any devices the resident has to assist with breathing. This may be oxygen concentrators or tanks, BiPAP (bilevel positive airway pressure) or CPAP (continuous positive airway pressure) machines, nebulizers etc.

Example: 1. The resident uses BiPAP during sleep for sleep apnea (moments during sleep when breathing stops). Home health in monthly to assess resident and equipment. Staff to document resident use or non-use of BiPAP at night. 2. The resident always sleeps with head of bed elevated and with 2 pillows to help with breathing.

NOTE: The Licensed Health Professional Support must complete the training and competency validation of staff prior to staff performing the task (using oxygen, BiPAP, bilevel positive airway pressure, or CPAP, continuous positive airway pressure, machines, nebulizers etc). Within 30 days the Licensed Health Professional Support must evaluate the resident and reevaluate the resident at least quarterly thereafter. The Licensed Health Professional Support should document any special positioning or instructions to aid the resident in breathing such as head of bed elevated, extra pillows, sleeping in semi-upright or up-right position.

Has Device(s) Document if applicable Does not use

Example: The resident has oxygen concentrator but refuses to use it.

or

Needs repair or replacement

Example: The resident has BiPAP unit but stated it is not currently working properly.

7. SKIN

Intent

To determine and record the condition of the resident's skin. Document the presence of pressure areas including ulcers (breaks or holes in the skin), skin tears, abrasions, burns, open sores (cancer sores), rashes, cuts, surgical wounds, etc after thoroughly observing the resident's body, including legs and feet, including the bottom of the feet. Additionally to document any skin treatments for current conditions as well as any protective or preventive skin care treatments the resident is currently receiving.

Definition

Skin is the tissue covering the outer body. For purposes of the resident assessment any surface area from the head to the feet and toes.

a. Normal

Document if the resident's skin is free of any pressure areas, open areas, rashes, skin tears, abrasions, burns, open sores, rashes, cuts, surgical wounds etc.

b. Pressure Areas

Document any area the resident has that is persistent area of skin redness (without a break in the skin) that may or may not disappear when the pressure is relieved.

Example: 1. The resident sits all day in the wheel chair. The lower buttocks are red and do not return to normal color when resident is returned to bed on his/her side. 2. The resident has a leg brace and there is a reddened area on the outer right ankle. The resident's right foot is swollen and the brace puts pressure on the ankle. The area returns to the normal color when the brace and shoe are removed.

c. Decubiti (Pressure Ulcer)

Document any skin ulcer/open lesion (sore). Decubiti (pressure sores) are defined as an area of skin redness (without a break in the skin) that does not disappear when the pressure is relieved **or** any open lesion (sore) caused by unrelieved pressure resulting in damage of underlying tissue. Decubiti (pressure sores) are usually over bony areas and are graded or staged to denote the degree of tissue damage observed. Observe resident's entire body including feet and legs.

Example: 1. Home Health visits twice weekly to assess and treat decubitus ulcer on the resident's left buttock. 2. Staff are to apply duoderm every 3rd day and as needed due to incontinence. 3. Home health visits daily to treat decubitus on resident's left heel and left buttocks. Staff are to keep the foot elevated on a pillow to keep pressure off the heel. Reposition resident every 2 hours to relieve pressure from the buttocks

NOTE: The Licensed Health Professional Support must complete the training and competency validation of staff, who provide treatment for decubiti, prior to performing the task, within 30 days evaluate the resident and reevaluate the resident at least quarterly thereafter.

d. Other

Document any other skin problem the resident may have. These may include skin tears, abrasions, burns, open sores (cancer sores), rashes, cuts, surgical wounds, etc.

Example: 1. The resident has a very red area with rash under both breasts. 2. The resident has 2 skin tears, one on the right elbow and one on the lower left leg.

e. Skin Care Needs

Document any skin care needs the resident has. This includes any prescribing practitioner's treatment orders or may also include the need for application of lotions or creams to protect the skin. Any other skin care needs such as frequent bathing, repositioning, or pressure relieving devices such as pads for the chair or pads for the bed, etc should also be documented.

Example: Home Health visits weekly to assess and treat decubitus ulcer on the resident's left buttock. Staff are to apply duoderm every 3rd day and as needed due to incontinence. 2. Home health visits daily to treat decubitus on resident's left heel. Staff are to keep the foot elevated on a pillow to keep pressure off the heel. 3. The resident had an alternating air mattress on the bed. 4. Staff are to wash under resident's breasts daily and apply physician ordered treatment. 5. Resident has very dry skin on feet and legs. Staff to assist resident in applying lotion to the feet and legs daily. 6. Resident likes to stay up all morning for activities. Return to bed after lunch and apply Vaseline to bottom, etc.

NOTE: The Licensed Health Professional Support must complete the training and competency validation of staff prior to performing the task for decubiti (pressure sore) care and if medications are applied the staff should have had medication administration skills validation form completed prior to staff applying treatment. Within 30 days the Licensed Health Professional Support must evaluate the resident who has decubiti (pressure sores) and at least quarterly thereafter.

8. BOWEL

Intent

To determine and record the resident's pattern of bowel continence.

Definition

The area of the body, through which, the resident eliminates solid waste (fecal) material. This area describes the resident's bowel pattern even with toileting plans, continence training programs, or appliances. It does not refer to the resident's ability to toilet self-e.g., the resident can receive extensive assistance in toileting and yet be continent, perhaps as a result of staff help. Incontinence means the resident has lost ability to control the bowel movements.

a. Normal

Document normal if the resident's bowel elimination is at least one bowel movement every three days. The resident has complete control of bowel function and is continent (including control achieved by care that involves, habit training, reminders, etc.).

b. Occasional Incontinence (less than daily)

Document if bowel incontinent episodes occur once a week.

Example: The resident is occasionally incontinent of bowel, usually this occurs if the resident has had to have a laxative due to constipation.

c. Daily Incontinence

Document if the resident has lost or has inadequate control of bowel elimination. Bowel incontinence is all the time or almost all the time.

Example: The resident is not able to notify staff when there is the need for a bowel movement. The resident has daily (twice weekly, etc.) incontinent bowel movements.

d. Ostomy

Document if the resident has a well established colostomy. A colostomy is a surgical opening made through the abdomen into the colon (large intestine) to the outside. This is how the resident eliminates solid waste (feces/bowel movements). Document if the resident had a well established ileostomy. An ileostomy is a surgical opening through the abdomen into the small intestine to the outside through which the solid waste (feces/bowel movement) is eliminated.

e. Type

Document the type of ostomy the residents has colostomy or ileostomy.

Example: 1.The resident has an ileostomy. 2. The resident has had a colostomy for 5 years as a result of surgery for an obstruction.

f. Self Care:

Yes or No

Document **YES** if the resident does own care of the ostomy.

NOTE: The Licensed Health Professional Support must evaluate the resident within 30 days and at least quarterly thereafter.

Document **NO** if resident does not care for the well -established ostomy.

NOTE: The Licensed Health Professional Support must complete the training and competency validation of staff prior to staff performing the task, within 30 days evaluate the resident and reevaluate the resident at least quarterly thereafter.

9. BLADDER

Intent

To determine and record the resident's pattern of bladder continence.

Definition

The area of the body, through which, the resident eliminates urine. This section describes the resident's bladder pattern even with toileting plans, continence training programs, or appliances. It does not refer to the resident's ability to toilet self-e.g., the resident can receive extensive assistance in toileting and yet be continent, perhaps as a result of staff help. Incontinence means the resident has lost the ability to control urination.

a. Normal

Document normal if the resident's bladder elimination is completely controlled and the resident is continent (including control achieved by care that involves prompted voiding, habit training, reminders, etc.).

b. Occasional Incontinence (less than daily)

Document if the resident's bladder incontinent episodes occur two or more times a week but not daily.

Example: The resident has incontinent episodes 2 to 3 times weekly, usually during sleep.

c. Daily Incontinence

Document if the resident has inadequate bladder control or has lost all bladder control. Bladder incontinent episodes occur multiple times daily.

Example: The resident is incontinent of urine and wears adult incontinence briefs at all times.

d. Catheter

Document if the resident has a tube in the bladder for eliminating urine.

Example: 1. The resident has an indwelling catheter. Staff is to wash around the catheter daily, position the catheter drainage bag below the bladder, and empty the drainage bag each shift. 2. Resident has an indwelling catheter but does self care of the catheter and the drainage bag. Home Health in monthly to change catheter.

NOTE: The Licensed Health Professional Support must complete the training and competency validation of staff prior to performing the task of positioning, cleaning and emptying drainage from the catheter, within 30 days evaluate the resident and reevaluate the resident at least quarterly thereafter.

e. Self Care

Document if the resident takes care of the catheter.

Document **YES** if the resident does own care of the catheter.

NOTE: The Licensed Health Professional Support must evaluate the resident within 30 days and at least quarterly thereafter.

Document **NO** if resident does not care for the catheter.

NOTE: The Licensed Health Professional Support must complete the training and competency validation of staff prior to performing the positioning, cleaning and emptying the drainage bag, within 30 days evaluate the resident and reevaluate the resident at least quarterly thereafter.

10. ORIENTATION

Intent

To determine and record the resident's ability to remember, think coherently, and organize daily self-care activities. Ask resident his name, where he lived, name of facility, day of the week, year etc.

Definition

This means the resident's awareness of the real world in relationship to him/herself, and awareness to person, place and time. This also means the ability to comprehend and adjust one's self in the environment with regard to identity of persons, location, time and situation.

a. Oriented

The resident's decisions in organizing daily routine and making decisions are consistent, reasonable, and organized reflecting lifestyle, culture and values.

b. Sometimes Disoriented

Document if the resident is confused at times and unaware of person, place or time. At times does not think coherently, and is unable to organize daily self-care routines such as bathing, dressing grooming, etc. The resident's decisions are poor requires reminders, cues, supervision in planning, organizing Activities of Daily Living (ADL).

Example: The resident is usually oriented to person, place and time but occasionally will become disoriented in the early evening. The resident forgets she is in adult care home.

c. Always Disoriented

Document if the resident is not aware of person, place or time, cannot think coherently or organize daily self-care activities such as bathing, dressing grooming, etc. Decisions making is severely impaired: the resident never or rarely makes decisions about activities and self care.

Example: 1. The resident is not aware of who he is, where he is, or time. 2. The resident rides in wheel chair through home looking for children. The resident is able to feed himself but unable to meet any of the other ADL tasks.

11. MEMORY

Intent

To determine and record the resident's memory/recall within the environment of the adult care home. A resident may have social graces and respond to staff and others with a look of recognition yet have no idea who they are.

Definition

The mental ability to retain and recall past experiences, remembering recent and past events.

a. Adequate

Document if the resident has sufficient memory to recall past experiences. Document resident is able to identify self, where he/she is (able to identify that he/she is currently living in an adult care home/home for older people), and able to identify the current day/month/year/season etc. The resident is able to locate own room, able to distinguish staff from family members, strangers, visitors, and other residents.

Example: 1. Resident is oriented to person, place and time can find his/her room. 2. The resident knows staff from family members, other residents and visitors.

b. Forgetful-Needs Reminding

Document if the resident does not remember past experiences without being given cues or prompted.

Example: 1. The resident has to be reminded to change into bedclothes. 2. The resident has to be reminded to go to the dining room to eat.

c. Significant Loss-Must Be Directed

Document if the resident has lost most of memory/recall of past experiences. The resident is unable to remember and complete ADL tasks and must be directed by staff or have staff complete task for the resident.

Example: 1. The resident does not leave the room unless going with staff. 2. The resident will complete some of the ADL tasks with assistance from staff, e.g. will wash his face and hands but staff must complete the rest of the bath and dress the resident. The resident can button the shirt after staff puts the shirt on. 3. The resident does not remember where the dining room is and must be taken to the dining room for each meal.

12. VISION

Intent

To document the resident's visual abilities and limitations, including eye pain and irritation (redness), assuming adequate lighting and assistance of visual appliances, if used.

Definition

How the resident sees; whether the resident experiences difficulties related to disease (e.g., cataracts, glaucoma, pain, dryness, redness etc.). Functional impairment may diminish the resident's ability to perform everyday activities (bathing, dressing, eating, using the toilet, walking, getting around inside and outside the facility) and participate in hobbies, or leisure activities (e.g., reading or watching television, using the computer etc.).

a. Adequate for Daily Activities

Document the resident's ability to see close objects in adequate lighting, using the resident's customary visual appliances for close vision (e.g., glasses contact lens, magnifying glass, etc.). The resident sees fine detail, including regular print in newspapers/books.

Example: The resident is able to read the newspaper and books with glasses using the bedside table lamp (or overhead room light).

b. Limited (Sees Large Objects)

Document the resident's ability to see close objects in adequate lighting, using the resident's customary visual appliances for close vision (e.g., eyeglasses, contact lens, magnifying glass, etc.). The resident has limited vision, is not able to see newspaper print, but can identify objects in the environment.

Example: The resident is unable to read the newspaper but can see people and objects well enough to walk inside of the adult care home. Resident is unable to walk outside without assistance.

c. Very Limited (Blind); Explain

Document if the resident has no vision or may see only light colors, or shapes; eyes do not appear to follow objects (especially people walking by). The resident may have limited or no sight in one or both eyes.

Example: 1. The resident is blind. 2. The resident can see large objects with the right eye only. The resident has no vision in the left eye. Place night table on the right side of the bed.

d. Uses: Glasses, Contact lens, Needs Repair or Replacement

Document if the resident uses any of these visual appliances regularly. Document if the visual appliances need repair or replacement.

Example: 1. The resident has glasses and uses them daily. The ear -piece on the right side is broken and needs to be repaired. 2. The resident has glasses but the lenses are broken and need replacement.

e. Comments:

Document any information about the resident's visual abilities or need of visual aides to see in this space.

Example: 1. The resident has glasses and uses them daily. The ear -piece on the right side is broken and needs to be repaired. 2. The resident refuses to wear the glasses and states he cannot see with them.

13. HEARING

Intent

To document the resident's ability to hear (or hear with hearing aides, if they are used), understand, and communicate with others. To document any problems the resident may have with the ability to hear.

Definition

To perceive sounds by the ear.

a. Adequate for Daily Activities.

Document if the resident hears all normal conversational speech, including when using the telephone, watching television, and engaged in group activities.

Example: Resident has no problems hearing.

b. Hears Loud Sounds/Voices

Document if the resident hears only loud sounds or voices.

Example: 1. Resident has problems hearing. Staff must speak loud and distinctly. 2. The resident does not like group activities, as he does not hear what the members of the group are saying. 3. Although hearing deficient, the resident compensates when the speaker adjusts tonal quality (speaks loudly) and speaks distinctly; or the resident can hear only when speaker's face is clearly visible or requires the use of a hearing-enhanced telephone.

c. Very Limited (Deaf); Explain

Document if the resident is highly impaired or there is absence of useful hearing. The resident hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly or is positioned face to face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

Example: 1. The resident is totally deaf for the past 10 years. 2. The resident is able to hear some sounds if you speak loudly and face to face.

d. Uses hearing Aid(s)

Document if the resident uses hearing aid(s).

Example: 1. The resident has hearing aid for the left ear. The resident can hear with the use of hearing aid if staff speak distinctly and face the resident. Without the hearing aid the resident does not hear staff speaking to him. 2. The resident has hearing aids but refuses to wear them.

e. Needs Repair or Replacement

Document if the resident's hearing aid(s) needs to be repaired or replaced.

Example: 1. The resident has hearing aid for the left ear. The battery is not working and the resident needs a new one. 2. The resident has lost hearing aid and needs a new one.

f. Comments:

Document any information about the resident's hearing abilities or need of hearing aid(s) in this space.

Example: 1. The resident has hearing aid for the left ear and uses it daily. The hearing aid is broken and needs to be repaired. 2. The resident refuses to wear the hearing aide and he cannot hear anything without it.

14. SPEECH/COMMUNICATION METHOD

Intent

To document the resident's ability to speak and communicate with others (using assistive devices, e.g., communication board). To document any problems the resident may have with the ability to communicate.

Definition

The expression of words, how the resident makes his or her needs and wishes known to others, use of verbal and non-verbal gestures or behaviors to make wants and needs known.

a. Normal

Document if the resident uses speech to communicate with others. There is no problem with communication.

Example: The resident speaks clearly and has no problem communicating what he wants or needs of others.

b. Slurred

Document if the resident uses speech but slurred or mumbles words.

Example: The resident can speak but some of the words are slurred/mumbled and it is difficult to understand what the resident is saying.

c. Weak

Document if the resident uses speech to communicate, but there is a lack of strength or clarity making it difficult to understand what the resident is trying to communicate.

Example: 1. The resident can speak but only says a few words at a time. It is not easy to hear due the resident's inability to project the words.

d. Other Impediments

Document if the resident has any other impediments to his or her speech, e.g., stuttering, cleft lip or cleft pallet, esophageal speech (taking in air through to esophagus gradually "belching" the air to say words), etc.

RESIDENT ASSESSMENT SELF-INSTRUCTION MANUAL

Example: 1. The resident stutters but can make his wants and needs known to others. 2. Resident has a cleft lip making it difficult to understand the resident's speech but if the resident takes time and staff is patient the resident can make wants and needs known.

e. No speech

Document if there is absence of words or no speech from the resident.

Example: The resident has no speech due to stroke.

f. Gestures

Document if the resident uses movements or non-verbal expressions rather than speech to make wants and needs known including actions such as pointing, facial expressions, nodding head twice for yes and once for no, squeezing another's hand in the same manner. Sounds may include grunting, banging, ringing a bell, etc.

Example: 1. The resident grunts and points to objects and people to get wants or needs communicated to others. 2. The resident will take staff's hand and leads to what she or he wants or needs.

g. Sign Language

Document the resident's use of hands to spell words or phrases. This is a highly developed language, which takes a long period of time to learn. The resident or family may teach staff certain hand signs to help get the resident's wants and needs met.

Example: The resident has been deaf since age 20. The resident uses sign language to communicate with his family. The resident and family are teaching the staff some words to help the resident meet his needs. The resident also writes out what he wants or needs.

h. Writing

Document if the resident writes notes to communicate with others.

Example: The resident writes on a pad what she needs and wants from others.

i. Foreign Language Only

Document if the resident speaks only a foreign language.

Example: The resident speaks only Spanish. The resident does not speak or understand English.

j. Other

Document if the resident uses flash cards, communication board or various electronic assistive (electrolarynx) devices to communicate his or her wants and needs to others.

Example: The resident uses a homemade board with words and phrases to communicate want and needs to others. The resident has an electrolarynx, which is a sound device that is held against the neck while it produces sounds.

k. None

Document if there is no vocal communication. Resident may hear sounds but does not have any speech, gestures, or sounds.

Example: The resident has no verbal nor non-verbal expressions to communication want or needs to others.

l. Assistive Devices

Document if the resident has any communication devices such as electrolarynx, communication board, flash cards, etc. **Example:** 1. The resident has flash cards but they are worn and difficult to use. 2. The resident has a homemade communication board but it is torn and needs to be replaced.

Has Device(s) Document if applicable Does not use

Example: The resident has a communication board but refuses to use it.
or

Needs repair or replacement

Example: Resident has electrolarynx and it is not currently working properly.

15. CARE PLAN

If the assessment indicates the resident has medically related personal care needs requiring assistance, show the plan for providing care. Check off the days of the week each ADL task is performed and rate each ADL task based on the following performance codes: 0-Independent 1-Supervision 2-Limited Assistance 3-Extensive Assistance 4-Totally Dependent (Please refer to the Adult Care Home Program Manual for more detail on each performance code or refer to the performance codes listed below.) NOTE: This statement is documented on the care plan.

ACTIVITIES OF DAILY LIVING (ADL)

Describe the specific type of assistance needed by the resident and provided by the staff, next to each ADL:

Refer to the DMA-3050R for the care plan, day, and performance code grid and document findings from the Resident Assessment.

PERFORMANCE CODES (EFFECTIVE 01-01-2000) (From Division of Medical Assistance)

0 - INDEPENDENT

The resident performs the activity without help, or may require minimal supervision or assistance only once or twice during a week. For example the resident who usually transfers on and off the toilet unassisted may need a staff member to stand by the toilet room door after especially tiring day away from the facility.

1-SUPERVISION

The resident can perform the activity when a staff member provides oversight, encouragement, and prompting, or with supervision plus some physical assistance only once or twice during a week. For example, an incontinent resident may be able to use the toilet room unassisted if regularly reminded to do so. Another example would be a resident who bathes daily with supervision and encouragement. The resident is able to wash himself completely with oversight from a staff member. Once or twice during a week, he may need a staff member to hold his hand and provide some support while he gets in and out of the tub.

2-LIMITED ASSISTANCE

The resident is highly involved in performing the activity for him/herself. The resident also requires help from staff in guided maneuvering of limbs or other non-weight bearing assistance three or more times during a week, or limited assistance plus more physical assistance only once or twice during a week. For example a resident may need a staff member to hold his shirt and physically guide his hand to the sleeve opening, but the resident can push his arm through the sleeve. Another example would be a resident who walks independently throughout the facility during the daytime, but wants staff to hold his hand and guide him while walking to the toilet room during the night.

3-EXTENSIVE ASSISTANCE

The resident can perform part of the activity for him/herself. The resident also requires either weight-bearing support from staff three or more times during a week, or staff member to perform the task for him/her (three or more times) during part (but not all) of the week. The following are examples: (a) on three occasions in one week, the resident needed a staff member to lean against and steady him while transferring from standing with a walker into a bed or chair; (b) a resident feeds himself breakfast and lunch with staff supervision; however due to fatigue the resident must be fed dinner by a staff member daily; (c) resident can walk within a room but requires weight-bearing assistance to walk outside of the room; (d) a resident is able to propel self in a wheelchair, however due to fatigue the resident requires a staff member to push the wheelchair three or more times a week; (e) resident is able to use an assistive device(s) (i.e. walker, cane, rollator walker), however he/she requires a staff member to provide weight-bearing assistance three or more times a week.

4-TOTALLY DEPENDENT

A staff member must complete the task for the resident at all times. For example, a resident who cannot do any part of dressing for himself, and requires total assistance with dressing from the staff. Another example is a resident who receives tube feeding administered completely by the staff. Another example would be a resident who is unable to walk, with or without, an assistive device(s), or a resident who is unable to propel self in a wheelchair and requires total assistance from the staff.

OTHER

(Include Licensed Health Professional Support (LHPS) Personal Care tasks, as listed in Rule10A NCAC 13F .0903 for Adult Care Homes and 10A NCAC 13G .0903 for Family Care Homes)

Example: 1. The resident receives FSBS (finger stick blood sugar) 4 times daily and sliding scale insulin based on the MD orders. 2. The resident wears TED hose, on each morning and off at night during sleep. 3. The resident is non-ambulatory and is transferred from bed to chair with a hooyer lift, or with two staff, etc. 4. The resident receives oxygen 2 liters per minute by nasal cannula as needed. The resident uses the oxygen approximately 2 to 4 times weekly usually at night.

ASSESSOR CERTIFICATION

“I certify that I have completed the above assessment of the resident’s condition. I found the resident’s needs personal care services due to the resident’s medical condition. I have developed the care plan to meet those needs.”

Resident/responsible party has received education on Medical Care Decisions and Advance Directives prior to admission. Document if the above was completed.

Print assessor’s name, signature and date at the completion of the Resident Assessment.

PHYSICIAN AUTHORIZATION

“I certify that the resident is under my care and has a medical diagnosis with associated physical/mental limitations warranting the provision of the personal care services in the above care plan.”

The physician may document that **the resident may take therapeutic leave as needed.**

Physician to print name, signature and date. **(NOTE: The care plan is to be signed by the resident’s physician within 15 calendar days of completion of the Resident Assessment.)**

Attention: Adult Care Home Providers (North Carolina Medicaid Bulletin November 2000)

P olicy for Correcting the DMA-3050

The Division of Medical Assistance (DMA) has implemented a policy to allow Adult Care Home (ACH) providers to make limited corrections to the ACH assessment and care plan form (DMA-3050).

Acceptable Format

Corrections to the DMA-3050 are acceptable when the incorrect information is lined through once with the new information noted, initialed, and dated by the assessor. Example: supervise toileting, assist on and off toilet.

Conditions

- The crossed out information must be legible.
- The corrected information must be dated before or on the date the assessor signs the DMA-3050.
- The corrections must be initialed and dated by the assessor.

**Bill Hottel, Adult Care Home Services Unit, Medical Policy Section
DMA, 919-857-4020**

**RESIDENT ASSESSMENT SELF-INSTRUCTIONAL MANUAL
FOR ADULT CARE HOMES**

AS THE STAFF DESIGNATED BY THE ADMINISTRATOR TO PERFORM RESIDENT ASSESSMENTS, I CERTIFY THAT I HAVE COMPLETED THE RESIDENT ASSESSMENT SELF-INSTRUCTIONAL MANUAL FOR ADULT CARE HOMES PRIOR TO PERFORMING THE REQUIRED RESIDENT ASSESSMENTS.

PRINT NAME _____

SIGNATURE _____

DATE _____

NOTE: Retain in facility files.