Winter Growth
Where friendships grow and care is extraordinary

Respite Care
Application & Information Sheet

Date:_____

Name: _____ Telephone: _____

Address_____

Social Security Number_____ Date of Birth_____

Insurance Name and Number_____

Medicare_____ Medicaid_____

Person with Authority

Check if: ❑ **Power of Attorney** ❑ **DPoA Healthcare** ❑ **Guardian**

Name_____ Address_____

Number: (H)_____ (W) _____ (C) _____

Email address:_____

Location during Respite Stay_____

Contact number during Respite Stay_____

Person to be notified in Emergency if unable to reach person with authority:

Name_____ Relationship_____

Number: (H)_____ (W) _____ (C) _____

Attending Physician

Name_____ Phone_____

Address_____

Presenting Problems:_____

_____

_____

Permission to leave building during visit

While _____ is staying in Respite Care, I authorize the following people to take the client out of the building during the day:_____;
(name)

_____; _____.

Take the client out of the building overnight:_____.

By signing this application, in addition to the above referenced people, I can verbally authorize other individuals to take the respite client out of the building by speaking to the Assisted Living Manager or designated representative and that such authorization will be documented.

Allergies

Food:_____

Medicines:_____

Other:_____

Please give specific information in order to better serve the respite visitor.

Medications

How are they usually taken? With water, with applesauce, crushed? : _____

_____

Bathing

How often?:_____ Specify assistance needed:_____

_____

Eating

Specify assistance needed (i.e. cuing, physical assistance, lidded cup, special utensils, etc.):

_____

_____

Dressing (Specify assistance needed):

_____

_____

Restroom

Assistance needed finding the restroom? ❑ Yes ❑ No

Assistance needed in the restroom? ❑ Yes ❑ No

Specify assistance needed:_____

_____

Uses the bathroom during the night? ❑ Yes ❑ No Frequency?_____

Are they likely to be disoriented? ❑ Yes ❑ No

Dental Care

Dentures? ❑ Yes ❑ No Soak Teeth? ❑ Yes ❑ No Brushing assistance needed? ❑ Yes ❑ No

Behavior

Does this person wander? ❑ Yes ❑ No

Might they try to leave the building? ❑ Yes ❑ No

Would they pace within the building? ❑ Yes ❑ No

Does this person hide personal items and then believe they are lost or stolen? ❑ Yes ❑ No

Could this person become combative under stress? ❑ Yes ❑ No

Please list any behavior problems and things that may help:

Problem_____What helps?_____

Problem_____What helps? _____

Problem_____What helps? _____

Daily Routine

Morning:

What is the approximate time this person wakes up in the morning?_____

Are they easy/difficult to wake? ❑ Yes ❑ No

Explain:_____

Evening:

Preferred evening activities (e.g. televison, reading,crossword,etc…)

_____

What is the approximate time this person goes to bed in the evening?_____

Meals:

Favorite Foods:_____

Strong Dislikes_____

Special Considerations:_____

_____

_____

Representative Signature:_____Date:_____

Winter Growth, Inc.
Short-Term Resident Rental & Service Agreement

The terms of this "Agreement" between Winter Growth Assisted Housing (hereinafter called "Provider", "we", "our") and _____(thereafter called "Resident", "you", "your") shall become effective as of _____ and will remain effective until either party indicates (in writing) to the other of the desire for a change.

Winter Growth, Inc. possesses a valid license to operate an Assisted Living Facility issued by the Office of Health Care Quality pursuant to Code of Maryland Regulations 10.07.14 (COMAR 10.07.14). The Agreement incorporates the provisions required by the State of Maryland pursuant to COMAR 10.07.14. The Provider and the State of Maryland strongly encourage you to have your attorney or other authorized representative review this agreement before you sign it.

Whereas the parties hereto (the "Parties") desire to set forth the terms and conditions for Resident's use of Provider's facilities (the "Facilities") located at (initial selected site):

_____ Montgomery 18110 Prince Philip Drive, Olney, MD 20832

_____ Howard 5460 Ruth Keeton Way, Columbia, MD 21044

NOW, THEREFORE, in consideration of the foregoing recitals, the mutual promises of the Parties set forth herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties agree as follows:

Resident's Representative

1. The authority of the Resident's Representative (the "Representative") to make decisions on behalf of the Resident shall be recognized by Winter Growth if appropriate documentation is received designating:

a. A guardian of the person under Estates and Trusts Article, §13-705, Annotated Code of Maryland;

b. A guardian of the property under Estates and Trusts Article, §13-201, Annotated Code of Maryland;

c. An advance directive that meets the requirements of Health-General Article, §5-602, Annotated Code of Maryland;

d. A surrogate decision maker with authority under Health-General Article, §5-605,

Annotated Code of Maryland;.

e. A power of attorney that meets the requirements of Estates and Trusts Article, §13-601, Annotated Code of Maryland;

f. A representative payee or other similar fiduciary; or

g. Any other person, if that person was designated by a resident who was competent at the time of designation, and the resident or representative has provided the assisted living program with documentation of the designation.

2. Winter Growth shall document in the Resident's record the name of the person, if any, with the authority identified above or include the documentation in the record.

3. Winter Growth may not recognize the authority of a Resident's Representative if the Representative attempts to exceed the authority:

a. Stated in the instrument that grants the representative authority; or

b. Established by State law.

4. List the Individual(s) to be contacted in the event of an emergency(use a separate piece of paper for additional contacts):

1st Person to be contacted Relationship Phone #s(indicate C-cell/H-home/W-work)

2nd Person to be contacted Relationship Phone #s(indicate C-cell/H-home/W-work)

Services and Accommodations

Winter Growth will provide the following services/amenities:

1. **Accommodations(All private rooms)**-We will provide a private room furnished with a bed and two pillows; lamp, comfortable chair, at least a two drawer chest of drawers, night stand with a drawer, a mirror and bed and bath linens. You are entitled to use your own furniture and/or linens, however, all upholstered furniture MUST be certified clear of dirt and pests by an authorized cleaner and is subject to inspection. In addition, you agree that you are responsible for the maintenance and repair of any personal belongings you bring to the Center. All mattresses MUST be new in the original packaging or you shall provide proof of purchases within the past thirty (30) days. For safety and sanitation reasons, the number and size of furniture pieces and personal items will be limited. Furniture must be in good repair for the above reasons as well. You will be assigned an open bedroom at the

time of your visit. You are also entitled to use and enjoy with all other residents the common areas of the Center.

2. **Staffing**-We will provide 24 hour supervision, seven days a week.

3. **Medication Management**-Our staff will supervise and/or administer the taking of medications per doctor's orders.

4. **Personal Care Assistance**- We will provide grooming, bathing, dressing, transferring, eating, and toileting as needed. **Please note:** Winter Growth's housing program is not a medical service. Nursing care is not available during hours that the Medical Day Care program is not in operation. Therefore, we are not able to serve those requiring this care on a twenty-four hour basis.

5. **Personal Toiletries**-Unless mandated by Maryland State regulations you are responsible to provide all necessary toiletries to include shampoo, deodorant, soap, and body wash.

6. **Meals**-We will serve three nutritionally balanced meals daily. Snacks are available 24 hours a day upon request. A five-week menu plan will be submitted to a Maryland approved nutritionist or dietitian for review and approval as deemed necessary.

7. **Utilities**-The cost of all utilities (gas, electric, water) is included. You are responsible for paying any other utility charges including, but not limited to, telephone, internet, and cable service. Access to a non-private phone for personal calls will be provided.

8. **Laundry and Linen Service**-We will launder your personal belongings and bed linens at least once a week.

9. **Housekeeping**-We will clean all areas used by residents at least weekly.

10. **Fire Protection**-We will establish a fire escape plan. The Center is provided with a sprinkler system, smoke detectors and fire extinguishers. Every effort is made to keep the center free of hazards. Fire extinguishers are checked monthly and fire drills are held quarterly. Exterior doors have an electronic locking system that allows them to be locked and released automatically with the fire alarm or a power outage.

ALL RESIDENTS MUST ABIDE BY THE PROVIDER'S SAFETY GUIDELINES. THE PROVIDER WILL NOT BE LIABLE FOR ACCIDENTS CAUSED BY A RESIDENT'S REFUSAL TO ACCEPT THE SAFETY GUIDELINES GIVEN BY THE PROVIDER. For the safety of all, smoking is not permitted inside the building including private rooms.

11. **Incident Reports**-We will keep a written account and record of each accident, illness, or any incident related to resident's health and well-being. We will also report any infectious disease, food poisoning, and dysentery to the appropriate government agency.

12. **Confidentiality**-We will provide for confidentiality of Resident files.

13. **Emergency**-In the event of an emergency situation, which could make it unsafe or unhealthy to continue to provide services at the facility, Winter Growth will make arrangements to temporarily relocate you to another one of its three facilities: 5460 Ruth Keeton Way, Columbia, Maryland 21044 / 5466 Ruth Keeton Way, Columbia, Maryland 21044 / 18110 Prince Philip Drive, Olney, MD 20832 or to a facility in which Winter Growth has a current Transfer Agreement.

Services Available But Not Included In Your Fees

1. **Therapeutic Services**-Physical Therapy, Speech Therapy and Occupational Therapy are available to you at your request. You are responsible for any fees associated with these services.

2. **Health Care Services**-You will be billed directly by the service provider.

Resident's Responsibilities

The Resident and/or Representative will:

1. **Personal Items**-***Winter Growth is not liable for any missing or damaged personal items.*** You must purchase clothing, toiletries, and necessary special personal items, such as incontinent pads, nutritional supplements, etc.

2. **Fees**-You and/or your Representative are responsible to pay a deposit PRIOR to your arrival and service fees when billed.

3. **Finances**-You or your Representative will handle the finances of the resident including the payments of monthly fees; co-payments for physician visits, hospitalizations, and rehabilitative therapies; and for the purchase or rental of essential or desired equipment and supplies. In addition, you or your Representative will arrange for, contract and pay for services not covered by the Resident agreement and purchase durable medical equipment as prescribed by the resident's physician. Winter Growth will provide assistance if requested in locating vendors.

4. **Transportation**-The Resident's Representative and/or family member **is responsible to provide transportation** to medical appointments and after discharge from a hospital or rehabilitation center. Winter Growth's community transportation may be available to assist with transportation. The family and/or Representative must contact the transportation department to make all arrangements. Transportation services are always **subject to availability and current rates will apply**.

5. **Emergency Room Visits**-If the Resident is transported to the hospital due to a medical emergency, a family member or the Representative will need to meet the Resident at the hospital. Winter Growth staff cannot leave the premises to be with the Resident in the hospital.

6. **Health Assessment**- The Representative shall assist Winter Growth staff in obtaining all required paperwork from the Resident's physician and other health care practitioners both upon admission and ongoing as requested by Winter Growth staff. You will accept regular medical supervision and take medication as prescribed by the Resident's physician or inform the physician of the intent to refuse so that staff may receive instructions from the physician.

7. **Medications**-You or your Representative will ensure all prescription medications are received in a timely manner to the facility.

8. **Right of Entry**-To ensure your safety and well-being, the staff has the right to enter your room; however, the staff will make every effort to be respectful of your privacy and will always knock before entering. **Please note:** if locks are deemed appropriate for the resident's room based on cognitive ability the Winter Growth staff SHALL have access to a key to the resident's room.

9. **Representatives/Advance Directives**-You or your Representative will provide us with accurate, complete and current information about yourself, authorized representatives, and health care providers, including but not limited to addresses, phone numbers, and other means of contact. You will also provide us with copies of any power of attorney, guardianship, living will, or conservator documents, or other legal documents relating to the making of health or financial decisions or decision-makers. You further agree to immediately notify us of changes relating to the information stated above.

10. **Records**-You acknowledge that we are licensed by the State of Maryland and will provide records for inspection by any regulatory officials.

11. **Visitors**-You have a right to have guests, however, all guests must visit during hours that will not disturb other residents. In addition, overnight guests are not permitted unless approved by Administration.

Complaint and Grievance Procedures

A copy of the resident's rights is attached and incorporated by reference into the agreement. This facility will honor and respect the Resident's rights.

All residents and Representatives have the right to make suggestions, register complaints or present grievances about the care or services provided including concerns about services being unfairly denied, not provided equally, or provided in a sub-standard manner. Please address these concerns to Cyndi Rogers, Executive Director at (410) 964-9616. If you are not satisfied with the response from either individuals, you may contact the Chairman of the Board at (301) 774-7501. You will receive a response to your concern(s) within 5 business days.

Should you be dissatisfied with the response or you do not receive a response, for those in Montgomery County you may contact the Office on Aging at (240) 777-3000 or send a written complaint to: DHMH, Licensure and Regulatory Services, 255 Rockville Pike, Suite

100, 1st Flr, Rockville, MD, 20850. In Howard County contact the Office on Aging at (410) 313-6410 or send a written complaint to: 6751 Columbia Gateway Drive, #2, Columbia, MD 21046. You can also contact the State Assisted Living Complaint Unit at 410-402-8217 or 1-877-402-8221 or send a written complaint to: MD DHMH, OHCQ, 7120 Samuel Morse Drive 2nd Floor, Columbia, MD 20146-3422.

Fees

The fee for Short-Term residential care at Winter Growth's Montgomery Center is $275.00. ***Fees are subject to change***. You will receive notice of any fee increase. A signed Addendum acknowledging any increase is preferred. However, if you fail to return the addendum and continue to use our services and pay the increased amount then Winter Growth will understand that you have agreed to the increase.

Winter Growth is entirely financially dependent on fees paid for our services. As a non-profit, our fees are set as low as possible while maintaining high quality of care. There is no accommodation in our fees to carry accounts past their due dates. **For Winter Growth to maintain financial viability, it is critical that any fees billed are submitted no later than the 15th day of the month following the month in which services were provided.**

A late fee of $25 will be assessed for payments not received by the due date. Should collection expenses be incurred by Winter Growth for unpaid accounts, this expense will be due from the resident as well as the past due fees and penalties.

Payment of Rental Fees

I _____ as the Representative of the Resident agree to have all charges incurred by the Resident that have not been paid in advance submitted within twenty-five days after the end of each calendar month.

This agreement constitutes the entire agreement between the Resident and Winter Growth, Inc.

_____ _____

Representative Signature **Date**

_____ _____

Winter Growth Representative & Title **Date**

Attachments: Housing Rules and Level of Care Fee Schedule, Residents Rights, Staffing Disclosure

Resident's Rights

A resident of an assisted living program has the right to:

1. Be treated with consideration, respect, and full recognition of the resident's human dignity and individuality;
2. Receive treatment, care, and services that are adequate, appropriate, and in compliance with relevant State, local, and federal laws and regulations;
3. Privacy, including the right to have a staff member knock on the resident's door before entering unless the staff member knows that the resident is asleep;
4. Be free from mental, verbal, sexual, and physical abuse, neglect, involuntary seclusion, and exploitation;
5. Be free from physical and chemical restraints;
6. Confidentiality;
7. Manage personal financial affairs;
8. Maintain legal counsel;
9. Attend or not attend religious services as the resident chooses, and receive visits from members of the clergy;
10. Possess and use personal clothing and other personal effects to a reasonable extent, and to have reasonable security for those effects in accordance with the assisted living program's security policy;
11. Determine dress, hair style, or other personal effects according to individual preference, unless the personal hygiene of a resident is compromised;
12. Meet or visit privately with any individual the resident chooses, subject to reasonable restrictions on visiting hours and places, which shall be posted by the assisted living manager;
13. Make suggestions, complaints, or present grievances on behalf of the resident, or others, to the assisted living manager, government agencies, or other persons without threat or fear of retaliation;
14. Receive a prompt response, through an established complaint or grievance procedure, to any complaints, suggestions, or grievances the resident may have;
15. Have access to the procedures for making complaints to:
    (a) The Long-Term Care Ombudsman Program of the Department of Aging as set forth in COMAR 32.03.02,
    (b) The adult protective services of the local department of social services,
    (c) The Office of Health Care Quality of the Department, and
    (d) The protection and advocacy agencies;
16. Have access to writing instruments, stationery, and postage;
17. Receive a prompt reasonable response from an assisted living manager or staff to a personal request of the resident;
18. Receive and send correspondence without delay, and without the correspondence being opened, censored, controlled, or restricted, except on request of the resident, or written request of the resident's representative;
19. Receive notice before the resident's roommate is changed and, to the extent possible, have input into the choice of roommate;
20. Have reasonable access to the private use of a common use telephone within the facility;
21. Participate in planning the resident's service plan and medical treatment;
22. Refuse treatment after the possible consequences of refusing treatment are fully explained; and
23. Retain personal clothing and possessions as space permits with the understanding that the assisted living program may limit the number of personal possessions retained at the facility for the health and safety of other residents.
24. Share a room with a spouse if it “is feasible to do so and not medically contraindicated” and both spouses agree to this arrangement.
25. Not be assigned to do any work for the assisted living program.

If you feel that these Rights are not being honored, please contact the Howard County Long-Term Care Ombudsman Program at 410-313-6423, the Maryland Department of Aging at 1-800-AGE-DIAL, or the Office of Health Care Quality at 410-402-8217.

Attachment #1

Winter Growth

RESIDENT ASSESSMENT TOOL

To be completed by a physician, certified nurse practitioner, registered nurse, or physician assistant within 30 days prior to admission, at least annually, & within 48 hours after a significant change of condition & each nonroutine hospitalization.

If this form is completed in its entirety by the Delegating Nurse/Case Manager (DN/CM), there is no need to complete an additional nursing assessment. If anyone other than the DN/CM completes this form, the DN/CM must document their assessment on a separate form.

An assisted living program may not provide services to an individual who at the time of initial admission requires: (1) More than intermittent nursing care; (2) Treatment of stage three or stage four skin ulcers; (3) Ventilator services; (4) Skilled monitoring, testing, & aggressive adjustment of medications & treatments where there is the presence of, or risk for, a fluctuating acute condition; (5) Monitoring for a chronic medical condition that is not controllable through readily available medications & treatments; or (6) Treatment for a disease or condition which requires more than contact isolation.
An exception is provided for residents who are under the care of a licensed general hospice program.

Resident: _____ DOB: _____ Assessment Date: _____

Primary Spoken Language: _____ ☐ Male ☐ Female

Allergies (drug, food, & environmental):

Current Medical & Mental Health Diagnoses:

Past Medical & Mental Health History:

Airborne Communicable Disease.

Test to verify the resident is free from active TB *(completed no more than 1 year prior to admission)*:

PPD Date: _____ Result: _____ mm OR Chest X-Ray Date: _____ Result: _____

Does the resident have any active reportable airborne communicable diseases? ☐ No ☐ Yes

(specify)

Vital Signs.

BP:_____ /_____ Pulse:_____ Resp:____ T:_____°F Height:____ft____in Weight:_____lbs

Pain? ☐ No ☐ Yes (specify site, cause, & treatment)

Resident: _____ DOB: _____ Assessment Date: _____

Neuro. Alert & oriented to: ☐ Person ☐ Place ☐ Time

Answers questions: ☐ Readily ☐ Slowly ☐ Inappropriately ☐ No Response

Memory: ☐ Adequate ☐ Forgetful - needs reminders ☐ Significant loss - must be directed

Is there evidence of dementia? ☐ No ☐ Yes (cause) _____

Cognitive status exam completed? ☐ No ☐ Yes (results) _____

Sensation: ☐ Intact ☐ Diminished/absent (describe below)

Sleep aids: ☐ No ☐ Yes (describe below) Seizures: ☐ No ☐ Yes (describe below)

Comments:

Eyes, Ears, & Throat. ☐ Own teeth ☐ Dentures Dental hygiene: ☐ Good ☐ Fair ☐ Poor

Vision: ☐ Adequate ☐ Poor ☐ Uses corrective lenses ☐ Blind - ☐ R ☐ L

Hearing: ☐ Adequate ☐ Poor ☐ Uses corrective aid ☐ Deaf - ☐ R ☐ L

Comments:

Musculoskeletal. ROM: ☐ Full ☐ Limited

Mobility: ☐ Normal ☐ Impaired → Assistive devices: ☐ No ☐ Yes (describe below)

Motor development: ☐ Head control ☐ Sits ☐ Walks ☐ Hemiparesis ☐ Tremors

ADLs: (S=self; A=assist; T=total) Eating: ___ Bathing: ___ Dressing: ___

Is the resident at an increased risk of falling or injury? ☐ No ☐ Yes (explain below)

Comments:

Skin. Intact: ☐ Yes ☐ No (if no, a wound assessment **must** be completed)

☐ Normal ☐ Red ☐ Rash ☐ Irritation ☐ Abrasion ☐ Other

Any skin conditions requiring treatment or monitoring? ☐ No ☐ Yes (describe condition & treatment)

Comments:

Respiratory. Respirations: ☐ Regular ☐ Unlabored ☐ Irregular ☐ Labored

Breath sounds: Right (☐ Clear ☐ Rales) Left (☐ Clear ☐ Rales)

Shortness of breath: ☐ No ☐ Yes (indicate triggers below)

Respiratory treatments: ☐ None ☐ Oxygen ☐ Aerosol/nebulizer ☐ CPAP/BIPAP

Comments:

Circulatory. History: ☐ N/A ☐ Arrhythmia ☐ Hypertension ☐ Hypotension

Pulse: ☐ Regular ☐ Irregular Edema: ☐ No ☐ Yes → Pitting: ☐ No ☐ Yes

Skin: ☐ Pink ☐ Cyanotic ☐ Pale ☐ Mottled ☐ Warm ☐ Cool ☐ Dry ☐ Diaphoretic

Comments:

Questions? Contact Winter Growth:
(410) 964-9616 (Columbia)
(301) 774-7501 (Olney)

Resident: _____ DOB: _____ Assessment Date: _____

Diet/Nutrition. ☐ Regular ☐ No added salt ☐ Diabetic/no concentrated sweets

☐ Mechanical soft ☐ Pureed ☐ Other _____ ☐ Supplements _____

Is there any condition which may impair chewing, eating, or swallowing? ☐ No ☐ Yes (explain below)

Is there evidence of or a risk for malnutrition or dehydration? ☐ No ☐ Yes (explain below)

Is any nutritional/fluid monitoring necessary? ☐ No ☐ Yes (describe type/frequency below)

Are assistive devices needed? ☐ No ☐ Yes (explain below)

Mucous membranes: ☐ Moist ☐ Dry Skin turgor: ☐ Good ☐ Fair ☐ Poor

Comments:

Elimination.

Bowel sounds present: ☐ Yes ☐ No Constipation: ☐ No ☐ Yes Ostomies: ☐ No ☐ Yes

Bladder: ☐ Normal ☐ Occasional Incontinence (less than daily) ☐ Daily Incontinence

Bowel: ☐ Normal ☐ Occasional Incontinence (less than daily) ☐ Daily Incontinence

(If any incontinence, describe management techniques)

Comments:

Additional Services Required. ☐ No ☐ Yes (indicate type, frequency, & reason)

☐ Physical therapy ☐ Home health ☐ Private duty ☐ Hospice ☐ Nursing home care ☐ Other

Comments:

Substance Abuse. Does the resident have a history of or current problem with the abuse of medications, drugs, alcohol, or other substances? ☐ No ☐ Yes (explain)

Comments:

Psychosocial. **KEY:** **N** = *Never* **O** = *Occasional* **R** = *Regular* **C** = *Continuous*

	N	O	R	C	Comments
Receptive/Expressive Aphasia					
Wanders					
Depressed					
Anxious					
Agitated					
Disturbed Sleep					

Questions? Contact Winter Growth:
(410) 964-9616 (Columbia)
(301) 774-7501 (Olney)

Resident: _____ DOB: _____ Assessment Date: _____

Psychosocial.	**KEY:** **N** *= Never*	**O** *= Occasional*	**R** *= Regular*	**C** *= Continuous*	
	N	**O**	**R**	**C**	**Comments**
Resists Care					
Disruptive Behavior					
Impaired Judgment					
Unsafe Behaviors					
Hallucinations					
Delusions					
Aggression					
Dangerous to Self or Others					*(if response is anything other than never, explain)*

Awake Overnight Staff. Based on the results of this assessment & your clinical judgment, indicate if the resident requires monitoring by awake overnight staff: ☐ Yes ☐ No (explain your reason)

Health Care Decision-Making Capacity. Indicate the resident's highest level of ability to make health care decisions:
☐ Probably can make higher level decisions *(such as whether to undergo or withdraw life-sustaining treatments that require understanding the nature, probable consequences, burdens, & risks of proposed treatment)*
☐ Probably can make limited decisions that require simple understanding
☐ Probably can express agreement with decisions proposed by someone else
☐ Cannot effectively participate in any kind of health care decision-making

Ability to Self-Administer Medications. Indicate the resident's ability to take his/her own medications safely & appropriately:
☐ Independently without assistance
☐ Can do so with physical assistance, reminders, or supervision only
☐ Needs to have medications administered by someone else

General Comments.

Health Care Practitioner's Signature: _____ Date: _____

Print Name & Title: _____

Resident: _____ DOB: _____ Assessment Date: _____

Skip this box if you are not the Delegating Nurse/Case Manager (DN/CM).

When the DN/CM completes this entire Resident Assessment Tool, including this box, there is no need to document a separate nursing assessment.

Has a 3-way check (orders, medications, & MAR) been conducted for all of the resident's medications & treatments, including OTCs & PRNs? ☐ Yes ☐ No (explain below)

Were any discrepancies identified? ☐ No ☐ Yes (explain below)

Are medications stored appropriately? ☐ Yes ☐ No (explain below)

Has the caregiver been instructed on monitoring for drug therapy effectiveness, side effects, & drug reactions, including how & when to report problems that may occur? ☐ Yes ☐ No (explain below)

Have arrangements been made to obtain ordered labs? ☐ Yes ☐ No (explain below)

Is the resident taking any high risk drugs? ☐ No ☐ Yes (explain below)

For all high risk medications (such as hypoglycemics, anticoagulants, etc), has the caregiver received instructions on special precautions, including how & when to report problems that may occur? ☐ Yes ☐ No (explain below) ☐ N/A

Is the environment safe for the resident? ☐ Yes ☐ No (explain below)

(Adequate lighting, open traffic areas, non-skid rugs, appropriate furniture, & assistive devices.)

Comments:

DN/CM's Signature: _____ Date: _____

Print Name: _____

Six months after this assessment is completed, it must be reviewed.
If significant changes have occurred, a new assessment must be completed.
If there have been no significant changes, simply complete the information below.

***Six-Month Review** Conducted By:*

Signature: _____ *Date:* _____

Print Name & Title: _____

Resident: _____ DOB: _____ Date Completed: _____

PRESCRIBER'S SIGNED ORDERS

(You may attach *signed* prescriber's orders as an alternative to completing this page.)

ALLERGIES (list all): _____

MEDICATIONS & TREATMENTS:
List all medications & treatments, including PRN, OTC, herbal, & dietary supplements.

Medication/Treatment Name	*Dose*	*Route*	*Frequency*	*Reason for Giving*	*Related Monitoring & Testing (if any)*
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					

Questions? Contact Winter Growth:
(410) 964-9616 (Columbia)
(301) 774-7501 (Olney)

Resident: _____ DOB: _____ Date Completed: _____

17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					

LABORATORY SERVICES:

Lab Test	*Reason*	*Frequency*
1.		
2.		
3.		
4.		
5.		
6.		

Total number of medications & treatments listed on these signed orders? _____

Prescriber's Signature: _____ Date: _____

Office Address: _____ Phone: _____

Questions? Contact Winter Growth:
(410) 964-9616 (Columbia)
(301) 774-7501 (Olney)