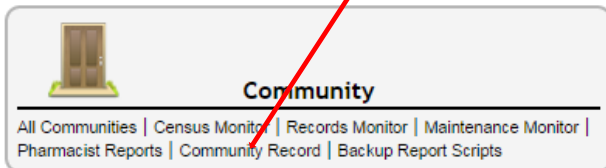




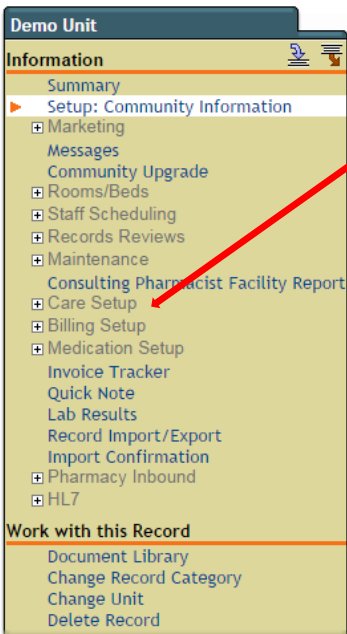
Community Record Setup

Nursing Assessment & Service Plan/ADL's

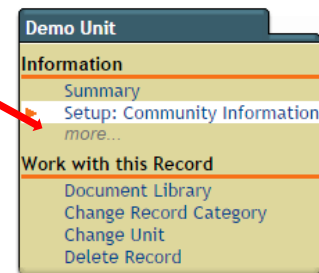
Select the "Community Record" link. This will take you to the Setup: Community Information



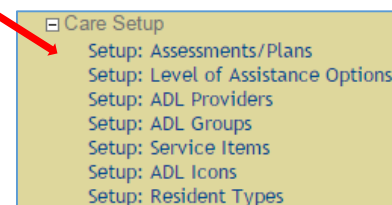
Step 1. Expand the Community navigation menu by clicking on the "more" link



Navigate to the "Care Setup" and click on the link to expand.



Select the "Setup: Assessment/Plans" link



Step 2. Select the sections you would like to display on the community Nursing Assessment.

Setup: Assessments/Plans

Required

NURSING ASSESSMENT SETUP

Select what sections you wish to have on your nursing assessment

State assessment
must save to take effect

<input type="radio"/> Custom	<input type="radio"/> Florida	<input type="radio"/> Louisiana	<input type="radio"/> Nebraska	<input type="radio"/> Oklahoma	<input type="radio"/> Vermont
<input type="radio"/> Alabama	<input type="radio"/> Georgia	<input type="radio"/> Maine	<input type="radio"/> Nevada	<input type="radio"/> Oregon	<input type="radio"/> Virginia
<input type="radio"/> Alaska	<input type="radio"/> Hawaii	<input type="radio"/> Maryland	<input type="radio"/> New Hampshire	<input type="radio"/> Pennsylvania	<input type="radio"/> Washington
<input type="radio"/> Arizona	<input type="radio"/> Idaho	<input type="radio"/> Massachusetts	<input type="radio"/> New Jersey	<input type="radio"/> Rhode Island	<input type="radio"/> West Virginia
<input type="radio"/> Arkansas	<input type="radio"/> Illinois	<input type="radio"/> Michigan	<input type="radio"/> New Mexico	<input type="radio"/> South Carolina	<input type="radio"/> Wisconsin
<input type="radio"/> California	<input type="radio"/> Indiana	<input type="radio"/> Minnesota	<input type="radio"/> New York	<input type="radio"/> South Dakota	<input type="radio"/> Wyoming
<input type="radio"/> Colorado	<input type="radio"/> Iowa	<input type="radio"/> Mississippi	<input type="radio"/> North Carolina	<input type="radio"/> Tennessee	
<input type="radio"/> Connecticut	<input type="radio"/> Kansas	<input type="radio"/> Missouri	<input type="radio"/> North Dakota	<input type="radio"/> Texas	
<input type="radio"/> Delaware	<input type="radio"/> Kentucky	<input type="radio"/> Montana	<input type="radio"/> Ohio	<input type="radio"/> Utah	

Select

<input type="checkbox"/> Assisted Living Type	<input checked="" type="checkbox"/> Cardiovascular	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Prosthetic devices
<input type="checkbox"/> Care Type	<input checked="" type="checkbox"/> Gastrointestinal	<input type="checkbox"/> Depression	<input checked="" type="checkbox"/> Toileting
<input type="checkbox"/> Providers	<input checked="" type="checkbox"/> Genitourinary	<input type="checkbox"/> Mood	<input type="checkbox"/> Incontinence care
<input type="checkbox"/> Medical History	<input checked="" type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Sensory	<input checked="" type="checkbox"/> Bathing
<input type="checkbox"/> Medical Transfers	<input checked="" type="checkbox"/> Neurological	<input type="checkbox"/> Eye Care	<input type="checkbox"/> Smoke
<input checked="" type="checkbox"/> Medication	<input checked="" type="checkbox"/> Endocrine	<input checked="" type="checkbox"/> Dental *	<input type="checkbox"/> Self-medicate
<input type="checkbox"/> Medication assistance	<input type="checkbox"/> Pain	<input type="checkbox"/> Oral *	<input type="checkbox"/> Leisure
<input checked="" type="checkbox"/> Blood pressure	<input type="checkbox"/> Primary Pain	<input checked="" type="checkbox"/> Mobility *	<input type="checkbox"/> Communication
<input type="checkbox"/> Heart rate	<input type="checkbox"/> Secondary Pain	<input type="checkbox"/> Ambulation *	<input checked="" type="checkbox"/> Housekeeping
<input type="checkbox"/> Respiratory rate	<input type="checkbox"/> Additional Pain	<input checked="" type="checkbox"/> Transferring	<input type="checkbox"/> Appointments
<input checked="" type="checkbox"/> Temperature	<input type="checkbox"/> Dementia	<input type="checkbox"/> Wandering	<input type="checkbox"/> Financial
<input type="checkbox"/> Glucose/Blood sugar	<input type="checkbox"/> Psychiatric*	<input type="checkbox"/> Fall	<input type="checkbox"/> Assault/Destructive
<input type="checkbox"/> O2 sats	<input type="checkbox"/> Mental Health/Psychosocial*	<input type="checkbox"/> Self Harm	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> O2/min	<input type="checkbox"/> Orientation	<input checked="" type="checkbox"/> Dietary	<input type="checkbox"/> Victimization
<input type="checkbox"/> Weight	<input type="checkbox"/> Memory	<input checked="" type="checkbox"/> Eating	<input type="checkbox"/> Behavior
<input type="checkbox"/> Height	<input type="checkbox"/> Cognitive	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Behavioral Management
<input checked="" type="checkbox"/> Integumentary	<input type="checkbox"/> Judgment	<input checked="" type="checkbox"/> Grooming	<input type="checkbox"/> Special treatment
<input type="checkbox"/> Immune System	<input type="checkbox"/> Hallucination	<input checked="" type="checkbox"/> Dressing	
<input checked="" type="checkbox"/> Respiratory	<input type="checkbox"/> Delusion	<input type="checkbox"/> Assistive devices	

Review Items: Immune System:	No recurring fever, no unexplained fatigue, no discolored blotches on or under the skin or in
Review Items: Cardiovascular:	Normal blood pressure and pulse no chest pain, edema, calf tenderness and no systolic, di
Review Items: Gastrointestinal:	No stomach pain, nausea, vomiting, abdomen is not bloated, no diarrhea or constipation an
Review Items: Genitourinary:	Normal urine output and color, no infections, burning, bladder distention, prostate problems
Review Items: Musculoskeletal:	No numbness, reduction in strength, cramping, swelling, tenderness, ROM limitations or stiff
Review Items: Neurological:	Normal sleep pattern, alertness, attention, and follows commands and doesn't have seizure
Review Items: Endocrine:	No palpitations, nervousness, fatigue, or insomnia
Pain Location System	<input checked="" type="radio"/> Advanced <input type="radio"/> Basic
Review Items: Pain:	No history of pain issues and has no pain currently
Review Items: Oral:	Teeth are intact and in good condition
Review Items: Ambulation:	Proper gait and balance without any devices
Review Items: Wandering:	Does not wander outside the facility/community and dose not require consta
Review Items: Eating:	Feeds self with no difficulties
Review Items: Weight Loss:	Is normal and steady
Review Items: Dressing:	Can dress self appropriately with out assistance
Review Items: Assistive Devices:	Not needed for day to day activity
Review Items: Continence:	No bowel or bladder incontinence
Review Items: Smoking:	Does not smoke
Review Items: Appointment:	Can schedule own appointments without assistance

Review Every

Each section checked will appear on the Nursing assessment. See addendum A. for detail of these sections.

When a sections above is selected the "Review Items" text is displayed below. This text is editable so that when a nursing assessment is created this text will be the default text displayed.

Input the number of days between standard assessments. This will generate a report or alert when the next assessment is due

SERVICE PLAN SETUP

Select what sections you wish to have on your service plan

Select

Each section checked will appear on the Service plan. See Addendum B

<input type="checkbox"/> Additional services	<input type="checkbox"/> External services	<input type="checkbox"/> Leisure	<input type="checkbox"/> Substance abuse
<input checked="" type="checkbox"/> Ambulation	<input type="checkbox"/> Eye Care	<input checked="" type="checkbox"/> Mobility	<input checked="" type="checkbox"/> Toileting
<input type="checkbox"/> Appointments	<input type="checkbox"/> Financial management	<input type="checkbox"/> Night checks	<input type="checkbox"/> Transferring
<input type="checkbox"/> Assistive devices	<input checked="" type="checkbox"/> Grooming	<input checked="" type="checkbox"/> Oral	<input type="checkbox"/> Transportation
<input checked="" type="checkbox"/> Bathing	<input checked="" type="checkbox"/> Hair	<input type="checkbox"/> Outside services	<input type="checkbox"/> Vital Signs
<input type="checkbox"/> Behavioral management	<input type="checkbox"/> Health checks	<input type="checkbox"/> Prosthetic devices	<input type="checkbox"/> Wandering
<input type="checkbox"/> Communication	<input type="checkbox"/> Health monitoring	<input type="checkbox"/> Purchases	<input type="checkbox"/> Wood/coal supply
<input type="checkbox"/> Dental	<input checked="" type="checkbox"/> Housekeeping	<input type="checkbox"/> Q2	
<input checked="" type="checkbox"/> Dressing	<input type="checkbox"/> Incontinence care	<input checked="" type="checkbox"/> Shave	
<input type="checkbox"/> Eating	<input checked="" type="checkbox"/> Laundry	<input type="checkbox"/> Smoke	

Time Individual ADLs Show Times

Review Every days

*** Required**

Input the number of days between service plans. This will generate a report or alert when the next service plan is due

Step 3. Set up Level of Assistance by selecting “Setup: Level of Assistance Options” in the community record left hand navigation.

- ▢ Care Setup
 - Setup: Assessments/Plans
 - Setup: Level of Assistance Options
 - Setup: ADL Providers
 - Setup: ADL Groups
 - Setup: Service Items
 - Setup: ADL Icons
 - Setup: Resident Types

Edit existing LOA options or enter new LOA options by clicking the new entry button.

Active LOA

Level of Assistance	Level Number	Edit	Delete
Independent	1		
Minimal Assist	2		
Moderate Assistance	3		
Total Assistance	4		

Step 4. Set up ADL providers by selecting “Setup: ADL Providers” in the community record left hand navigation.

- ▢ Care Setup
 - Setup: Assessments/Plans
 - Setup: Level of Assistance Options
 - Setup: ADL Providers
 - Setup: ADL Groups
 - Setup: Service Items
 - Setup: ADL Icons
 - Setup: Resident Types

Edit existing ADL Providers or enter new ADL Provider by clicking the new entry button.

Setup: ADL Providers

ADL Provider	Edit	Delete
Care Giver		
CNA		
Housekeeping		
Life Engagement		
Nursing		
Resident		

Step 5. Set up ADL groups by selecting “Setup: ADL Groups” in the community record left hand navigation.

Setup: ADL Groups

Active ADL Groups

ADL Groups

ADL Groups	Edit Delete
Cities	
Harbors	
Music	
Western	

New Entry

Step 6. Set up Service Items by selecting “Setup: Service Items” in the community record left hand navigation.

Setup: Service Items

* Required

This will set the default care for your community. Any time the care is selected on the residents service plan it will use the defaults you set here. The values are used to help determine the tier level for the residents.

Caution: If editing the "Custom Name", change only phrasing, not the kind of service. If a service is not listed, click the New Entry button on the right.

Service Items Detail

Service Category: Behavior

Generic Name: Behavioral management
 Custom Name: * Behavioral management
 Provided By: Care Giver Housekeeping Nursing CNA Life Engagement Resident
 Category: Behavior
 Description: Behavioral Management Note/Instructions

GL Code: [dropdown]

Service Item Level Of Assistance Value

Independent	Value *	0
Minimal Assist	Value *	0

Service Category: Continance

Generic Name: Incontinence care
 Custom Name: * Incontinence care
 Provided By: Care Giver Housekeeping Nursing CNA Life Engagement Resident
 Category: Continance
 Description: [text area]

GL Code: [dropdown]

Service Item Level Of Assistance Value

Independent	Value *	0
Minimal Assist	Value *	0

Active

Generic Name: Feed the fish
 Custom Name: * Feed the fish
 Provided By: Care Giver Housekeeping Nursing CNA Life Engagement Resident
 Category: Housekeeping
 Description: [text area]

GL Code: [dropdown]

Service Item Level Of Assistance Value

Independent	Value *	0
Minimal Assist	Value *	0

New Entry

Step 7. Create a new Nursing Assessment by selecting a resident then clicking on the Nursing Assessment link on the left hand navigation. Then click the new entry button.


BENCH, JOHNNY

Information

- ▶ Summary
- Name and E-mail
- Contact Information
- ▣ General Resident
 - Resident Info
 - Individual Worksheet
 - Primary Contacts
 - Providers
 - Insurance
 - Medical History
 - Temporary Warnings
 - Admissions/Re-Admission
 - Discharge/Transfer
 - ▣ Assessments
 - Nursing Assessment**
 - Service Plan

Nursing Assessment New Entry


BENCH, JOHNNY


Code status: Do NOT Resuscitate (DNR)	Current date: 04/13/2015	
Age: 69	Primary care physician: Fisher, Sam	
Date of birth: 06/10/1945	Physician phone: (801) 336-3043 Fax: [no data]	
Gender: Male	Room #: Demo Unit--112A	
Spouse:	Location: Western	
Marital Status:	Community: Autumn Leaves- Demo Unit	
	Admission: 12/16/2014 12:50PM	

Edit
Delete

No Entries Found

A new nursing assessment will appear with all the sections displayed that were checked when setting up the nursing assessment/service plan. See **Step 2**.

Assessment Date * 04/13/2015 

Next Review Date 10/10/2015 

Assessment Type * Initial 45 Day 6 Month 14 Day 90 Day Annual 30 Day 180 Day Significant Change

Assisted Living Type Assisted Living Type 1 Assisted Living Type 2

Care Type Directed Care Personal Care Supervisory

PROVIDERS

Provider	Role
Fisher, Sam	Admitting physician, Attending physician, Primary care MD

Assisted Living Type

 Care Type

 Providers

MEDICAL HISTORY

Diagnosis:

Medical Conditions:

Notes:

Medical History

MEDICAL TRANSFERS

Date	Transfer Type	Destination	Reason	Discontinue Medications
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Medical Transfers

MEDICATIONS

Medication	Dosage	Route of Admin	Schedule	Prescribed By	Start Date	Dispensing Instructions
ACETAMINOPHEN	(650mg) 8:00am, 8:00pm (650mg) PRN	Oral	Pain	FISHER, SAM	01/22/2015	TAKE 2 TABS (650MG) BY M
ALBUTEROL	(180mcg) PRN	Inhalation	Asthma	FISHER,	01/16/2015	2 PUFFS BY MOUTH FOUR TIMES DAILY AS NEEDED FOR

Medication

Step 8. Determine Level of Assistance and provide instructions for the Service Plan when completing sections that push data from the Nursing Assessment to the Service Plan.

TOILETING ASSESSMENT

Toileting Has signs of toileting issues No signs of toileting issues

Level of Assistance: Total Assistance
 Demo Unit
 Independent
 Minimal Assist
 Moderate Assistance
 Total Assistance

Devices: Bed pan Grab bars Incontinence pads
 Urinal Commode Raised toilet seat

Notes:

MOBILITY ASSESSMENT

Mobility Has signs of mobility issues No signs of mobility issues

History of Falls: Yes

Findings: Poor gait Amputation Decreased mobility
 Decreased ROM Wound Orthopedic issues
 Weakness Paralysis Prosthesis issues
 Fracture Poor balance Bedridden

Level of Assistance:
 Demo Unit
 Independent
 Minimal Assist
 Moderate Assistance
 Total Assistance

Devices: Cane Crutches Cushion
 Walker Guide dog Ramp access
 Hoyer lift Hospital bed Electric cart
 Transfer board Leg brace(s) Bed rails
 Wheelchair Prosthesis

Level of Assistance will be pushed to the Service Plan

Notes and Devices will be pushed to the Service Plan and appear as instructions.

Step 9. Sign and save the completed Nursing Assessment. *Note: When a service plan is completed, it will lock down the Nursing Assessment to become uneditable. You can save a nursing assessment and your progress without clicking on the completed signature

Only check when completed. This locks down the nursing assessment and becomes uneditable

Completed Nursing Assessment Reviewed By

BENCH, JOHHNY Responsible Party

* Required

Save when either saving your progress (not completed) or when the nursing assessment is completed.

Step 10. Complete a Service Plan by selecting a resident then clicking on the Service Plan link on the left hand navigation. A partially completed Service Plan will have been created when a previous Nursing Assessment was completed. Click the edit pencil to view/edit the Service Plan

BENCH, JOHNNY Select/View Resident

Information

- Summary
- Name and E-mail
- Contact Information
- General Resident
 - Resident Info
 - Individual Worksheet
 - Primary Contacts
 - Providers
 - Insurance
 - Medical History
 - Temporary Warnings
 - Admissions/Re-Admission
 - Discharge/Transfer
- Assessments
 - Nursing Assessment
 - Service Plan**

Service Plan

BENCH, JOHNNY

Code status: Do NOT Resuscitate (DNR)
 Age: 69
 Date of birth: 06/10/1945
 Gender: Male
 Spouse:
 Marital Status:

Current date: 04/13/2015
 Primary care physician: Fisher, Sam
 Physician phone: (801) 336-3043 Fax: [no data]
 Room #: Demo Unit--112A
 Location: West Jam
 Community: Autumn Leaves- Demo Unit
 Admission: 12/16/2014 12:50P.M.

Plan Date: 04/13/2015

Service Plan Complete

Edit Delete

Level of Assistance, Devices and Notes are pushed from the Nursing Assessment to the Service Plan

TOILETING ASSESSMENT

Toileting Has signs of toileting issues No signs of toileting issues

Level of Assistance: Total Assistance

Devices:

- Bed pan
- Urinal
- Grab bars
- Commode
- Incontinence pads
- Raised toilet seat

Notes: Toileting Note

Service Item: Toileting

Inactive Active Value:

Service Item: **Toileting**

Category: Continenace

Level of Assistance: * Total Assistance

Provider: * Demo Unit

- Care Giver
- CNA
- Housekeeping
- Life Engagement
- Nursing
- Resident

Start Date: * 04/13/2015 End Date: * 04/13/2115

PRN Scheduled

Interval:

- or -

Days:

- * Su M Tu W Th F Sa

Scheduled Time:

- * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
- PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
- Bedtime 10:00am 3:00pm 8:00pm 1:00am
- 6:00am 11:00am 4:00pm 9:00pm 2:00am
- 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Instructions: Incontinence pads, Raised toilet seat Toileting Note

Step 11. Complete the Service Plan by Selecting the Provider, Adding instructions and Scheduling the Time.

Service Item: **Toileting**

Inactive Active Value:
 Service Item: **Toileting**
 Category: Contenance
 Level of Assistance: * **Total Assistance**
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * 04/13/2015 End Date: * 04/13/2115
 PRN Scheduled
 Interval - or - Days
 Scheduled Time *

<input checked="" type="checkbox"/> Su	<input checked="" type="checkbox"/> M	<input checked="" type="checkbox"/> Tu	<input checked="" type="checkbox"/> W	<input checked="" type="checkbox"/> Th	<input checked="" type="checkbox"/> F	<input checked="" type="checkbox"/> Sa
<input type="checkbox"/> AM	<input type="checkbox"/> 8:00am	<input type="checkbox"/> 1:00pm	<input type="checkbox"/> 6:00pm	<input type="checkbox"/> 11:00pm	<input type="checkbox"/> 4:00am	
<input type="checkbox"/> PM	<input type="checkbox"/> 9:00am	<input type="checkbox"/> 2:00pm	<input type="checkbox"/> 7:00pm	<input type="checkbox"/> 12:00am	<input type="checkbox"/> 5:00am	
<input type="checkbox"/> Bedtime	<input type="checkbox"/> 10:00am	<input type="checkbox"/> 3:00pm	<input type="checkbox"/> 8:00pm	<input type="checkbox"/> 1:00am		
<input type="checkbox"/> 6:00am	<input type="checkbox"/> 11:00am	<input type="checkbox"/> 4:00pm	<input type="checkbox"/> 9:00pm	<input type="checkbox"/> 2:00am		
<input type="checkbox"/> 7:00am	<input type="checkbox"/> 12:00pm	<input type="checkbox"/> 5:00pm	<input type="checkbox"/> 10:00pm	<input type="checkbox"/> 3:00am		

Instructions: Incontinence pads, Raised toilet seat
Toileting Note

Select a provider. If a provider was selected for this ADL during the Setup Service Items (Step 6) then provider would be checked already. This can still however be changed/edited here.

PRN Scheduled
 *

If this ADL is a PRN enter the number of times/month that this ADL may be given. Zero may be entered if unknown.

Only check when completed. This locks down the service plan and becomes uneditable. It also generates ADL's to be charted on.

Service Plan Complete

Reviewed By

BENCH, JOHHNY

Responsible Party

* Required

Save when either saving your progress (not completed) or when the Service Plan is completed.

Addendum A

When a selection is selected on the Setup: Assessment/Plans the resulting sections will then be displayed on the Nursing Assessment

Assisted Living Type Assisted Living Type 1 Assisted Living Type 2
 Care Type Directed Care Personal Care Supervisory

PROVIDERS

Provider	Role
Fisher, Sam	Admitting physician, Attending physician, Primary care MD

MEDICAL HISTORY

Diagnosis:
 Medical Conditions:
 Notes:

MEDICAL TRANSFERS

Date	Transfer Type	Destination	Reason	Discontinue Medications	Notes
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MEDICATIONS

Medication	Dosage	Route of Admin	Schedule	Prescribed By	Start Date	Dispensing Instructions
ACETAMINOPHEN	(650mg) 8:00am, 8:00pm (650mg) PRN	Oral	Pain	FISHER, SAM	01/22/2015	TAKE 2 TABS (650MG) BY MOUTH TWICE DAILY
ALBUTEROL SULFATE HFA	(180mcg) PRN	Inhalation	Asthma	FISHER, SAM	01/16/2015	2 PUFFS BY MOUTH FOUR TIMES DAILY AS NEEDED FOR SHORTNESS OF BREATH
Ativan	(0.5mg) AM, 7:00am every 90 days	01 Oral (PO)	anxiety	Fisher, Sam	02/16/2015	take 0.5mg by mouth once daily

Medication Assistance Type

Self-administer
 Self-Directed
 Refill reminder
 Storing medication
 Remind to take

Checking label for correct resident
 Checking dosage against label
 Confirm taking as directed
 Opening container
 Specified dosage placed in container/hand

Observing while medication is taken
 Admin by family/designated person
 Significant (Total)

Level of Assistance
 Notes

Medication Allergies

Medication History

Medication History	Medication Assistance Type	Level Of Assistance	Note	Medication Allergies
--------------------	----------------------------	---------------------	------	----------------------

Assisted Living Type

Care Type

Providers

Medical History

Medical Transfers

Medication

Medication assistant

VITAL SIGNS

Blood Pressure	
Heart Rate	
Respiratory Rate	
Temperature	
Glucose/Blood sugar	
O2 Sats	
O2/Min	
Weight	
Height ft' in"	

- Blood pressure
- Heart rate
- Respiratory rate
- Temperature
- Glucose/Blood sugar
- O2 sats
- O2/min
- Weight
- Height

INTEGUMENTARY ASSESSMENT

Integumentary System Has signs of integumentary system issues No signs of integumentary system issues

Bruises, rashes, scars, other marks

Findings

- Abnormal skin temperature
- Excessively dry
- Mucous membranes dry
- Needs lotion frequently
- Pressure sore
- Reassess skin daily
- Reassess skin monthly
- Reassess skin weekly
- Skin discoloration
- Skin torn
- Ulcer in stage 1 or 2

Integumentary

Notes

Integumentary History

Integumentary Assessment History		
Marks		Findings
Notes		

IMMUNE SYSTEM ASSESSMENT

Immune System Has signs of immune system issues No signs of immune system issues

Findings

- HIV/AIDS
- Primary Immune Deficiency
- Communicable Disease

Immune System

Notes

Immune System History

Immune System History		
		Notes
Findings		

RESPIRATORY ASSESSMENT

Respiratory System Has signs of respiratory system issues No signs of respiratory system issues

Findings

- Adventitious sounds
- Breath sounds not vesicular
- Breathing hard/loud/irregular
- Chest tightness
- Cough
- Mucous membranes not pink
- Nail beds not pink
- Obstruction of airways
- Shortness of breath
- Shortness of breath on extension
- Sputum discolored
- Wheezing

Respiratory

Devices

- Oxygen
- Bypass bipap
- Volume ventilator
- CPAP
- Nebulizer

Notes

Respiratory History

Respiratory System History		
		Devices
Findings	Notes	

CARDIOVASCULAR ASSESSMENT

Cardiovascular Has signs of cardiovascular issues No signs of cardiovascular issues

History of chest pain?

- No
- Yes

Findings

- Calf Tenderness
- Chest pain
- Circulation problem
- Congestive heart failure
- Edema
- Heart trouble
- High blood pressure
- Peripheral pulses not palpable
- S1 and S2 irregular
- Vein distention

Cardiovascular

Notes

Cardiovascular History

Cardiovascular History		
		Findings
History of Chest Pain	Notes	

GASTROINTESTINAL ASSESSMENT

Gastrointestinal System Has signs of gastrointestinal system issues No signs of gastrointestinal system issues

- Findings
- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Abdomen not soft | <input type="checkbox"/> Low fluid intake | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Abnormal bowel movements | <input type="checkbox"/> Nausea | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Digestive problem | <input type="checkbox"/> No bowel sounds | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Gall bladder problem | <input type="checkbox"/> Pain on palpation | |
| <input type="checkbox"/> Liver function problem | <input type="checkbox"/> Poor appetite | |

Gastrointestinal

Notes

Gastrointestinal History **Gastrointestinal History** Findings Notes

GENITOURINARY ASSESSMENT

Genitourinary Has signs of genitourinary issues No signs of genitourinary issues

- Findings
- | | | |
|--|---|--|
| <input type="checkbox"/> Bladder distended | <input type="checkbox"/> Frequent | <input type="checkbox"/> Renal failure |
| <input type="checkbox"/> Breast mass or pain | <input type="checkbox"/> History of UTI | <input type="checkbox"/> Unable to empty bladder w/o difficulty/pain |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Urgency |
| <input type="checkbox"/> Discolored urine | <input type="checkbox"/> Prostate problems | |

Genitourinary

Notes

Genitourinary History **Genitourinary History** Findings Notes

MUSCULOSKELETAL ASSESSMENT

Musculoskeletal Has signs of musculoskeletal issues No signs of musculoskeletal issues

- Findings
- | | | |
|---|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Activity limitation | <input type="checkbox"/> Limited ROM | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Nodules | <input type="checkbox"/> Tenderness |
| <input type="checkbox"/> Functional limitations | <input type="checkbox"/> Numbness | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Inflammation | <input type="checkbox"/> Osteoporosis | |

Musculoskeletal

Notes

Musculoskeletal History **Musculoskeletal History** Findings Notes

NEUROLOGICAL ASSESSMENT

Neurological Has signs of neurological issues No signs of neurological issues

- Findings
- | | | |
|---|---|---------------------------------|
| <input type="checkbox"/> Brain trauma | <input type="checkbox"/> Lethargy | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Obtundation | <input type="checkbox"/> Stupor |
| <input type="checkbox"/> Irregular sleep patterns | <input type="checkbox"/> Spinal cord injury | |

Neurological

Notes

Neurological History **Neurological History** Findings Notes

ENDOCRINE ASSESSMENT

Endocrine System Has signs of endocrine system issues No signs of endocrine system issues

- Findings
- | | | |
|-----------------------------------|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Growth disorder |
|-----------------------------------|---|--|

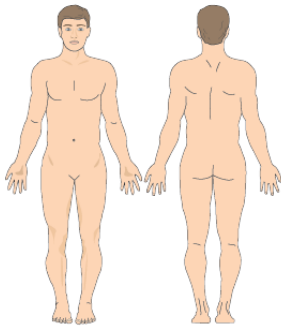
Endocrine

Notes

Endocrine History **Endocrine History** Findings Notes

PAIN ASSESSMENT

- Pain Has signs of pain issues No signs of pain issues
- Findings History of pain PRN medication relieves pain Able to communicate pain verbally
 Scheduled medication relieves pain Herbal medication relieves pain
- Primary Secondary Additional



Primary Pain Location

Pain Intensity Occurs 1 2 3 4 5 6 7 8 9 10

Secondary Pain Location

Intensity Occurs 1 2 3 4 5 6 7 8 9 10

Additional Pain Location

Intensity Occurs 1 2 3 4 5 6 7 8 9 10

Notes

Pain

Primary Pain
 Secondary Pain
 Additional Pain

DEMENTIA ASSESSMENT

- Dementia Has signs of dementia issues No signs of dementia issues
- Findings Difficulty recalling recent events Trouble finding the right words to express thoughts
 Not recognizing familiar people Difficulty performing calculations

Notes

Dementia History **Dementia History** Findings Notes

Dementia

PSYCHIATRIC ASSESSMENT

- Psychiatric Has signs of psychiatric issues No signs of psychiatric issues
- Findings Anxiety disorder Major depression Schizophrenia
 Bipolar Personality disorder Psychotic disorder

Notes

Psychiatric History **Psychiatric History** Findings Notes

Psychiatric

MENTAL HEALTH/PSYCHOSOCIAL

- Mental Health/Psychosocial Has signs of mental health/psychosocial issues No signs of mental health/psychosocial issues
- Findings Anxiety disorder Major depression Schizophrenia
 Bipolar Personality disorder Psychotic disorder

Notes

Mental Health/Psychosocial History **Mental Health/Psychosocial History** Findings Notes

Mental Health/Psychosocial

ORIENTATION ASSESSMENT

Orientation Has signs of orientation issues No signs of orientation issues

Findings Oriented to person, place, time and situation Oriented to time Frequently disoriented, even in familiar surroundings/requires supervision
 Oriented to person Oriented to situation Always disoriented/requires constant supervision/extensive intervention
 Oriented to place Occasionally disoriented, but can function independently in familiar surroundings

Notes

Orientation History **Orientation History** Findings Notes

Orientation

MEMORY ASSESSMENT

Memory Has signs of memory issues No signs of memory issues

Findings Poor Recent Memory Confabulation ADHD
 Poor Remote Memory ADD

Notes

Memory History **Memory History** Findings Notes

Memory

COGNITIVE ASSESSMENT

Cognitive Has signs of cognitive issues No signs of cognitive issues

Findings Slight memory loss Needs some supervision Severe memory loss
 Occasional reminders Significant memory loss Autism
 Memory anxiety Needs ADL assistance Epilepsy/Seizure disorder
 Moderate memory loss Personality changes Mental retardation
 Frequent reminders Constant supervision Cerebral palsy

Notes

Cognitive History **Cognitive History** Findings Notes

Cognitive

JUDGMENT ASSESSMENT

Judgment Has signs of judgment issues No signs of judgment issues

Findings Judgment is occasionally poor Judgment is frequently poor Cannot make appropriate decisions for self
 May make inappropriate decisions in complex/unfamiliar situations Needs protection/supervision because of unsafe/inappropriate decisions Needs intense supervision
 Needs monitoring/guidance in decision-making Judgment is always poor

Notes

Judgment History **Judgment History** Findings Notes

Judgement

HALLUCINATION ASSESSMENT

Hallucination Has signs of hallucination issues No signs of hallucination issues

Findings Occasionally has hallucinations that interfere with functioning Frequently has hallucinations that interfere with functioning Currently has hallucinations that significantly impair ability for self care
 Hallucinations currently well controlled, possibly with medication May need monitoring by behavioral health professional/may or may not need medication May require medication/routine monitoring by behavioral health professional

Notes

Hallucination History **Hallucination History** Findings Notes

Hallucination

DELUSION ASSESSMENT

Delusion Has signs of delusion issues No signs of delusion issues

Findings Occasionally has delusions that interfere with functioning Frequently has delusions that interfere with functioning Currently has delusions that significantly impair ability for self care
 Delusions currently well controlled, possibly with medication May need monitoring by behavioral health professional/may or may not need medication May require medication/routine monitoring by behavioral health professional

Notes

Delusion History **Delusion History** Findings Notes

Delusion

ANXIETY ASSESSMENT

Anxiety Has signs of anxiety issues No signs of anxiety issues

Findings Occasionally has anxiety that interferes with functioning Frequently has anxiety that interferes with functioning Currently has anxiety that significantly impairs ability for self care
 Anxiety currently well controlled, possibly with medication May need monitoring by behavioral health professional/may or may not need medication May require medication/routine monitoring by behavioral health professional

Notes

Anxiety History **Anxiety History** Findings Notes

Anxiety

DEPRESSION ASSESSMENT

Depression Has signs of depression issues No signs of depression issues

Findings Occasionally has depression that interferes with functioning Frequently has depression that interferes with functioning Currently has depression that significantly impairs ability for self care
 Depression currently well controlled, possibly with medication May need monitoring by behavioral health professional/may or may not need medication May require medication/routine monitoring by behavioral health professional

Notes

Depression History **Depression History** Findings Notes

Depression

MOOD ASSESSMENT

Mood Has signs of mood issues No signs of mood issues

Findings Helpless Fearful Constricted
 Tearful Angry Decreased Motivation
 Hypervigilant Belligerent Hopeless
 Flat Apathetic Sullen
 Oppositional Anxious Resentful
 Overwhelmed Euphoric Despondent

Notes

.....

Mood

SENSORY ASSESSMENT

Sensory Has signs of sensory issues No signs of sensory issues

Findings Hearing loss within normal range Hearing loss Anosmia
 Vision loss within normal range Vision loss Ageusia

Notes

Sensory History **Sensory History** Findings Notes

Sensory

EYE ASSESSMENT

Eye Has signs of eye issues No signs of eye issues

Findings Visual limitation Cataract surgery Macular degeneration
 Cataracts Glaucoma

Level of Assistance **Demo Unit** Minimal Assist Total Assistance
 Independent Moderate Assistance

Notes

Eye History **Eye History** Findings Notes Level of Assistance

Eye Care

DENTAL ASSESSMENT

Dental Has signs of dental issues No signs of dental issues

Findings Dentures Edentulous Caries/Cavity

Level of Assistance

Notes

Dental History **Dental History** Findings Notes Level of Assistance

Dental

ORAL ASSESSMENT

Oral Has signs of oral issues No signs of oral issues

Findings Dentures Edentulous Caries/Cavity

Level of Assistance

Notes

Oral History

Oral History	
Findings	Level of Assistance
Notes	

Oral

MOBILITY ASSESSMENT

Mobility Has signs of mobility issues No signs of mobility issues

History of Falls Yes

Findings Poor gait Amputation Decreased mobility
 Decreased ROM Wound Orthopedic issues
 Weakness Paralysis Prosthesis issues
 Fracture Poor balance Bedridden

Level of Assistance

Devices Cane Crutches Cushion
 Walker Guide dog Ramp access
 Hoyer lift Hospital bed Electric cart
 Transfer board Leg brace(s) Bed rails
 Wheelchair Prosthesis

Notes

Mobility History

Mobility History	
History of Falls	No
Level of Assistance	Findings
Notes	Mobility Devices

Mobility

AMBULATION ASSESSMENT

Ambulation Has signs of ambulation issues No signs of ambulation issues

Findings Poor gait Amputation Decreased mobility
 Decreased ROM Wound Orthopedic issues
 Weakness Paralysis Prosthesis issues
 Fracture Poor balance Bedridden

Level of Assistance

Devices Cane Crutches Cushion
 Walker Guide dog Ramp access
 Hoyer lift Hospital bed Electric cart
 Transfer board Leg brace(s) Bed rails
 Wheelchair Prosthesis

Notes

Ambulation History

Ambulation History	
Findings	Level of Assistance
Devices	Notes

Ambulation

TRANSFERRING ASSESSMENT

Transferring Has signs of transferring issues No signs of transferring issues

Transfer types needed Supine to sitting Standing to sitting
 Sitting to standing Sitting to supine

Level of Assistance

Notes

Transferring History

Transferring History	
Types	Level of Assistance
Notes	

Transferring

WANDERING ASSESSMENT

Wandering Has signs of wandering issues No signs of wandering issues

Findings Wanders within residence/facility Combative about returning Has consistent history of getting lost/being combative about returning
 May wander outside, but does not jeopardize health/safety Requires professional consultation and/or intervention Requires constant supervision/behavioral program/professional consultation and intervention
 May wander outside, but health/safety may be jeopardized Wanders outside and leaves immediate area

Level of Assistance

Notes

Wandering History **Wandering History** Findings Notes Level of Assistance

Wandering

FALL ASSESSMENT

Fall Has signs of fall issues No signs of fall issues

Findings History of falls Physical weakness Decreased vision
 Balance problem Decreased awareness

Notes

Fall History **Fall History** Findings Notes

Fall

SELF-HARM ASSESSMENT

Self-Harm Has signs of self-harm issues No signs of self-harm issues

Findings Self-injurious (self-mutilation, suicidal ideation/plans/gestures), but can be redirected from behavior Self-injurious and may require behavioral control/intervention/medication Self-injurious and requires constant supervision/behavioral control/intervention and/or medication

Notes

Self-Harm History **Self-Harm History** Findings Notes

Self Harm

DIETARY ASSESSMENT

Dietary Has signs of dietary issues No signs of dietary issues

Diet Type Reg w/ added nutrients Mechanically altered High-fiber
 ADA calorie-calc Diabetic Kosher
 Liquid Low-sodium Vegetarian
 Pureed Low-fat
 Soft Low-cholesterol

Nutritional Risk Less than 2 meals/day Tooth or mouth problem Gained or lost 10 pounds in the last 6 months w/out dieting
 Less than 2 servings of fruits & vegetables/day Run out of money for food Illness/condition that changes the kind and/or amount of food
 Less than 2 servings of milk & dairy/day Frequently eats alone Not always physically able to shop, cook, feed self
 More than 2 drinks beer, liquor or wine/day More than 2 different prescribed or OTC drugs/day Difficulty swallowing

Notes

Food Allergies

Dietary Preferences

Food Dislikes

Dietary History **Dietary History** Diet Type Notes Nutritional Risk Food Allergies Dietary Preferences Food Dislikes

Dietary

EATING ASSESSMENT

- Eating Has signs of eating issues No signs of eating issues
- Findings Usually good Eats in dining room G tube
 Usually poor Eats in room J tube
 Eats with assistance NG tube TPN

Eating

Level of Assistance

Notes

Eating History

Eating History	Findings	Level of Assistance
	Notes	

WEIGHT LOSS/GAIN ASSESSMENT

- Weight Has signs of weight issues No signs of weight issues

Usual weight
proper healthy weight for this resident

Current Weight

Notes

Weight Loss

Weight Loss History

Weight Loss History	Usual Weight	Weight
	Notes	

GROOMING ASSESSMENT

- Grooming Has signs of grooming issues No signs of grooming issues

Findings Unkempt, Dirty Poor attention to ADL's
 Disheveled Bizarre, Atypical

Grooming

Level of Assistance

Notes

Grooming History

Grooming History	Findings	Level of Assistance
	Notes	

DRESSING ASSESSMENT

- Dressing Has signs of dressing issues No signs of dressing issues

Level of Assistance

Notes

Dressing

Dressing History

Dressing History	Level of Assistance	Notes

ASSISTIVE DEVICES ASSESSMENT

- Assistive Device Needed for daily activity Not needed for daily activity

Devices Hearing aid Walker Wheel chair
 Cane Glasses Crutches

Assistive devices

Level of Assistance

Notes

Assistive Device History

Assistive Devices History	Assistive Devices	Level of Assistance
	Notes	

PROSTHETIC ASSESSMENT

Prosthetic Devices Has prosthetic devices Has no prosthetic devices

Level of Assistance

Notes

Prosthetic History

Prosthetic History	
Level of Assistance	Notes

Prosthetic devices

TOILETING ASSESSMENT

Toileting Has signs of toileting issues No signs of toileting issues

Level of Assistance

Devices Bed pan Grab bars Incontinence pads
 Urinal Commode Raised toilet seat

Notes

Toileting History

Toileting History		
Level of Assistance	Notes	Devices

Toileting

CONTINENCE ASSESSMENT

Continence Has signs of continence issues No signs of continence issues

Findings Bowel & bladder continent Bladder continent only
 Bowel continent only Bowel & bladder incontinent

Level of Assistance

Notes

Continence History

Continence History		
Findings	Level of Assistance	Notes

Incontinence care

BATHING ASSESSMENT

Bathing Has signs of bathing issues No signs of bathing issues

Type Tub bath Shower Sponge bath

Level of Assistance

Devices Bath bench Handheld shower
 Grab bar/Tub rail Hydraulic lift

Notes

Bathing History

Bathing History			
Type	Level of Assistance	Notes	Devices

Bathing

SMOKING ASSESSMENT

Smoking Has smoking issues Does not smoke

Type Cigarettes Cigars w/ lighter
 Pipe Snuff w/ matches

History of unsafe use No Yes

Level of Assistance

Notes

Smoking History

Smoking History	
Type	Level of Assistance

Smoke

MEDICATION USE/SELF-MEDICATE ASSESSMENT

Self-Medicate Has signs of self-medicate issues No signs of self-medicate issues

Findings

<input type="checkbox"/> Can not determine need for medications	<input type="checkbox"/> Can not name medications on the container	<input type="checkbox"/> Can not tell side effects of medication and when they are to be reported to the doctor
<input type="checkbox"/> Can not identify number of medications	<input type="checkbox"/> Can not read the name of medication	<input type="checkbox"/> Can not follow directions on how to take the medication i.e. w/ juice, after meal
<input type="checkbox"/> Can not distinguish tablet/capsule sizes	<input type="checkbox"/> Can not state why he/she is taking the medication	<input type="checkbox"/> Can not determine the dosage of each medication per administration
<input type="checkbox"/> Can not distinguish tablet/capsule shapes	<input type="checkbox"/> Doesn't know the time of day medications are to be taken	
<input type="checkbox"/> Can not distinguish tablet/capsule colors	<input type="checkbox"/> Can not get the right medication container at the right time	

Notes

Medication use/Self-medicate History **Self-Medicate History** Findings Notes

Self-medicate

LEISURE ASSESSMENT

Leisure Has signs of leisure issues No signs of leisure issues

Level of Assistance

Current Interests

Past Interests

Leisure History **Leisure History** Level of Assistance Past Interests Current Interests

Leisure

COMMUNICATION ASSESSMENT

Communication Has signs of communication issues No signs of communication issues

Findings

Devices

<input type="checkbox"/> Needs assistance with phone calls	<input type="checkbox"/> Lifeline	<input type="checkbox"/> Elec communication device
<input type="checkbox"/> Corrective lenses	<input type="checkbox"/> Hearing aids	<input type="checkbox"/> Picture book
<input type="checkbox"/> Symbol book	<input type="checkbox"/> Sign language interpreter	<input type="checkbox"/> Teletypewriter
<input type="checkbox"/> Magnifying glass	<input type="checkbox"/> Foreign language interpreter	<input type="checkbox"/> Literacy tutoring

Level of Assistance

Notes

Communication History **Communication History** Devices Level of Assistance Findings Notes

Communication

HOUSEKEEPING ASSESSMENT

Housekeeping Assistance needed for this resident No signs of housekeeping issues

Type

<input type="checkbox"/> Trash	<input type="checkbox"/> Tidy	<input type="checkbox"/> Tuck In
<input type="checkbox"/> Vacuum	<input type="checkbox"/> Dusting	
<input type="checkbox"/> Turndown	<input type="checkbox"/> Bed Making	

Level of Assistance

Notes

Housekeeping History **Housekeeping History** Type Notes Level of Assistance

Housekeeping

APPOINTMENT ASSESSMENT

Appointment Has signs of appointment scheduling issues No signs of appointment scheduling issues

Level of Assistance

Notes

Appointment History

Appointment History	Level of Assistance	Notes

Appointments

FINANCIAL ASSESSMENT

Financial Has signs of financial issues No signs of financial issues

Findings Has trouble handling financial affairs

Notes

Financial History

Financial History	Findings	Notes

Financial

ASSAULT ASSESSMENT

Assault Has assault issues No assault issues

Findings Sometimes assaultive Frequently assaultive/may require professional consultation/behavioral program
 Requires special tolerance/management, but not professional intervention Is assaultive/needs constant supervision/behavioral program/professional consultation/intervention

Notes

Assault History

Assault History	Findings	Notes

Assault/Destructive

SUBSTANCE ABUSE ASSESSMENT

Abuse Has signs of abuse issues No signs of abuse issues

Findings Infrequently abuses drugs/alcohol Sometimes abuses drugs/alcohol Frequently abuses drugs/alcohol
 Some interpersonal/health problems, but does not significantly impair functioning Moderate problems with peers/family/law/etc and may require intervention Significant problems with others and severely impairs independent functioning

Level of Assistance

Notes

Abuse History

Abuse History	Findings	Level of Assistance	Notes

Substance abuse

VICTIMIZATION ASSESSMENT

Victimization Has signs of victimization issues No signs of victimization issues

Findings Not clearly aware of surroundings Frequently unable to discern/avoid situations of abuse/neglect/exploitation Requires constant supervision
 Sometimes able to discern/avoid situations of abuse/neglect/exploitation Inability to discern/avoid abuse/neglect/exploitation

Notes

Victimization History

Victimization History	Findings	Notes

Victimization

BEHAVIORAL ASSESSMENT

Behavioral Has signs of behavioral issues No signs of behavioral issues

Findings Awake/out-of-bed at night Undressing inappropriately Anxious/worried
 Destroying belongings Smearing/throwing feces Hiding/hoarding
 Eating non-edible items Unwanted touching of others Wandering outside
 Resisting ADL assistance Aggressive reaction to touch Refusal to eat
 Repetitive behavior/speech Hallucinations/imaginings Physically combative
 Losing personal property Restless/Despondent Sleeping much of day
 Rummaging through other apts Unusual gait Wandering in building
 Verbally offensive/abusive General inactivity Suspicious/accusatory
 Inappropriate sexual behavior Sad/tearful Eating others' food

Notes

Behavioral History

Behavioral History	Findings	Notes

Behavior

BEHAVIOR MANAGEMENT ASSESSMENT

Behavior Management Has need of behavior management No need of behavior management

Findings

- Wandering/Searching
- Anxious
- Wandering/Other's rooms
- Tapping/waving hand/feet
- Undressing self
- Picking at skin/hair
- Movement repetitions
- Scratching self/others
- Screaming
- Spitting
- Crying
- Rummaging
- Verbal abuse
- Hitting/Kicking
- Withdrawl
- Pacing

Behavior Management

Level of Assistance

Typical Misbehavior Times

- Random
- AM
- PM
- Near shift change
- Before a visit
- After a visit
- Before activities
- After activities
- Before meals
- After meals

Typical Misbehavior Location

Are Others at risk?

No Yes

Misbehavior Triggers

- Physical discomfort
- Boredom
- Mental confusion
- Fatigue
- Hunger
- Disease associated changes
- Fear/Worry
- Loneliness
- Specific individual
- Need toileting
- Pain
- Miscommunication
- Thirst

Misbehavior Remedies

- One-on-one attention
- Activity
- Food
- Talking
- Pain medication
- Drink
- Toileting
- Nap
- Walking

Notes

Behavior Management History

Behavior Management History

Findings	Level of Assistance
Misbehavior Times	Misbehavior Location
Are others at risk	Triggers
Remedies	Notes

SPECIAL TREATMENTS ASSESSMENT

Special Treatments Has need for special treatment No need for special treatment

Notes

Special treatment

Special Treatments History

Special Treatments History

Notes

Assisted Living Facilities, Type II, are intended to enable persons experiencing functional impairment to receive 24-hour personal care and health-related services in a place of residence with sufficient structure to meet their care needs in a safe manner. Assisted Living Facilities, Type II, provide care in a home-like setting that provides an array of coordinated supportive personal and health care services available 24 hours per day to residents who need any of these services as required by Utah Department of Health rule. Residents must be capable of achieving mobility sufficient to exit the facility or to a zone of safety with the limited assistance of one person. Assisted Living Facilities, Type II may accept or retain residents who require significant (total) assistance from staff or others in three (3) or more ADL's, provided the staffing level and coordinated supportive health and social services meet the needs of the resident. Residents may receive regular or intermittent health care services from a licensed health care professional. Assisted Living Facilities, Type II may not accept or retain Dependent residents i.e., a resident who requires inpatient hospital or 24-hour continual nursing care that will last longer than 15 calendar days after the day on which the nursing care begins; or who is unable to evacuate from the facility without the physical assistance of two persons. Residents who manifest behavior that is assaultive, threatening or dangerous to themselves or others; that is sexually or socially inappropriate; who have Tuberculosis or other chronic communicable disease that is unable to be treated in the facility or on an outpatient basis; who require inpatient care in a hospital or long-term nursing care; or who require significant assistance during night sleeping hours are not eligible for admission. An Assisted Living Type II facility initial assessment must be completed by a physician, advanced practice registered nurse, physician assistant, or a registered nurse prior to admission. To the best of my knowledge this resident meets the admission criteria for an Assisted Living Type II facility.

only sign once assessment is completed

Completed Nursing Assessment

Reviewed By

BENCH, JOHNNY

Responsible Party

* Required

Addendum B

When a selection is selected on the Setup: Assessment/Plans the resulting sections will then be displayed on the Service Plan

Category: Other

Service Item: **Additional services**

Inactive Active
 Service Item: **Additional services** Value: Instructions:

Category: Other
 Level of Assistance: *

Provider: * **Demo Unit**
 Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing

Start Date: * End Date: *

PRN Scheduled
 Interval - or - Days

Scheduled Time *

<input checked="" type="checkbox"/> Su	<input checked="" type="checkbox"/> M	<input checked="" type="checkbox"/> Tu	<input checked="" type="checkbox"/> W	<input checked="" type="checkbox"/> Th	<input checked="" type="checkbox"/> F	<input checked="" type="checkbox"/> Sa
<input type="checkbox"/> AM	<input type="checkbox"/> 8:00am	<input type="checkbox"/> 1:00pm	<input type="checkbox"/> 6:00pm	<input type="checkbox"/> 11:00pm	<input type="checkbox"/> 4:00am	
<input type="checkbox"/> PM	<input type="checkbox"/> 9:00am	<input type="checkbox"/> 2:00pm	<input type="checkbox"/> 7:00pm	<input type="checkbox"/> 12:00am	<input type="checkbox"/> 5:00am	
<input type="checkbox"/> Bedtime	<input type="checkbox"/> 10:00am	<input type="checkbox"/> 3:00pm	<input type="checkbox"/> 8:00pm	<input type="checkbox"/> 1:00am		
<input type="checkbox"/> 6:00am	<input type="checkbox"/> 11:00am	<input type="checkbox"/> 4:00pm	<input type="checkbox"/> 9:00pm	<input type="checkbox"/> 2:00am		
<input type="checkbox"/> 7:00am	<input type="checkbox"/> 12:00pm	<input type="checkbox"/> 5:00pm	<input type="checkbox"/> 10:00pm	<input type="checkbox"/> 3:00am		

Category: Physical

Service Item: **Ambulation**

Inactive Active
 Service Item: **Ambulation** Value: Instructions:

Category: Physical
 Level of Assistance: *

Provider: * **Demo Unit**
 Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing

Start Date: * End Date: *

PRN Scheduled
 Interval - or - Days

Scheduled Time *

<input checked="" type="checkbox"/> Su	<input checked="" type="checkbox"/> M	<input checked="" type="checkbox"/> Tu	<input checked="" type="checkbox"/> W	<input checked="" type="checkbox"/> Th	<input checked="" type="checkbox"/> F	<input checked="" type="checkbox"/> Sa
<input type="checkbox"/> AM	<input type="checkbox"/> 8:00am	<input type="checkbox"/> 1:00pm	<input type="checkbox"/> 6:00pm	<input type="checkbox"/> 11:00pm	<input type="checkbox"/> 4:00am	
<input type="checkbox"/> PM	<input type="checkbox"/> 9:00am	<input type="checkbox"/> 2:00pm	<input type="checkbox"/> 7:00pm	<input type="checkbox"/> 12:00am	<input type="checkbox"/> 5:00am	
<input type="checkbox"/> Bedtime	<input type="checkbox"/> 10:00am	<input type="checkbox"/> 3:00pm	<input type="checkbox"/> 8:00pm	<input type="checkbox"/> 1:00am		
<input type="checkbox"/> 6:00am	<input type="checkbox"/> 11:00am	<input type="checkbox"/> 4:00pm	<input type="checkbox"/> 9:00pm	<input type="checkbox"/> 2:00am		
<input type="checkbox"/> 7:00am	<input type="checkbox"/> 12:00pm	<input type="checkbox"/> 5:00pm	<input type="checkbox"/> 10:00pm	<input type="checkbox"/> 3:00am		

Category: **Management**
Service Item: **Appointments**

Inactive Active
 Service Item: **Appointments** Value:
 Category: Management
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: **Assistive devices**

Inactive Active
 Service Item: **Assistive devices** Value:
 Category: Physical
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Category: **Hygiene**
Service Item: **Bathing**

Inactive Active
 Service Item: **Bathing** Value:
 Category: Hygiene
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Category: Behavior

Service Item: **Behavioral management**

Inactive Active
 Service Item: **Behavioral management** Value: Instructions:
 Category: Behavior
 Level of Assistance: *

Provider: * **Demo Unit**
 Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing

Start Date: * End Date: *

PRN Scheduled
 Interval:

Days: * Su M Tu W Th F Sa

Scheduled Time: *

<input type="checkbox"/> AM	<input type="checkbox"/> 8:00am	<input type="checkbox"/> 1:00pm	<input type="checkbox"/> 6:00pm	<input type="checkbox"/> 11:00pm	<input type="checkbox"/> 4:00am
<input type="checkbox"/> PM	<input type="checkbox"/> 9:00am	<input type="checkbox"/> 2:00pm	<input type="checkbox"/> 7:00pm	<input type="checkbox"/> 12:00am	<input type="checkbox"/> 5:00am
<input type="checkbox"/> Bedtime	<input type="checkbox"/> 10:00am	<input type="checkbox"/> 3:00pm	<input type="checkbox"/> 8:00pm	<input type="checkbox"/> 1:00am	
<input type="checkbox"/> 6:00am	<input type="checkbox"/> 11:00am	<input type="checkbox"/> 4:00pm	<input type="checkbox"/> 9:00pm	<input type="checkbox"/> 2:00am	
<input type="checkbox"/> 7:00am	<input type="checkbox"/> 12:00pm	<input type="checkbox"/> 5:00pm	<input type="checkbox"/> 10:00pm	<input type="checkbox"/> 3:00am	

Service Item: **Communication**

Inactive Active
 Service Item: **Communication** Value: Instructions:
 Category: Management
 Level of Assistance: *

Provider: * **Demo Unit**
 Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing

Start Date: * End Date: *

PRN Scheduled
 Interval:

Days: * Su M Tu W Th F Sa

Scheduled Time: *

<input type="checkbox"/> AM	<input type="checkbox"/> 8:00am	<input type="checkbox"/> 1:00pm	<input type="checkbox"/> 6:00pm	<input type="checkbox"/> 11:00pm	<input type="checkbox"/> 4:00am
<input type="checkbox"/> PM	<input type="checkbox"/> 9:00am	<input type="checkbox"/> 2:00pm	<input type="checkbox"/> 7:00pm	<input type="checkbox"/> 12:00am	<input type="checkbox"/> 5:00am
<input type="checkbox"/> Bedtime	<input type="checkbox"/> 10:00am	<input type="checkbox"/> 3:00pm	<input type="checkbox"/> 8:00pm	<input type="checkbox"/> 1:00am	
<input type="checkbox"/> 6:00am	<input type="checkbox"/> 11:00am	<input type="checkbox"/> 4:00pm	<input type="checkbox"/> 9:00pm	<input type="checkbox"/> 2:00am	
<input type="checkbox"/> 7:00am	<input type="checkbox"/> 12:00pm	<input type="checkbox"/> 5:00pm	<input type="checkbox"/> 10:00pm	<input type="checkbox"/> 3:00am	

Service Item: **Dental**

Inactive Active
 Service Item: **Dental** Value: Instructions:
 Category: Hygiene
 Level of Assistance: *

Provider: * **Demo Unit**
 Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing

Start Date: * End Date: *

PRN Scheduled
 Interval:

Days: * Su M Tu W Th F Sa

Scheduled Time: *

<input type="checkbox"/> AM	<input type="checkbox"/> 8:00am	<input type="checkbox"/> 1:00pm	<input type="checkbox"/> 6:00pm	<input type="checkbox"/> 11:00pm	<input type="checkbox"/> 4:00am
<input type="checkbox"/> PM	<input type="checkbox"/> 9:00am	<input type="checkbox"/> 2:00pm	<input type="checkbox"/> 7:00pm	<input type="checkbox"/> 12:00am	<input type="checkbox"/> 5:00am
<input type="checkbox"/> Bedtime	<input type="checkbox"/> 10:00am	<input type="checkbox"/> 3:00pm	<input type="checkbox"/> 8:00pm	<input type="checkbox"/> 1:00am	
<input type="checkbox"/> 6:00am	<input type="checkbox"/> 11:00am	<input type="checkbox"/> 4:00pm	<input type="checkbox"/> 9:00pm	<input type="checkbox"/> 2:00am	
<input type="checkbox"/> 7:00am	<input type="checkbox"/> 12:00pm	<input type="checkbox"/> 5:00pm	<input type="checkbox"/> 10:00pm	<input type="checkbox"/> 3:00am	

Service Item: Dressing

Inactive Active
 Service Item: **Dressing** Value: Instructions:
 Category: Hygiene
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Category: Meal

Service Item: Eating

Inactive Active
 Service Item: **Eating** Value: Instructions:
 Category: Meal
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: External services

Inactive Active
 Service Item: **External services** Value: Instructions:
 Category: Other
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Eye Care

Inactive Active
 Service Item: **Eye Care** Value: Instructions:
 Category: Physical
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Financial management

Inactive Active
 Service Item: **Financial management** Value: Instructions:
 Category: Management
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Grooming

Inactive Active
 Service Item: **Grooming** Value: Instructions:
 Category: Hygiene
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Hair

Inactive Active
 Service Item: **Hair** Value: Instructions:
 Category: Hygiene
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Category: Health checks

Service Item: Health checks

Inactive Active
 Service Item: **Health checks** Value: Instructions:
 Category: Health checks
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Health monitoring

Inactive Active
 Service Item: **Health monitoring** Value: Instructions:
 Category: Health checks
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: **Housekeeping**

Inactive Active
 Service Item: **Housekeeping** Value: Instructions:
 Category: Housekeeping
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Category: Continance

Service Item: **Incontinence care**

Inactive Active
 Service Item: **Incontinence care** Value: Instructions:
 Category: Continance
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: **Laundry**

Inactive Active
 Service Item: **Laundry** Value: Instructions:
 Category: Housekeeping
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Leisure

Inactive Active
 Service Item: **Leisure** Value: Instructions:
 Category: Other
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Mobility

Inactive Active
 Service Item: **Mobility** Value: Instructions:
 Category: Physical
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Night checks

Inactive Active
 Service Item: **Night checks** Value: Instructions:
 Category: Health checks
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Oral

Inactive Active
 Service Item: **Oral** Value: Instructions:
 Category: Hygiene
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Outside services

Inactive Active
 Service Item: **Outside services** Value: Instructions:
 Category: Other
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Prosthetic devices

Inactive Active
 Service Item: **Prosthetic devices** Value: Instructions:
 Category: Physical
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Purchases

Inactive Active
 Service Item: **Purchases** Value:
 Category: Management
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Q2

Inactive Active
 Service Item: **Q2** Value:
 Category: Health checks
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Shave

Inactive Active
 Service Item: **Shave** Value:
 Category: Hygiene
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Smoke

Inactive Active
 Service Item: **Smoke** Value:
 Category: Other
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Substance abuse

Inactive Active
 Service Item: **Substance abuse** Value:
 Category: Other
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Toileting

Inactive Active
 Service Item: **Toileting** Value:
 Category: Continance
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Transferring

Inactive Active
 Service Item: **Transferring** Value: Instructions:
 Category: Physical
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Transportation

Inactive Active
 Service Item: **Transportation** Value: Instructions:
 Category: Management
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: Vital Signs

Inactive Active
 Service Item: **Vital Signs** Value: Instructions:
 Category: Health checks
 Level of Assistance: *
 Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing
 Start Date: * End Date: *
 Vital Signs * Blood pressure Temperature O2/min
 Heart rate Glucose/Blood sugar Weight
 Respiratory rate O2 sats
 PRN Scheduled
 Interval
 - or -
 Days * Su M Tu W Th F Sa
 Scheduled Time * AM 8:00am 1:00pm 6:00pm 11:00pm 4:00am
 PM 9:00am 2:00pm 7:00pm 12:00am 5:00am
 Bedtime 10:00am 3:00pm 8:00pm 1:00am
 6:00am 11:00am 4:00pm 9:00pm 2:00am
 7:00am 12:00pm 5:00pm 10:00pm 3:00am

Service Item: **Wandering**

Inactive Active Value:

Service Item: **Wandering** Instructions:

Category: Health checks

Level of Assistance: *

Provider: * **Demo Unit** Housekeeping Resident
 Care Giver Life Engagement
 CNA Nursing

Start Date: * End Date: *

PRN Scheduled

Interval:

Days: * Su M Tu W Th F Sa

Scheduled Time: *

<input type="checkbox"/> AM	<input type="checkbox"/> 8:00am	<input type="checkbox"/> 1:00pm	<input type="checkbox"/> 6:00pm	<input type="checkbox"/> 11:00pm	<input type="checkbox"/> 4:00am
<input type="checkbox"/> PM	<input type="checkbox"/> 9:00am	<input type="checkbox"/> 2:00pm	<input type="checkbox"/> 7:00pm	<input type="checkbox"/> 12:00am	<input type="checkbox"/> 5:00am
<input type="checkbox"/> Bedtime	<input type="checkbox"/> 10:00am	<input type="checkbox"/> 3:00pm	<input type="checkbox"/> 8:00pm	<input type="checkbox"/> 1:00am	
<input type="checkbox"/> 6:00am	<input type="checkbox"/> 11:00am	<input type="checkbox"/> 4:00pm	<input type="checkbox"/> 9:00pm	<input type="checkbox"/> 2:00am	
<input type="checkbox"/> 7:00am	<input type="checkbox"/> 12:00pm	<input type="checkbox"/> 5:00pm	<input type="checkbox"/> 10:00pm	<input type="checkbox"/> 3:00am	