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| A picture containing text, clipart  AI-generated content may be incorrect. | | **CONFIDENTIAL INFORMATION – DO NOT DISCLOSE NOT FOR PUBLIC DISCLOSURE**  **Assisted Living Facility Resident Characteristic Roster and Sample Selection** | | | | | | | | | | | | | | | | | Attachment D | | | | | | |
|  | |  | | | | | | | | | | | | | | | | | TOTAL CENSUS | | | | | | |
| ASSISTED LIVING FACILITY NAME | | | | | | | | | | | LICENSE NUMBER | | | | | | | | ENTRANCE DATE | | | | | | |
| LICENSOR NAME | | | | Visit Type:  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 **O**stomy care; **T** - resident receiving **T**ube feeding; **I** – resident receiving **I**njections;  **ND** – resident receiving **N**urse **D**elegation. |
| Medication: Independent Administration  Assistance Family Assistance | **I** – resident assessed as **I**ndependent with their medication; **A** – resident assessed as needing medication **A**ssistance; **AD** – resident assessed **M**edication **A**dministration; **F** – resident receiving **F**amily assistance with medications. |
| Mobility / Falls / Ambulation Devices | **A** – resident requires **A**ssistance with transfers or cannot ambulate independently without assistance from staff or assistive devices; **F** – resident experienced a **F**all within the last 30 days; **D** – resident uses a **D**evice to assist with ambulation. |
| Behavior / Psychosocial 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 **E**xit **S**eeking behaviors; **W** – resident has shown **W**andering behaviors |
| Smoking | **S** – resident Smokes. |
| DD / Mental Health | **DD** – resident has a **D**evelopmental **D**isabilities case manager; **MH** – resident receives **M**ental **H**ealth 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 **H**earing **I**mpaired; **D** – resident is **D**eaf. |
| Vision Deficit / Blindness | **X** – resident is blind or has severe vision deficit which requires additional staff support |
| Diabetic: Insulin / Non-Insulin | **I** – resident is **I**nsulin dependent; **N** – resident is **N**on-insulin dependent diabetic. |
| Assist with ADL’s | **I** – resident assessed as **I**ndependent; **MIN** – resident assessed as needing **Min**imal assistance with ADL’s such as cueing reminders, supervision, and/or encouragement; **MOD** – resident assessed as needing **Mod**erate assistance with ADL’s such as guiding, standby assistance for transfers, or ambulation, bathing and toileting; **MAX** – resident assessed as needing **Max**imum 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 **P**ressure ulcer; **S** – resident has a **S**tasis wound; **W** – resident has a **W**ound or skin issue other than pressure or stasis ulcer. |
| Incontinent / Appliance (catheter) / Dialysis | **UI** – resident **I**ncontinent of bladder and/or bowel; **C** – resident has **C**atheter; **D** – resident requires **D**ialysis. |
| 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 **W**eight **L**oss within last 60 days; **WG** – resident has had more than a 3 – 5-pound **W**eight **G**ain within the last 60 days. |
| Medical Devices | **X** – resident receives dialysis treatments; **M** – resident uses **M**edical devices such as 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 (**P**rivate pay); **S** – all or part of a resident care is paid for by the **S**tate. |
| 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. |