Office of the State Long Term Care Ombudsman
Department of Aging and Disability Services

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Reference for CD provided at Staff Ombudsman Training, June 6, 2007.
Individualized Assessment of Resident with Behavior Symptoms

Individualized Assessment - Mary
(PowerPoint slides)

- Vignette

- Focus on Individualized Care
  - Meaning of the 1987 Nursing Home Reform Law
  - Each resident’s individualized needs must be discovered and addressed

- Complete the resident assessment process. Thorough assessment is vital so staff can provide care that enhances quality of life

- Develop A Care Plan
  - Analyze assessment information
  - Develop a care plan
  - Hold a care plan conference every 90 days after the initial plan to determine how things are going and if changes need to be made

- Behavioral symptoms vs. Resident as problem

- Emphasize Assessment and Care Plan
  - Uniqueness of each resident
  - Staff’s responsibility in meeting each individual resident’s needs
  - Reframe the questions from “problem” to “unmet need”

- Identify Potential QUESTION with Plausible Answer

- Convert from traditional care plans to “I” care plans

- Determine what should be done to individualize care
  - Most staff want to do a good job
  - Address issues in a positive, non-confrontational manner

- Take the following steps
  - Ask for a Care Plan Conference
  - Ask the right questions - “why, when, where, and how” - to help staff think of as many reasons for the behavior as possible
  - Keep the focus on the resident’s needs
  - Know resident rights under the law
  - Monitor care plan implementation and address lack of implementation immediately
  - Work closely with nurse aides and professional nurses to orient them to the person
  - Make sure the person's doctor is aware of and supportive of his or her care plan
  - Request outside consultation from the ombudsman, if necessary

Office of the State LTC Ombudsman
Texas Department of Aging and Disability Services

June 2007
Use the other documents on the CD as you want.

**My Personal Directions for Quality Care**
As an exercise, have the ombudsmen complete a form of their personal directions.

**Basics of Individualized Quality Care**
This document from the National Citizens Coalition for Nursing Home Reform identifies specific care issues, shows ways that the resident and family can provide input into the care plan process, and shares tips on ways to monitor implementation. It also shows the value of transforming staff attitudes through use of “I” Care Plans.

**Assessment and Care Planning**
As a quick overview, ombudsmen can see the basic requirements. Use this consumer information sheet for public awareness purposes as well.

**Client Assessment Review and Evaluation**
Physicians must prescribe nursing home care. The facility staff complete this form for a person to be admitted to a nursing home. Consider reviewing this if no one has seen a CARE form.
Link to CARE Form
[www.dads.state.tx.us/handbooks/forms/default.asp?HB=MPM-LTCF&Form=3652-A](http://www.dads.state.tx.us/handbooks/forms/default.asp?HB=MPM-LTCF&Form=3652-A)

**Minimum Data Set**
Certified volunteer ombudsmen do not have access to residents' clinical records. However, it may be of interest to see the variety of information collected by facility staff. Point out the items that help staff know the person as an individual.
Link to MDS 2.0 form -
Individualized Assessment of Resident with Behavior Symptoms
Mary lived alone for almost 20 years after her husband died. She was fiercely independent and, although frail at 87, was still able to tend her garden. Her daughter Sue began to notice Mom was not able to remember recent events. Then, she forgot to turn off the stove and burned dinner. Later, she was found 5 miles from her home, lost and disoriented.

After tests, Mary was diagnosed with dementia. Sue searched for the best nursing home. Within a month, Mary moved to Sunnyside Manor. Sue felt great relief because her mom was safe and secure.

Her euphoric feeling was short-lived. A month after the move, staff listed a litany of things Mary was doing wrong. “She wandered into other resident’s rooms; became disruptive and screamed when nurse aides wanted her to go to the TV room; tried to sneak out the back door…”

On Sue’s next visit, Mom was tied in a chair. Staff explained that her mom “hit the nurse aide” today. When Sue demanded that staff release her mom, they said they had a right to protect themselves from her outbursts and the only other option was to discharge her.
The Meaning of Individualized Care

Nursing Home Reform Law, 1987

❖ Protects each nursing home resident, and

❖ Requires nursing homes "to provide service and activities to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in accordance with a written plan of care."

Each resident’s individualized needs must be discovered and addressed.
Resident Assessment Process

Nursing home staff must thoroughly and carefully assess each person in order to meet his or her needs.

Many things should be taken into account.

- Life history, daily routine, strengths, interests, food preferences, and other personal information
- Functional abilities including walking, dressing, using the toilet and eating
Resident Assessment Process

Many things should be taken into account.

- Physical or mental conditions that affect a resident
- Potential for improvement
Resident Assessment Process

Many things should be taken into account.

- Communication abilities
- Nutritional status and medications
A thorough assessment is **VITAL** to knowing the resident so staff can provide care in a manner that enhances **QUALITY OF LIFE**.

- **Assessment must be completed within**
  - 14 days of admission
  - 7 days for Medicare residents.

- **Annual assessment must take place or**
  - Significant change in resident’s condition.
Developing A Care Plan

- Analyze assessment information

- Develop a care plan
  - Use an interdisciplinary team
  - Make certain that all medical and non-medical issues are agreed upon and addressed. Listen to and address resident and family concerns in the plan
  - Do not rush. Good care planning takes time

- Hold a care plan conference every 90 days after the initial plan to determine how things are going and if changes need to be made
Mary, the resident, was perceived as the problem.

From this negative, blame-the-victim perspective, staff can do little or no constructive problem-solving to address her needs.

Staff need to look from a new vantage point - through Mary’s perspective.

Mary cannot tell you what is wrong.

She expresses her distress in behavioral symptoms.
Assessment and Care Plan Emphasize

- Uniqueness of each resident
- Staff’s responsibility in meeting each individual resident’s needs

Reframe the question

FROM
"Why is the resident a problem?"

TO
"What do Mary’s behavioral symptoms mean (unmet need) and how can staff help her?"
Symptoms include

- “Aimless” wandering
- Disruptiveness
- Striking other residents and staff

Restraints will lead to

- Decreased mobility and ability
- Listlessness
- Increased agitation
- Physical problems
- More work for staff
**QUESTION:**

Why is Mary wandering?

Does Mary have a history of spending time outside?

If she enjoys wandering, can staff help her do this safely?

Are staff taking her outside for exercise?

**Answer:**

Mary spent many hours outside taking long walks, caring for her garden, and visiting neighbors. This is a life-long routine and should be continued.

Staff assumed that Mary should sit and watch TV. Mary had not been taken outside at all during her month at the nursing home.
QUESTION:
Why would Mary scream?
Is there a physical reason for the behavior (pain or infection)?
What types of activities did Mary enjoy before the dementia?
Is the TV room too noisy?

Answer:
Mary never enjoyed watching TV. She likes to look at the garden from the window in her room. Despite her dementia, she is still aware of her likes and dislikes and these should be respected.
QUESTION:
What happened when the nurse aide was hit?
Was she trying to get Mary to do something she didn’t want to do?
Did Mary feel threatened?
Are staff trained to work with residents with dementia?

Answer:
As the nurse aide approached, she yelled at Mary and Mary felt threatened.
It is important for the nurse aide to be gentle and soft spoken in her approach.
“I” Care Plans

- Mary wanders.
- Keep her safe in a chair so she doesn’t get hurt.
- I need to walk.
- Staff will walk outside with Mary.
- Mary strikes out at staff.
- Arrange activities to keep her occupied, e.g., watch TV room.
- I need to do things that I enjoy.
- Staff will take me to the garden and I will enjoy the plants.
What should be done?

Most nursing home staff want to do a good job. It is important that your first approach addresses issues in a positive, non-confrontational manner.

Take the following steps

- Ask for a Care Plan Conference

- Make sure the right questions are asked. Use “why, when, where, and how” questions to help staff think of as many reasons for the behavior as possible
Take the following steps

- **Keep the focus on the resident’s needs**

- **Know resident rights under the law**
  - Residents cannot be forced to leave the home without specific notice and appeal rights
  - Physical restraints cannot be used to treat symptoms treatable by individualized care
Take the following steps

- Monitor implementation of care plan and address lack of implementation immediately

- Work closely with nurse aides and professional nurses to orient them to the person
Take the following steps

- Make sure the person's doctor is aware of and supportive of the resident’s care plan

- Request outside consultation from the ombudsman, if necessary
Local Resources

Local Ombudsman Program
1-800-252-2412

Texas Department of Aging & Disability Services

SOURCE:
http://nursinghomeaction.org/pdf/ASSESS2_SHT.pdf
My Personal Directions
for Quality Living

Name:
Date:

To My Caregivers (paid and unpaid):

I am recording my personal preferences and information about my self, in case I need long-term care services in my home or in a long-term care facility. I hope this information will be useful to those who assist me. Please always talk to me about my day-to-day life to see what it is that I want and enjoy. However, the information below may provide some help in understanding me and in providing my care.

I want my caregivers to know:

The way I like to awaken & begin my day:

The way I relax and prepare to sleep at night:

Activities I enjoy:

Things that I would like to have in my room:
### Foods that I enjoy:

*For comfort:*

*For fun:*

*Other:*

### Things I do not like:

### I become anxious when:

### Things that calm or soothe me:

### Things that make me laugh:

### Religious preferences:

### Other:
At the end of my life, I would like:

For more information about me please talk to:

This form was developed by the National Citizens’ Coalition for Nursing Home Reform to encourage communication between those of us who might need care and those who will be providing the care. Please adapt this tool to express your personal preferences, requests and wishes. Be sure to give a copy to your family members and/or trusted friends and talk with them about what you have written.

National Citizens’ Coalition for Nursing Home Reform
1828 L. Street NW, Suite 801
Washington DC 20036

http://nursinghomeaction.org
EXAMPLE

My Personal Directions for Quality Living

Name: Alice H. Hedt
Date: June 16, 2005

To My Caregivers (paid and unpaid):

I am recording my personal preferences and information about my self, in case I need long-term care services in my home or in a long-term care facility. I hope this information will be useful to those who assist me. Please always talk to me about my day-to-day life to see what it is that I want and enjoy. However, the information below may provide some help in understanding me and in providing my care.

I want my caregivers to know:

I have led an active and busy life, raising three children (born in four years) and working as an advocate for nursing home residents. My family and friends are very important to me. I enjoy traveling and talking with people who have different life experiences and viewpoints. I have been married for over 30 years. I particularly enjoy singing in choirs and spending time outdoors by water or in the mountains.

The way I like to awaken & begin my day:

I enjoy ☺ coffee and like to start my day quietly, read the paper, have a quiet devotion time, and then have breakfast while watching the news on TV.

The way I relax and prepare to sleep at night:

I am a terrible sleeper. Don’t worry if I am up several times, reading, puttering and checking e-mails.

Activities I enjoy:


Things that I would like to have in my room:

My favorite reclining chair- it has heat and vibrates, and an afghan.
Pictures of where I have traveled.
The books I have had with me all of my adult life.
I would very much like a window with a bird feeder and flowers.
Art posters on the wall – Matisse, O’Keefe
Foods that I enjoy:

For comfort: mashed potatoes and gravy, macaroni and cheese (home-made); egg biscuits

For fun: watermelon, white sheet cake with vanilla icing, caramel ice cream sundaes - the ones from MacDonald’s are cheap and good; caramel corn

Other: I enjoy most ethnic foods, especially Thai, Mexican and Vietnamese; I like to drink different kinds of green tea and Merlot.

Things I do not like:

Crafts. Food that is really spicy. Prejudice. Chin hairs – please pluck mine!

I become anxious when:

I feel pressured to do things that I don’t think I should do.

Things that calm or soothe me:

Talking with close friends; music; massage; talk radio (especially the game shows)

Things that make me laugh:

Children – especially my granddaughter and God children; old movies; funny stories.

Religious preferences:

While I have been a Lutheran my whole life and my husband is a Lutheran minister, I am very open to most spiritual experiences and worship opportunities.

Other:

I like lotions and soaps that smell good, especially lavender. I enjoy all kinds of music and I like projects – coordinating activities, etc. I prefer sleeping on my left side and need a pillow that is comfortable to me because I have some neck pain. I need my glasses.
At the end of my life, I would like:

To have a few family and friends with me. I do not want to be alone when I die. It would be very nice if someone would read hymns, psalms, and poetry to me. Please see my living will and advanced directives. I would like for Pastor Wiggins to provide spiritual support if he is available.

For more information about me please talk to:

My husband Fred; my children – Matt, Melissa and Bethany; my friends, especially Beverly, Sue, Rosemary, Marj, Elma, Sarah, Cilla and Nancy.

This form was developed by the National Citizens’ Coalition for Nursing Home Reform to encourage communication between those of us who might need care and those who will be providing the care. Please adapt this tool to express your personal preferences, requests and wishes. Be sure to give a copy to your family members and/or trusted friends and talk with them about what you have written.

National Citizens’ Coalition for Nursing Home Reform
1828 L. Street NW, Suite 801
Washington DC 20036
http://nursinghomeaction.org 202-332-2275
Each and every person in a nursing home has a right to good care under the 1987 Federal Nursing Home Reform Law. The law, which is part of the Social Security Act, says that a nursing home must help each resident “attain or maintain” his or her highest level of well being - physically, mentally, and emotionally. To give good care, staff must assess and plan care to support each resident’s life-long patterns, current interests, strengths, and needs. Care planning conferences are a valuable forum for residents and families to voice concerns, ask questions, give suggestions, learn nursing home strategies, and give staff information (such as resident background and daily routine). This requirement in the law is vital to making sure residents get good care.

**Resident Assessment**

Assessments gather information about the health and physical condition of a resident and how well a resident can take care of themselves. This includes assessing when help may be needed in activities of daily living (ADLs) or “functional abilities” such as walking, eating, dressing, bathing, seeing, hearing, communicating, understanding, and remembering. Assessments also should examine a resident’s habits, activities, and relationships in order to help him or her live more comfortably and feel at home in the facility.

The assessment helps staff to be aware of strengths of the resident and also determine the reason for difficulties a resident is having. An example of where a good assessment helps: A resident begins to have poor balance. This could be the result of medications, sitting too much, weak muscles, poorly fitting shoes, or a urinary or ear infection. Staff must find out the cause of a problem in order to give good treatment. Figuring out the cause is much easier with a good assessment.

Assessments must be done within 14 days of the resident’s admission to a nursing home (or 7 days for Medicare residents) and at least once a year after that. Reviews are held every three months and when a resident’s condition changes.

**Plan of Care**

After the assessment is completed, the information is analyzed and a care plan is developed to address all the needs and concerns of the resident. The initial care plan must be completed within seven days after the assessment. The care plan is a strategy for how the staff will help a resident every day. This care plan says what each staff person will do and when it will happen (for example, a nursing assistant will help Mrs. Jones walk to each meal to build her strength). Care plans must be reviewed regularly to make sure they work and must be revised as needed. For care plans to work, residents must feel they meet their needs and must be comfortable with them.

**Care Planning Conference**

The care plan is developed by an interdisciplinary team -- nurse, nurse aide, activities and dietary staff, and social worker, with critical input from the resident and/or family members. All participants discuss the resident’s care at a Care Plan Conference to make certain that all medical and non-medical issues, including meals, activities, therapies, personal schedule, medical and nursing care, and emotional needs are agreed upon and addressed. Resident and family member concerns should be listened to by staff and addressed in the care plan. A good Care Plan Conference takes time. It should not be rushed, and could take at least one hour. Every 90 days after development of the initial plan, or whenever there is a big change in a resident’s physical or mental health, a Care Plan Conference is held to determine how things are going and if changes need to be made.

**Good Care Plans Should**

- Be specific to that resident;
- Be followed as an important guideline for providing good care for the resident;
- Be written so that everyone can understand it and know what to do;
- Reflect the resident’s concerns and support his or her well-being;
- Use a team approach involving a wide variety of staff and outside referrals as needed;
- Assign tasks to specific staff members;
- Be re-evaluated and revised routinely.

**Steps for Residents and Family Participation in Care Planning**

Residents and family members have the right to be involved in the care plan conference in order to make choices about care, services, daily schedule, and life in the nursing home. Even if a resident has dementia, involve them in care planning as much as possible. Be aware that they may understand and communicate at some level and help the staff to find ways to communicate and work with them. They can express when they hurt or suffer if they are actively listened to. Participating in care plan conferences is a way to be heard, raise questions, and come to a clear agreement with the facility about how the resident will be cared for.

**Before the meeting:**
- Ask staff to hold the meeting at a convenient time for you and/or your family member;
- Ask for a copy of the current care plan (if one already exists) so that you can examine each aspect thoughtfully;
- Know about or ask the doctor or staff about your or your loved one’s condition, care, and treatment;
- Plan your list of questions, needs, problems, and goals, and;
- Think of examples and reasons to support changes you recommend in the care plan.

**During the meeting:**
- Make sure the resident is involved and listened to carefully.
- Discuss options for treatment and for meeting your needs and preferences;
- Ask questions if you need terms or procedures explained to you;
- Be sure you understand and agree with the care plan and feel it meets your needs;
- Ask for a copy of the care plan;
- Find out who to talk to if changes in the care plan are needed, and;
- Find out who to talk to if there are problems with the care being provided.

**After the meeting:**
- Monitor whether the care plan is being followed;
- Inform the resident’s doctor about the care plan if s/he was not directly involved;
- Talk with nurse aides, staff or the doctor about the care plan, and;
- Request another meeting if the plan is not being followed.
- See NCCNHR’s “Resolving Problems in Nursing Homes” for additional information.

If you are interested in learning more, the National Citizens’ Coalition for Nursing Home Reform (NCCNHR) has several publications that may be of interest. Call 202-332-2275 for a publication list or visit the website at http://www.nccnhr.org.

- **Nursing Homes: Getting Good Care There.** Cost: $14.95
- **Avoiding Physical Restraint Use - consumer booklet.** Cost: $7.50
- **Avoiding Drugs Used as Chemical Restraints - consumer booklet,** Cost: $7.50
  *Order both Restraint booklets for $14*
- **Using Resident Assessment and Care Planning: An Advocacy Tool for Residents and their Advocates,** Cost: $12

Prices listed do not include shipping and handling.
**THE BASICS OF INDIVIDUALIZED QUALITY CARE**

**Consumer Fact Sheet No. 16**

**April 2005**

*Individualized care* is the right of every nursing home resident. The Nursing Home Reform Law of 1987 requires that residents receive services and activities to “attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care…” *Quality of care means what care is provided.* The law also requires nursing facilities to “care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.” An emphasis is placed on dignity, choice, and self-determination for residents. *Quality of life means how care is provided.*

The law requires nursing facilities to provide quality of care in a way that supports quality of life for each resident. When facilities do this they achieve individualized care for each resident. Residents and family members should expect the facility to provide individualized care based on Quality of Care Basics. Read a real resident’s experience in one nursing home and follow how an *Individualized Plan of Care* should be developed. For this example, four areas of care will be used: (1) the assessment and care plan process (the basis for individualized care), (2) toileting, (3) hydration, and (4) mobility. (For more information, see Burger et al “Nursing Homes: Getting Good Care There,” Chapters 4 and 5, available from NCCNHR).

**How One Nursing Home Resident and Her Daughter Can Achieve the Basics of Individualized Care**

Your mother lived independently until she suffered a stroke two months ago. Your need to work prevents you from bringing her to your home for care. Together you made the decision that she would go to a nursing home for rehabilitation. The stroke left her with right-sided weakness (she is also right-handed) and some inability to make herself understood. Based on your mother’s excellent response to rehab in the hospital, her physician thinks she should continue to make progress and return home in eight to twelve weeks.

The nursing home staff welcomed your mom. You both felt confident about your decision. Your mom’s roommate was glad for the company and was patient with her slow speech. Your mom asked you to attend the first care planning conference with her. The staff said your mom would receive physical therapy three times a week, and speech and occupational therapy once a week.

You’re both pleased with the therapy program, but your mother complained that the nursing staff will not take her to the toilet except as part of the therapy sessions. A fastidious woman, your mother knows when she has to go the bathroom and was determined to use the toilet, not a brief (diaper), bedpan, or commode.

At the end of her second month in the facility you noticed that you had difficulty opening your mother’s right hand for the manicure she loved to get. Her skin looked very dry and flaky. Your mom’s spirits seemed to be sinking. In fact, recently she seemed to be getting worse, not better.

When you mentioned these concerns to the staff, you were told that this happens to all frail, old people. The nursing staff then suggested speaking with the doctor to obtain an order for an antidepressant. You became really concerned.
**ASSESSMENT AND CARE PLANNING**

The Resident Assessment and Care Plan Process

In order to know what care and services to provide and how to provide them, the law requires a careful and thorough assessment of your mom. Staff needs to learn your mom’s strengths and needs. A list of assessment items relating to your mom includes:

- Her life history, daily routines, strengths, interests, food likes and dislikes, and other personal information. (Think of this information as the important details about your mother that reflects who she is as an individual, and which will form the basis for planning her care.)
- Her ability to function including walking, dressing, using the toilet, and eating. (The stroke has affected your mom’s right and dominant side, so she will need assistance to regain independence.)
- Physical or mental conditions that may affect her ability to recover. (Except for the stroke, she is quite healthy mentally and physically.)
- Her potential for improvement. (Her physician expects her to recover and go home.)
- Communication abilities. (Her speech is slowed.)
- Nutritional status and medications. (She must relearn to feed herself and manage her own medications.)

The assessment is completed by day 7 in a skilled unit (your mother’s situation at first); by the 14th day in a nursing facility (long term chronic care); and once a year thereafter, or whenever a resident’s condition changes. The assessment is done by the interdisciplinary team (IDT) that includes: the resident, direct caregiver(s), nurse, physician, physical therapist, occupational therapist, speech therapist, activity therapist, dietitian, and social worker. The assessment information is the foundation for the care planning process.

Developing an Individualized Care Plan

The Care Plan, by law, is initially prepared with participation to the extent practicable of the resident or the resident’s family or legal representative. The initial care plan must be complete by the 21st day of her stay, and subsequent care plan reviews are repeated quarterly, or whenever there is a major change in a resident’s condition. The initial care plan process begins during the assessment. It is called an Individualized Care Plan because each resident’s conditions, abilities, needs, routines, and goals are unique, requiring a plan of care (road map for care) that reflects who this individual is. The overarching goal is for your mother to return home and live as independently as possible. There are many little goals along the way. Care plan goals are all measurable, time limited, and the team member responsible for each is identified. This simply means that each goal will be clearly identified and stated. Each goal will also list an estimated time for accomplishment, as well as the specific team member(s) responsible in assisting to achieve that goal.

Physical Therapy will help your mother to regain the ability to walk. Occupational Therapy will assist her in attaining independence in dressing, eating, and toileting. Speech Therapy will help to improve her slow speech pattern. But therapy only takes up a few hours each day. The IDT must plan what happens for the rest of the 24-hour period. This plan must support your mother’s goal for independence and prevent any harm from occurring. The Plan of Care must then be relayed to each staff member, including the Certified Nursing Assistants (CNAs), so that everyone is consistent in helping your mom reach her stated goals.

Traditionally, nursing homes have used nursing/medical model care plans. That type of plan is not suited to individualized nursing home care. It is written from the staff perspective rather than each resident’s perspective.

Here is an example of what you may find:

<table>
<thead>
<tr>
<th>Problem</th>
<th>Goal</th>
<th>Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incontinence</td>
<td>Will become independent in toileting</td>
<td>Assist to Bedpan at 6 am, 9am, 12 noon, 4pm, 9pm (or when requests) (CNA)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assess ability to stand and pivot on left leg in one week to transfer to commode or toilet, 2/14/05 (N/PT*).</td>
</tr>
</tbody>
</table>

*CNA=Certified Nursing Assistant, N=Nursing; PT=Physical Therapy; OT=Occupational Therapy; ST=Speech Therapy; D=Dietary

Here is an example of an individualized care plan written from a resident’s perspective:

<table>
<thead>
<tr>
<th>Need</th>
<th>Goal</th>
<th>Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>I need assistance with using the bathroom</td>
<td>I want to regain my independence in using the toilet so that I may go home.</td>
<td>I know when I have to go to the bathroom and will tell you. Please assist me to the bedpan on my usual schedule from home at 6 am, 9am, 12 noon, 4pm, 9pm (and when I request) (CNA). Assess my ability to stand and pivot on left leg in one week. Then help me to the commode or toilet, 2/14/05 (N/PT*).</td>
</tr>
</tbody>
</table>

*CNA=Certified Nursing Assistant, N=Nursing; PT=Physical Therapy; OT=Occupational Therapy; ST=Speech Therapy; D=Dietary
Three examples of Basic Quality of Care Practices follow: Toileting, Hydration, and Mobility

TOILETING

Basic Quality of Care Practices for Toileting

- If a resident can toilet with a little assistance, then assistance must be available as needed 24 hours a day.
- Toileting assistance is given according to a written individualized schedule and whenever a resident asks.
- The number of people to safely assist with transfer/ambulation is clearly stated and are available. This may change as the resident becomes more independent (e.g. two-person assist, one person assist, and staff monitor for safety).
- The toileting equipment is appropriate to the person’s ability, and changes as ability improves (e.g. bedpan, commode, bathroom toilet).
- Each resident has a clearly identified, functional method of asking for assistance (e.g. call bell or other signal device placed for easy use).

Privacy is assured in toileting so a resident is never exposed (e.g. room door is closed, curtain between beds is pulled, window blinds are closed).

Nurses/CNAS and others observe the urine for color, smell, and amount as described in the Care Plan.

Your Mom and You

Your mom knows when she has to use the toilet, but needs help. Her bladder has always functioned well and she still uses the toilet after breakfast, before lunch, late afternoon, before bed at 9:00pm, and upon awakening. Her routine is to use the toilet five times in a 24-hour period.

Before the care plan meeting you and your mother think about her routines and review the quality of care basics. Your mother’s individualized care plan for the first four weeks might say:

<table>
<thead>
<tr>
<th>Need</th>
<th>Goal</th>
<th>Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need assistance to the bathroom</td>
<td>Gain independence in toileting</td>
<td>Assist to bedpan at 6am, 9am, 12 noon, 4pm, 9pm (or when requests) (CNA*). Assess ability to stand and pivot on left leg to transfer to commode or toilet in one week, 2/14/05 (N/PT)</td>
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<td></td>
<td>Assist to bedside commode: (same schedule) (CNA). Assess ability to walk to bathroom (15 feet) with assistance in two weeks, 3/1/05 (N/PT).</td>
</tr>
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<td></td>
<td></td>
<td>With each incontinent episode, assist resident to wash with her own personal soap. After careful drying, apply a skin barrier cream (CNA).</td>
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<td></td>
<td></td>
<td>Monitor skin for redness, irritation, skin breakdown, turgor, etc. (N).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Weekly skin assessment for redness, irritation, skin breakdown, turgor, etc. (N).</td>
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<td></td>
<td>Place hand washing supplies (sanitizing hand wipes) on left side of the bed within easy reach (CNA/N).</td>
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<td></td>
<td>Place a trash disposal system on left side of the bed within easy reach (CNA/N).</td>
</tr>
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<td></td>
<td></td>
<td>Two-person assist to bathroom (same schedule) (CNA). Assess ability for one person to assist in one week, 3/8/05 (N/PT).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>One-person assist to bathroom (same schedule) (CNA). Assess ability for independence with cane in two weeks, 3/22/05 (N/PT).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monitor safety of self-toileting with the use of quad cane (N).</td>
</tr>
</tbody>
</table>

*CNA=Certified Nursing Assistant, N=Nursing; PT=Physical Therapy; OT=Occupational Therapy; ST=Speech Therapy; D=Dietary
Tips for Monitoring the *Individualized Care Plan* for Toileting/Continence

- Be vigilant that your mother is toileted on *her individualized* schedule rather than someone else’s schedule (e.g. on her lifelong schedule every 3-5 hours, rather than every two hours, which does not help your mother and wastes staff time).

- Be especially watchful on evenings, nights, weekends, Mondays and Friday, and holidays, when there may be less staff. If the facility is short staffed, or staff is poorly monitored, then they may tell a resident that she must use a brief (diaper). This is both a quality of care and quality of life issue. The indignity of soiling herself and the feelings of helplessness may be the cause of depression.

- Provide your mom with her special soap and skin creams. Also provide the easy-open, sanitizing hand wipes. Check remaining quantities to see if they are being used.

- Check that the call bell is on her left side so she can request help until she can use her right side.

- Staff shortages can cause staff to withhold fluids so the need to toilet is less frequent. Does she drink her tea when pills are passed, at lunch, and between meals?

- Telephone the charge nurse at odd hours (e.g. 1a.m); ask about the number of available staff on duty. Keep a record of who you spoke to and what was said.

- While visiting, check that the call bell is on the left side and monitor the timeliness of staff assistance to the toilet. Ask your mom if she ever has to wait too long for assistance to the bathroom. Incontinence causes wet skin and clothing, which may lead to skin breakdown and pressure ulcers.

- When possible, vary your visit times to avoid staff from becoming too familiar with your arrival times (some staff members are inclined to give care only when the family is expected to visit).

- If you help your mother to the bathroom, be sure you are aware of her current transfer, ambulation, and assist ability. This is to avoid the possibility of injury to your mother or yourself. When in doubt, always ask.
**HYDRATION**  
*(getting enough to drink)*

**Basic Quality of Care Practices for Hydration**

- Most residents should drink about eight glasses of fluid a day.
- Fluids that the resident likes should be available, within reach, 24 hours a day. At mealtime, fluids should be served at a temperature that is safe and is according to the resident’s preference.
- If a resident cannot remember to drink, then staff must remember and assist with drinking throughout the day according to the resident’s lifelong routine.
- If a resident cannot drink, then staff must assist at meals, between meals, and at night as needed.
- If a resident needs to relearn how to drink, then staff must teach her and take responsibility for providing the rest of the fluid through IV, naso-gastric, or stomach tube.
- A resident is assessed by Occupational Therapy and, if needed, given special equipment such as a large handled/weighted cup to foster independence in drinking.

- Fluids are the right consistency to promote safe swallowing (e.g. thin liquids, thickened liquids, jello, puddings), to avoid the possibility of liquids going into the lungs, causing a condition called *Aspiration Pneumonia*.
- Staff monitor the amount of fluid taken every 24 hours and monitor for signs of dehydration (e.g. dry, flaky skin, poor skin tension, dry, cracked lips, dry mucous membranes in mouth, increased irritation, restlessness or confusion, and the presence of strong, odorous, dark colored urine).
- Staff should also keep track of the amount of urine passed each 24 hours (this is referred to as “I & O”), Intake and Output, the monitoring of the amount of fluids taken in compared to the amount of urine passed out).
- Staff monitors the progress of a resident to drink independently and changes the care plan as often as needed to reach that goal.

**Your Mom and You**

You noticed already that your mom has very dry skin and seems to be shriveling up before your eyes. Her urine smells strong, another sign of not enough to drink. To effectively address this issue, your mother’s individualized care plan might say:

<table>
<thead>
<tr>
<th>Need</th>
<th>Goal</th>
<th>Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistance with drinking an adequate amount of fluids</td>
<td>Gain independence in hydration</td>
<td>Encourage to use both hands and large handled cup filled with iced tea at meals. Put bedside/chair side tea on left side. Hates water, likes iced tea. Assess ability to use right hand in two weeks, 2/21/05 (N/OT/D).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encourage use of right hand using large handled cup filled with iced tea. Put bedside/chair side tea on right side. Assess ability for independent drinking in two weeks, 3/7/05 (N/OT/D).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monitor and record independent hydration (eight glasses/64 ounces/2000cc per 24 hours) for one week to assure ability to hydrate independently (N).</td>
</tr>
</tbody>
</table>

* CNA=Certified Nursing Assistant, N=Nursing; PT=Physical Therapy; OT=Occupational Therapy; ST=Speech Therapy; D=Dietary
Tips for Monitoring the *Individualized Plan of Care* for Hydration

- Make sure the large handled cup is at the bedside on the left side until your mother is able to reach with her right side, then reverse bedside table to force use of her right hand.

- You and your family members agree to bring your mother’s favorite iced tea mix. You follow-up to be sure your mother is having this drink.

- Families should see residents drink fluids at meals three times a day, between meals when pills are passed (usually 4-8 ounces), and before bedtime at the very minimum.

- Check your mother’s skin, eyes, and mouth for increased dryness, especially on Mondays, Fridays, weekends, and holidays. Report any signs of dryness to staff.

- Notice and report the presence of any skin changes/irritations/breakdown, as well as the presence of strong, dark, odorous, or small amounts of urine.

- Advise the staff of the amount of fluids that were taken during your visit so that it can be calculated in the 24 hour total (I & O).
MOBILITY

Basic Quality of Care Practices for Mobility

- Any part of a resident’s body that moves independently upon entering the nursing home must be maintained by the resident or staff.
- If any part of the body cannot be moved independently, then staff must move it for the resident (e.g. move each joint in each finger).
- Active and passive range of motion (ROM) exercises are done at least twice a day to prevent loss of mobility (e.g. if your mom is able to move her left arm above her head on the day of admission, that ability is maintained by active range of motion).
- Passive ROM is done for a person until active ROM is achieved (e.g. if your mom is not able to lift her arm above her head on the day of admission, then that ability is attained first through passive ROM and then active ROM).
- Active ROM is done with a resident or independently by a resident.
- A resident who can walk without assistance should maintain that ability.
- A resident who does not need a wheelchair on admission should not use one.
- When a resident is sitting or lying down, alignment of the body (so that the two sides look equal) is accomplished by use of pillows, bolsters, towel rolls, and wedges.

Your Mom and You

Your mother’s right side is weak and special care is needed to prevent permanent damage from a Contracture, which occurs because weak muscles tend to shorten or contract. You noticed her curled right hand (remember the manicure?) indicating harm is already occurring. Her individualized care plan might say:

<table>
<thead>
<tr>
<th>Need</th>
<th>Goal</th>
<th>Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assistance with keeping joints mobile</td>
<td>Prevent contractures</td>
<td>Assist with passive ROM exercises of all joints on right side when dressing and undressing. Assist with active ROM on left side (CNA). Assess ability to participate actively on right side in one week, 2/14/05 (N/PT).</td>
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<tr>
<td></td>
<td></td>
<td>Position in bed, chair, and wheelchair for good body alignment with pillows, bolsters, and blankets. Use small rolled towel for the right hand (CNA). Assess in one week, 2/14/05 (N/PT).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assist with and teach active ROM exercises of all joints on right and left side when dressing and undressing. Assess ability to do these active exercises independently in one month, 3/14/05 (N/OT/PT).</td>
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<tr>
<td></td>
<td></td>
<td>Assess right hand contracture for possible need of splint; provide instructions for application (OT).</td>
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<tr>
<td></td>
<td></td>
<td>Assess ability to do active exercises independently on both sides in one month, 3/14/05 (N/OT/PT).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Position in bed, chair, and wheelchair for good body alignment with pillows and bolsters. Assess for teaching independence in positioning in three weeks, 3/7/05 (N/PT).</td>
</tr>
</tbody>
</table>

* CNA=Certified Nursing Assistant, N=Nursing; PT=Physical Therapy; OT=Occupational Therapy; ST=Speech Therapy; D=Dietary
Tips for Monitoring the *Individualized Care Plan for Mobility*

- Ask your mom if the certified nursing assistants (CNAs) are assisting with the active ROM to her left side at 10:00 a.m. and 8:00 p.m.

- Ask CNAs to describe and demonstrate the active exercise program to you. They may not know how to do them.

- Visit your mom on Mondays, Fridays, evenings, weekends, and holidays to be sure ROM is occurring as scheduled each day. (PT and OT programs are usually closed on weekends and holidays and nursing staff is often reduced).

- Help your mother take responsibility for these exercises as soon as possible.

Encourage your mother to do ROM exercises on her own as much as she can, adding more as her strength and flexibility improve.

- If your mom is leaning to her right side when she sits in a chair, ask the staff for help in repositioning her. She should be supported on her right side so that it looks even with the left (e.g. good body alignment should be maintained as much as possible).

- If a hand splint or hand roll is being used, remove and check your mom’s hand for cleanliness, an unpleasant odor, and skin irritations.
Tips on How to be a Proactive Partner in Care

It is important, to the extent possible, that you remain involved in monitoring the care that your loved one receives. Below are some important tips for staying involved.

❖ Work closely with the nurse and CNAs to provide important details of your mother’s life (e.g. toileting schedule, preferred drinks, usual appearance of body and skin).

❖ Participate in the IDT care planning conference. Ask for one if you have unanswered concerns. If the professional jargon becomes too confusing, suggest using an “I” Care Plan format (described on the next page).

❖ Know the specific goals as outlined in the Care Plan.

❖ Be aware of any changes in the Plan of Care; ask the staff to keep you informed.

❖ Monitor the steps of the Plan of Care as outlined; address lack of implementation immediately.

❖ Physical, Occupational, and Speech Therapy are only parts of the Care Plan. Assure the basics of 24 hour care are covered on the plan, including nutrition, hydration, toileting, activities (not just bingo), mobility to support the goals of the therapy.

❖ When possible, make frequent telephone calls to the nursing facility. Avoid calling at times of high activity for example, the change of shifts, meal times and medication pass times.

❖ Know your rights under the law. Individualized care identifies both what and how care is to be provided.

❖ Remember, care and services are provided to maintain current abilities and attain those abilities lost by a resident’s condition. Abilities should decrease only if a new disease occurs, there is an irreversible progression of the condition, or a resident refuses care. In this nursing home the cause of your mother’s hand contracture, incontinence, and dehydration was directly related to her lack of Basic Quality of Individualized Care.
A Best Practice

**First Person Care Plans**

In the previous sections we have outlined the *Basic Quality Practices* in three areas of care and how they can and should be individualized for the resident. As illustrated, care plans tend to be very clinical, written in language that residents and CNAs do not understand. Try suggesting the use of an “*I*” *Care Plan* written in the words you and your mother would use. You will notice that a resident “problem” becomes a “need” and the “intervention” is changed to “approaches.” This language turns the whole thought and planning process around so that it is the resident who identifies her own particular goals. Clarity is further enhanced when the resident’s own words and phrases are used. Let’s look at mobility in an “*I*” *Care Plan*.

If the nursing home where your family member resides does not use the “*I*” *Care Plan*, you can suggest ways to individualize her care in the interdisciplinary care planning meeting. For instance, it will help staff to know that your mother wants to become stronger; therefore that should be written. Your mother’s strongest time of day should be in writing in the care plan. Ask for a copy of the care plan and rewrite it in the first person with your mother. Let’s look at mobility using an “*I*” *Care Plan*.

<table>
<thead>
<tr>
<th>Need (1)</th>
<th>Goal (1)</th>
<th>Approaches (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I need to keep my left side strong</td>
<td><strong>Long-Term Goal:</strong> I want to return to my home for my birthday on June 1st. <strong>Short-Term Goal:</strong> “I want to be able to go to the bathroom on my own.”</td>
<td>“I want to help the staff move each joint on my left side.” “Please remind me when dressing and undressing to move each joint on my left side.” “Remind me to reach for my tea, which is on my left side until I can use my right side,” 2/14/05 (CNAs/N/OT).</td>
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<table>
<thead>
<tr>
<th>Need (2)</th>
<th>Goal (2)</th>
<th>Approaches (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I need to strengthen my right side</td>
<td>I want staff to help me strengthen my right side.</td>
<td>“I want to help the staff strengthen the right side of my body.” “Please help me by moving every joint on my right side until I can begin to do it by myself,” 2/14/05 (PT/CNAs/N/OT).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Need (3)</th>
<th>Goal (3)</th>
<th>Approaches (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Please schedule my physical therapy early in the day when I am most energetic. I fade in the afternoon,” 2/14/05 (PT/CNAs/N/OT).</td>
<td>“I topple over on my right side. This is very uncomfortable. Please put pillows and towels to support my right side so that it looks like my left side when I sit in the chair. Then I can stay out of bed for an extra hour, until four every afternoon, and be up for supper at 6:00p.m.” (CNA/N)</td>
<td>“My right hand feels better when I am grasping a big rolled towel” (CNA/N).</td>
</tr>
</tbody>
</table>

CNA=Certified Nursing Assistant,  N=Nursing; PT=Physical Therapy; OT=Occupational Therapy; ST=Speech Therapy; D=Dietary
Tips for Moving Toward an “I” Care Plan

- Share your individual needs and preferences at the care planning conference
- Be sure the information is written in the care plan
- Show how the information will improve care
- Help staff to add personal information if they do not see why it is important

Nursing Homes: Getting Good Care There, Second Edition, by Sarah Greene Burger, Virginia Fraser, Sara Hunt, and Barbara Frank. 2002. A consumer guide on achieving the best possible nursing home experience for a relative or friend. With clarity and compassion, the authors use everyday language and real-life examples to show that care respecting each resident's individuality, dignity and physical and emotional well-being is within reach. $11.95 plus $3.00 shipping and handling.

Nursing Home Staffing, by Sarah Greene Burger and NCCNHR Staff. 2002. A guide for residents, families, friends, and caregivers. $7.50 plus $3.00 shipping and handling.

Residents’ Rights Week Packets from previous years are available through NCCNHR. See www.nursinghomeaction.org for pricing and ordering information.

NCCNHR Consumer Fact Sheets available at www.nursinghomeaction.org include:

- Resident Rights: An Overview
- Care Planning and Assessment
- Residents’ Rights in Nursing Homes
- Neglect and Abuse
- Restraints
- Involuntary Discharge and Transfer
- Assessment and Care Planning: The Key to Good Care
- Consumer Guide to Choosing a Nursing Home
- Individualized Assessment for Residents with Behavior Symptoms
- Access and Visitation in Nursing Homes
- Family Involvement in Nursing Home Care
- Malnutrition in Nursing Home Residents
- Long-term Care Resources on the Internet

Order NCCNHR Consumer Fact Sheets and publications from:
National Citizens' Coalition for Nursing Home Reform

This consumer fact sheet is part of the National Citizens’ Coalition for Nursing Home Reform’s Maryland Family Council Project. Funding for this fact sheet was made possible by a grant from the State of Maryland Department of Health and Mental Hygiene, Office of Health Care Quality.
Form 3652-A Client Assessment, Review and Evaluation (CARE)
# Texas Nursing Facility and Community Based Alternative Care
## Client Assessment, Review, and Evaluation (CARE)

### Facility Name

Recipient/Responsible Party Address (Street or P.O. Box, City, State, ZIP)

<table>
<thead>
<tr>
<th>001. Recipient No.</th>
<th>002. Social Security No.</th>
<th>003. HIC/Medicare No.</th>
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**FOR DADS USE ONLY**

<table>
<thead>
<tr>
<th>004. Name (Last, First, Middle)</th>
<th>005. Date of Birth</th>
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### Recipient No.

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### HIC/Medicare No.

<table>
<thead>
<tr>
<th>026. Height (ins.)</th>
<th>027. Weight (lbs.)</th>
<th>028. Blood Pressure</th>
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### Diagnosis

<table>
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<tr>
<th>026.</th>
<th>027. Weight (lbs.)</th>
<th>028. Blood Pressure</th>
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<thead>
<tr>
<th>DX</th>
<th>DIAGNOSIS (print neatly)</th>
<th>CODE</th>
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<tbody>
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<td></td>
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<td>016.</td>
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<td>019.</td>
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<td>020.</td>
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</table>

### Ordered Medications and Dosage

<table>
<thead>
<tr>
<th>ORDERED MEDICATIONS AND DOSAGE (print neatly)</th>
<th>RA</th>
<th>FREQ.</th>
<th>DX</th>
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<tbody>
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</table>

### Physician's Evaluation and Recommendation

Do you have plans for the eventual discharge of this patient? Y=Yes N=No

<table>
<thead>
<tr>
<th>PHYSICIAN'S EVALUATION AND RECOMMENDATION</th>
</tr>
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<tbody>
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</table>

### Rehabilitative Services

<table>
<thead>
<tr>
<th>REHABILITATIVE SERVICES</th>
<th>A. IDENT. NEEDS</th>
<th>B. LEVEL OF SERVICE</th>
<th>C. FREQ./WEEK</th>
<th>D. HOURS/WEEK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy</td>
<td>030.</td>
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<tr>
<td>Occupational Therapy</td>
<td>031.</td>
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<tr>
<td>Speech/Hearing Therapy</td>
<td>032.</td>
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</tbody>
</table>

### To your knowledge, does the recipient have a condition of mental illness, related condition, and/or mental retardation?

(Y=Yes N=No) 034. MI RC MR

### Activities of Daily Living

<table>
<thead>
<tr>
<th>ACTIVITIES OF DAILY LIVING</th>
<th>VALUE</th>
<th>RESTRAINTS/SAFETY DEVICES</th>
<th>VALUE</th>
<th>THERAPEUTIC INTERVENTIONS</th>
<th>VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility/Amb.</td>
<td>050.</td>
<td>Geriatric Chair</td>
<td>065.</td>
<td>Decub./Stas. Ulc. Care</td>
<td>089.</td>
</tr>
<tr>
<td>Dress/Groom</td>
<td>051.</td>
<td>Vest/Belt</td>
<td>066.</td>
<td>Enteral Feeding</td>
<td>090.</td>
</tr>
<tr>
<td>Transfer</td>
<td>052.</td>
<td>Wrist/Mitten</td>
<td>067.</td>
<td>Parenteral Feeding</td>
<td>091.</td>
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<tr>
<td>Toilet</td>
<td>054.</td>
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<tr>
<td>Bladder Control</td>
<td>055.</td>
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<tr>
<td>Bowel Control</td>
<td>056.</td>
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<tr>
<td>SENSORY/PERCEPT. STATUS</td>
<td>VALUE</td>
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<tr>
<td>Vision</td>
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<td>Hearing</td>
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<td>Func. Commun.</td>
<td>059.</td>
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<tr>
<td>Orientation/Memory</td>
<td>060.</td>
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<td>Consciousness Lev.</td>
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<tr>
<td>BEHAVIORAL STATUS</td>
<td>VALUE</td>
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<tr>
<td>Verb. Aggression</td>
<td>062.</td>
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</tbody>
</table>

### Health Status/Problems

<table>
<thead>
<tr>
<th>HEALTH STATUS/PROBLEMS</th>
<th>VALUE</th>
<th>THERAPEUTIC INTERVENTIONS</th>
<th>VALUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seizures</td>
<td>068.</td>
<td>Decub./Stas. Ulc. Care</td>
<td>089.</td>
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<td>Hemi-/Paraplegia</td>
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<td>Rect' Fract.(3 mo.)</td>
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<td>Rect' Amp.(6 mo.)</td>
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<td>Internal Bleeding</td>
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<td>Terminal Illness</td>
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### Comments

Comments:

Provider Certification:
On behalf of this facility, I certify that to the best of my knowledge this information is true and accurate. I also certify that this information represents those items of the individual's treatment plan as documented by the physician in the medical record. I further certify that this facility can provide the prescribed physical and medical care.

Signature–Director of Nurses

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Signature–Assessor (RN/LVN)

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Texas Department of Aging and Disability Services

Form 3652-A/05-98

Signature–DADS RN

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Signature–Director of Nurses

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Signature–Assessor (RN/LVN)

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Signature–MD/DO

Date