

Resident Name _____
 Date of Birth _____
 Date Completed _____

Assisted Living Manager's Assessment

This form is to be completed by the Assisted Living Manager or their designee. Questions noted with an asterisk are "triggers" for awake overnight staff.

Instructions: Record score in the blank next to each question.

Activities of Daily Living

- 13.* _____ **Resident Eats**
 0 Independently
 1 With supervision, or set-up, or cuing and coaching
 2 With physical assistance or use of adaptive devices, such as built up utensil, plate guard, or Geri-cup, to feed self
 *3 Must be fed or needs tube feeding
- 14.* _____ **Resident's Mobility** (moves from place to place)
 0 Independently
 1 With supervision, or stand-by, or cuing and coaching
 *2 One-person physical assistance
 *3 Two-person physical assistance, or needs complete mechanical assistance (e.g., Hoyer Lift)
- 15.* _____ **Resident Transfer to Bed, Chair, or Toilet**
 0 Independently (or with assistive device)
 1 With supervision, or stand-by or set-up, or cuing and coaching
 *2 One-person physical assistance
 *3 Two-person physical assistance, needs complete assistance
- 16.* _____ **Bed Mobility** (how resident moves to and from lying position, turns side to side, and positions body while in bed)
 0 Independently (or with assistive device)
 1 With supervision, or stand-by or set-up, or cuing and coaching
 *2 One-person physical assistance
 *3 Two-person physical assistance, needs complete assistance
- 17.* _____ **Resident Use of Stairs**
 0 Independently (or with assistive device)
 1 With supervision, or stand-by, or cuing and coaching
 2 One-person physical assistance
 3 Two-person physical assistance, or unable to use stairs
- 18.* _____ **Resident Continence**
 0 Independently
 *1 With supervision, or stand-by or set-up, or cuing and coaching
 *2 Needs physical assistance from one other person
 *3 Incontinent, needs complete assistance
19. _____ **Resident Completes Bathing**
 0 Independently
 1 With supervision, or stand-by or set-up, or cuing and coaching
 2 Needs physical assistance (e.g., help in and out of tub, washing hair)
 3 Must be bathed, needs complete assistance or mechanical assistance (e.g., Hoyer Lift)
20. _____ **Resident Completes Grooming (teeth, make-up, shaving, hair)**
 0 Independently
 1 With supervision, or stand-by or set-up, or cuing and coaching
 2 Needs physical assistance
 3 Must be groomed, needs complete assistance

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21. _____ **Resident Gets Dressed/Changes Clothes**
 0 Independently
 1 With supervision, or stand-by or set-up, or cuing and coaching
 2 With physical assistance
 3 Must be dressed, needs complete assistance

21(a) _____ Add scores for Items 13 - 21. Enter total in blank space at left.

Instrumental Activities of Daily Living

Note: Incapacities identified in this section do not imply services will be provided.

Instructions: Check the letter that most closely reflects the resident's capabilities.

22. **Resident Can Prepare Light Meal**
 A – Independent, plans and prepares adequate meals
 B – With supervision, set-up, or cuing and coaching
 C – One-person physical assistance
 D – Unable to prepare meals
23. **Resident Can Do Light Chores**
 A – Independent
 B – With supervision, set-up, or cuing and coaching
 C – One-person physical assistance
 D – Unable to do light chores
24. **Resident Can Do Shopping**
 A – Independent
 B – With supervision or cuing and coaching (e.g., choosing items)
 C – With one-person physical assistance/someone to go with them
 D – Unable to do shopping
25. **Ability to Manage Finances**
 A – Family or resident manages all financial matters independently, writes checks, pays bills/rent, goes to bank
 B – With supervision, writes checks, pays bills/rent, goes to bank
 C – Manages day-to-day purchases, but needs help with purchases and banking
 D – Unable to manage finances or handle money
26. **Transportation**
 A – Travels by self, all modes of transportation
 B – Needs some assistance/escort
 C – Complete assistance/needs specialized vehicle
27. **Resident Can Use Telephone**
 A – Independent
 B – With assistance dialing/using directory
 C – Unable to use telephone

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Behaviors/Communication

Does the resident exhibit any of the following behaviors? Check the appropriate box to indicate frequency of each behavior. For scoring purposes use the highest frequency noted. See the User's Guide for definitions of frequency.

28. **Withdrawn:** Frequency of behavior(s) (check appropriate response):

- | | | | | |
|-------------------------------------|--------------------------------|-------------------------------------|----------------------------------|-------------------------------------|
| A. Refuses to leave room | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Continuous |
| B. Refuses to socialize with others | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Continuous |

Explain _____

29.* **Wanders:** Frequency of behavior(s) (check appropriate response):

- | | | | | |
|--|--------------------------------|-------------------------------------|-----------------------------------|--------------------------------------|
| A. Persistent moving/walking about without purpose | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Continuous |
| B. Looks for non-existent place (former house/apartment/bus) | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Continuous |
| *C. Actively tries to leave facility | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular* | <input type="checkbox"/> Continuous* |
| D. Wanders during day | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Continuous |
| *E. Wanders in evening and/or at night | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular* | <input type="checkbox"/> Continuous* |

Explain _____

30.* **Sleep disturbance:** Frequency of behavior(s) (check appropriate response):

- | | | | | |
|--|--------------------------------|-------------------------------------|-----------------------------------|--------------------------------------|
| *A. Unable to sleep or agitated at night | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular* | <input type="checkbox"/> Continuous* |
| B. Frequently falls asleep during day | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Continuous |

Explain _____

31.* **Verbally inappropriate:** Frequency of behavior(s) (check appropriate response):

- | | | | | |
|---------------------------------------|--------------------------------|-------------------------------------|-----------------------------------|--------------------------------------|
| A. Uses foul language | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Continuous |
| *B. Sounds angry and threatens others | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular* | <input type="checkbox"/> Continuous* |

Explain _____

32.* **Disruptive behaviors:** Frequency of behavior(s) (check appropriate response):

- | | | | | |
|---|--------------------------------|-------------------------------------|-----------------------------------|--------------------------------------|
| A. Yells | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Continuous |
| B. Demands attention without regard to others | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Continuous |
| *C. Takes other's possessions | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular* | <input type="checkbox"/> Continuous* |
| *D. Socially inappropriate behaviors (e.g., disrobes, urinates, or defecates in public) | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular* | <input type="checkbox"/> Continuous* |
| *E. Sexually inappropriate behaviors (e.g., unwanted touching, public masturbation) | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular* | <input type="checkbox"/> Continuous* |

Explain _____

33.* **Combative behaviors:** Frequency of behavior(s) (check appropriate response):

- | | | | | |
|---|--------------------------------|-------------------------------------|-----------------------------------|--------------------------------------|
| *A. Throws objects indiscriminately | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular* | <input type="checkbox"/> Continuous* |
| *B. Strikes out, kicks, or punches at others | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular* | <input type="checkbox"/> Continuous* |
| *C. Pinches, bites, spits at others, scratches, or pulls hair | <input type="checkbox"/> Never | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular* | <input type="checkbox"/> Continuous* |

Explain _____

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34.* **Resistive/uncooperative behaviors:** Frequency of behavior(s) (check appropriate response):

- A. Refuses to wash Never Occasional Regular Continuous
- B. Refuses to eat Never Occasional Regular Continuous
- C. Refuses to drink Never Occasional Regular Continuous
- *D. Refuses to care for self Never Occasional Regular* Continuous*
- E. Refuses to allow others to assist Never Occasional Regular Continuous
- F. Refuses medications Never Occasional Regular Continuous
- *G. Refuses to comply with safety advice Never Occasional Regular* Continuous*

Explain _____

35.* **Communication** (check and/or explain appropriate response):

- A. Communicates needs, ideas, & wishes Unable* Sometimes Able* Usually Always
- *B. Unwilling to communicate needs/wishes Never Occasional Regular* Continuous*

Explain _____

36. **Eating patterns** and food preferences (check all that apply):

- Eats full meals Eats only two meals Eats small portions Finger foods
- Eats only what they want, but maintains weight
- Eats only when they want Supplements (type ordered) _____
- Prefers: Fruit Vegetables Meats Snacks or snack foods

Explain _____

Daily Social and Recreational Needs

37. **Resident Support System** (check all that apply):

- Resident has Legal representative for health care decisions Surrogate decision maker (family member/significant other)
- Family is local Involved Not involved
- Family lives out of area Involved Not involved
- Problems with family circumstances Yes No
- Problems with personal relationships Yes No

Explain _____

38. **Spiritual needs and status** _____

39. **Education/Work History** (check/complete all that apply):

- Did not complete high school
- Completed high school or GED
- College
- Lifetime or last occupation _____

40. **Interests/Hobbies:** _____

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41. **Activity Status** (interest and ability to participate in, check and explain):

A. Structured and group activities Yes No Varies
Explain _____

B. Self-directed activities Yes No Varies
Explain _____

42. **Current Daily Routine** (e.g., up in the morning, bedtime, normal sleep cycle prior to move in, meal time preferences)

43. **Interest/participation in programs away from facility** (e.g., Senior Centers, Adult Day Care, or Rehabilitation Programs)

Print Name of Person Completing Assessment: _____

Position of Person Completing Assessment: _____

Date Completed: _____

Signature of Person Completing Assessment