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| Transforming Lives | **CONFIDENTIAL INFORMATION – DO NOT DISCLOSENOT FOR PUBLIC DISCLOSURE****Assisted Living Facility Resident Characteristic Rosterand Sample Selection** | Attachment D |
|  |  | TOTAL CENSUS |
| ASSISTED LIVING FACILITY NAME | LICENSE NUMBER | INSPECTION DATE |
| LICENSOR NAME | Visit Type: **[ ]**  Initial **[ ]**  Full **[ ]**  Follow up **[ ]**  Complaint: Number   |
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| RESIDENT ROOM | ADMIT DATE | RESIDENT ID NUMBER | RESIDENT NAME | Nursing Services | Medication: Ind. (I), Assist (A), Adm. (Ad), Fam. (F) | Mobility / Falls / Ambulation Devices | Behavior / Psycho Social Issues | Dementia / Alzheimer’s / Cognitive impairment | Exit Seeking / Wandering | Smoking | DD / Mental Health | Language / Communication Issue / Deafness / Hearing issues | Vision Deficit / Blindness | Diabetic: Insulin/Non-Insulin | Assist with ADL’s | Wounds / Skin Issue | Incontinent / Appliance (catheter) Dialysis | Special Dietary Needs / Scheduled Snacks | Weight Loss / Weight Gain | Medical Devices  | Pay Status: Private = P State = S | Recent Hospitalization | Oxygen / Respiratory Therapy | Home Health / Hospice / Private Caregiver | Other |
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| RESIDENT ROOM | ADMIT DATE | RESIDENT ID NUMBER | RESIDENT NAME | Nursing Services | Medication: Ind. (I), Assist (A), Adm. (Ad), Fam. (F) | Mobility / Falls / Ambulation Devices | Behavior / Psycho Social Issues | Dementia / Alzheimer’s / Cognitive impairment | Exit Seeking / Wandering | Smoking | DD / Mental Health | Language / Communication Issue / Deafness / Hearing issues | Vision Deficit / Blindness | Diabetic: Insulin/Non-Insulin | Assist with ADL’s | Wounds / Skin Issue | Incontinent / Appliance (catheter) Dialysis | Special Dietary Needs / Scheduled Snacks | Weight Loss / Weight Gain | Medical Devices  | Pay Status: Private = P State = S | Recent Hospitalization | Oxygen / Respiratory Therapy | Home Health / Hospice / Private Caregiver | Other |
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| **Coding:** In order to assist in more accurate communication of resident characteristics, the following coding legend has been provided.  If characteristics do not apply, leave box blank. |
|  | MARK THE BOX: |
| Nursing Services(services only a licensed nurse can provide) | **O** - resident receiving Ostomy care; **T** - resident receiving Tube feeding; **I** – resident receiving Injections; **ND** – resident receiving Nurse Delegation. |
| Medication: Independent Administration Assistance Family Assistance | **I** – resident assessed as Independent with their medication; **A** – resident assessed as needing medication assistance;**AD** – resident assessed medication administration; **F** – resident receiving Family assistance with medications. |
| Mobility / Falls / Ambulation Devices | **A** – resident requires Assistance with transfers or cannot ambulate independently without assistance from staff or assistive devices; **F** – resident experienced a Fall within the last 30 days; **D** – resident uses a Device to assist with ambulation. |
| Behavior / Psycho Social Issues | **X** – resident shows or has behaviors such as those requiring special training or assistance increasing the amount of time staff needs to assist resident. |
| Dementia / Alzheimer’s / Cognitive impairment | **X** – resident shows or has behaviors requiring special training or assistance increasing the amount of time staff needs to assist resident. |
| Exit Seeking / Wandering | **ES** – resident has shown Exit Seeking behaviors; **W** – resident has shown Wandering behaviors |
| Smoking | **S** – resident Smokes. |
| DD / Mental Health | **DD** – resident has a Developmental Disability case manager; **MH** – resident receives Mental Health services and/or has a mental health case manager. |
| Language / Communication Issues / Deafness / Hearing Issues | **X** – resident has a language or communication issue which requires additional staff support; **HI** – resident is Hearing Impaired; **D** – resident is Deaf. |
| Vision Deficit / Blindness | **X** – resident if blind or has severe vision deficit which requires additional staff support |
| Diabetic: Insulin / Non-Insulin | **I** – resident if Insulin dependent; **N** – resident is **N**on-insulin dependent diabetic. |
| Assist with ADL’s | **I** – resident assessed as Independent; **MIN** – resident assessed as needing MINimal assistance with ADL’s such as curing reminders, supervision, and/or encouragement; **MOD** – resident assessed as needing MODerate assistance with ADL’s such as guiding, standby assistance for transfers, or ambulation, bathing and toileting; **MAX** – resident assessed as needing MAXimum assistance with ADL’s such as needing a one person or two person transfer, resident was incontinent of bowel or bladder and required staff to assist with care; resident needed assistance with turning, sitting up or laying down, staff must physically turn the resident every two hours. |
| Wounds / Skin Issue | **P** – resident has a Pressure ulcer; **S** – resident has a Stasis wound; **W** – resident has a Wound or skin issue other than pressure or stasis ulcer. |
| Incontinent / Appliance (catheter) / Dialysis | **UI** – resident Incontinent of bladder and/or bowel; **C** – resident has Catheter; **D** – resident requires Dialysis. |
| Special Dietary Needs / Scheduled Snacks | **X** – resident requires a special prescribed diet. |
| Weight Loss / Weight Gain | **WL** – resident has had more than a 3 – 5 pound Weight Loss within last 60 days; **WG** – resident has had more than a 3 – 5 pound Weight Gain within the last 60 days. |
| Medical Devices | **X** – resident receives dialysis treatments; **M** – if part of a residents care is the use of side rails, transfer poles, chair / bed alarms / belt restraints. |
| Pay Status | **P** – all or part of a resident’s care is paid by the resident or their family; **S** – all of part of a resident care is paid for by the state. |
| Recent Hospitalization | **X** – resident has been hospitalized within the last 60 days. |
| Oxygen / Respiratory Therapy | **X** – resident receives oxygen and/or respiratory therapy or treatments. |
| Home Health / Hospice / Private Caregiver | **HH** – resident receives Home Health services; **HOS** – resident receives HOSpice services; **P** – resident receives care from Private caregiver. |