



DEPARTMENT OF HEALTH & MENTAL HYGIENE

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MARYLAND'S ASSISTED LIVING RESIDENT
ASSESSMENT AND LEVEL OF CARE SCORING TOOL



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Introduction

The Assisted Living Resident Assessment Tool consists of four components, which include the Health Care Practitioner's Resident Physical Assessment, the Assisted Living Manager's Resident Assessment, the Level of Care Scoring Tool, and the Identifiers for Awake Overnight Staff. The Resident Assessment Tool is based on the Assisted Living Program regulations (COMAR 10.07.14) and is designed to provide the case manager/delegating nurse and the assisted living manager with the necessary resident-based information to provide or arrange for services that meet the needs of the residents in the assisted living program.

The purpose of this guide is to explain the Assisted Living Resident Assessment Tool and how it must be used to develop comprehensive service plans for residents, including assessment of nursing needs and the need for awake overnight staff.

Resident Population

Assisted living residents are diverse. They may be of any adult age, 18 years or older, and span the spectrum of personality types, lifestyles, values attitudes, habits, preferences, and expectations. Their functional status may range from being independent to needing total care. While some residents choose assisted living primarily for its lifestyle, many others need assistance because of the impact of aging, illness, developmental disabilities, or other problems.

The Department has confirmed, from a review of national and Maryland-specific studies, that residents in assisted living programs are more frail than anticipated when the program was implemented in 1996. According to these studies, up to two-thirds of residents in assisted living programs have moderate to severe dementia and less than half receive adequate treatment for this condition. Most residents have multiple medical diagnoses, some debilitating, and take, on average, 9 to 14 medications per day.¹

Assisted living, therefore, is a community-based residential medical program. Many residents have significant physical, functional, and psychosocial problems that may affect their quality of life, ability to make choices, ability to function and to care for themselves, and even their health and survival. It is essential to identify and address these significant issues.

¹ Johns Hopkins University, Division of Geriatric Psychiatry and Neuropsychiatry. Study on Dementia Care in Maryland's Assisted Living Program.
Hawes, Catherine. "Assisted Living: Policy Implications of Data". Presentation to the Association of Health Facility Survey Agencies, October 2005.

The information captured in the Assisted Living Resident Assessment Tool is essential for the case manager/delegating nurse and assisted living manager in developing a resident-centered service plan to meet resident needs and Maryland regulatory requirements.

The Spectrum of Assisted Living Providers

In Maryland, an "assisted living program" is defined as a "residential or facility-based program that provides housing and supportive services, supervision, personalized assistance, health-related services, or a combination of these services to meet the needs of residents who are unable to perform, or who need assistance in performing, the activities of daily living or instrumental activities of daily living in a way that promotes optimum dignity and independence for residents".² This definition captures a large variety of programs, such as:

- Large programs caring for over 150 residents;
- Small programs caring for fewer than four residents;
- Programs that may be not-for-profit and for-profit;
- Programs that only take SSI or SSDI payments;
- Programs that only accept private payment; and,
- Programs with wide ranges of diverse services - from those offering only minimal supervision to those providing services similar to nursing homes.

Assisted living providers are responsible for addressing the physical, functional, and psychosocial needs of residents. The Assisted Living Resident Assessment Tool is designed to help assisted living providers identify those needs and prepare to meet them. Completion of the Assisted Living Resident Assessment Tool and adherence to its findings are required by Maryland regulations. (COMAR 10.14.07.21)

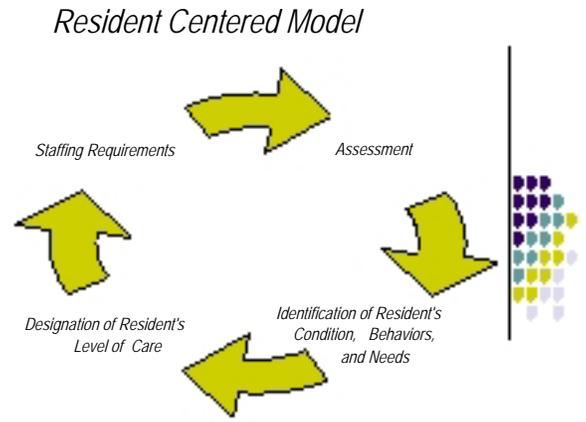
The Basis for the Resident Assessment and Level of Care Scoring Tool

Maryland has a Resident Centered Model for regulating assisted living programs that focuses on the specific needs of individual residents. Assisted living programs are required to develop a staffing plan that identifies the type and number of staff needed to meet the 24-hour scheduled and unscheduled needs of residents.

² Maryland Health-General Article §19-1801.

The Assisted Living Resident Assessment Tool, which is based on the Assisted Living Program regulations, is resident-oriented and accounts for many different variations of resident needs. It is designed to help the case manager/delegating nurse and the assisted living manager collect essential information about each resident's physical, functional, and psychosocial strengths and deficits.

The Health Care Practitioner's Resident Physical Assessment must be completed and verified by a health care practitioner. The Assisted Living Manager's Resident Assessment must be completed by the assisted living manager or designee. The case manager/delegating nurse is responsible for reviewing the assisted living manager's portion of the Resident Assessment Tool.



The Assisted Living Resident Assessment Tool provides the opportunity to gather information about the resident's strengths and needs in order to identify the scope of services that the assisted living program will either need to provide or make arrangements to provide. The ability to paint an accurate picture of the resident will depend heavily on the amount and accuracy of the information obtained. The assessment must be based on the resident's ability to perform:

- (1) Activities of daily living,
- (2) Instrumental activities of daily living tasks, and
- (3) Self administration of medication.

The assessment must focus on the resident's ability to perform the task(s), not on facility policy about what the staff shall perform for the resident. Whenever possible, both the practitioner and provider portions have been designed to allow for checking-off or circling of answers, with written areas to provide details.

The Level of Care Scoring Tool is based on a simple principle: The amount of care and service a resident needs depends on the complexity of his/her physical, functional, and psychosocial problems and needs. Provider responsibilities to meet those needs may be divided into the following areas.

Monitoring and Assessment

The provider has the responsibility to observe, evaluate, document, and report information, which includes:

- Medical illnesses and conditions; and
- Cognitive impairments, psychiatric illnesses, and behavior issues.

Monitoring includes observation and/or reporting of any changes in health care status, behavior changes or mood disturbances, including suicidal ideation.

Provider Care and Service

The provider has the responsibility to assist, cue, coach, treat, or manage various conditions, problems, or situations. These include:

- Performing treatments for physical/medical conditions;
- Medication management;
- Assistance with activities of daily living (ADLs); risk factor management (falls, skin breakdown, etc.); and,
- Management of problematic behavior.

As specified in the Assisted Living Program regulations, the provider may arrange any combination of direct and outside services that adequately fulfill these responsibilities.

The Level of Care Scoring Tool

The Level of Care Scoring Tool calculates a level of care for the resident. The Level of Care reflects the complexity of the services required to meet the needs of a resident. The level of care scoring concept recognizes that all residents may not need the same amount of services, or need them as often.

The resident's overall level of care score (Level 1, 2, or 3) gives you a picture of the total care and service needs of the resident. The completed assessment will help identify the resources and staff needed to care for a specific resident.

Additionally, the Scoring Tool will direct the Assisted Living Program when a resident's needs require awake overnight staff. In the event the Scoring Tool identifies awake overnight staff is required, only a licensed health care practitioner (physician, certified nurse practitioner, registered nurse, or certified nurse mid-wife) or case manager/delegating nurse may counter the need by explaining in writing why awake overnight staff is not required.

The Process

The process for assessing prospective or current residents and figuring out their level of care is divided into the following steps:

- (1) Complete the Health Care Practitioner and Assisted Living Manager components of the Assisted Living Resident Assessment Tool.
- (2) Review the assessments.
- (3) Use the Level of Care Scoring Tool to score each component of the assessment.
- (4) Add up the scores for each section, as indicated on the Level of Care Scoring Tool. Add up the score for each of the seven sections to arrive at your total score. A maximum of 115 points is possible.
- (5) The levels of care are identified as follows:
 - Level 1 = a total score of 0 - 20;
 - Level 2 = a total score of 21 - 40; and,
 - Level 3 = a total score of 41 or higher.

Definitions

1. **Assessment** means a process of evaluating an individual's health, functional and psychosocial history and condition using the Resident Assessment Tool.
2. **Agitation** means excessive motor activity, usually non-productive, which is repetitious and difficult for the resident to control. This includes the inability to sit still, pacing, hand wringing, picking or pulling at clothing or other objects, rocking back and forth, restlessness/fidgeting, facial contortions that are not drug induced, shouting, low tolerance for frustration, irritability and physical or verbal outbursts that may or may not be disease related. It is accompanied by feelings of tension.
3. **Continuous** means ongoing, with little or no break between episodes.
 - Example - Behaviors that can not be redirected, or reappear shortly after redirection.
 - Example - Use of oxygen by the resident that is needed at all times, but may be removed for brief periods during transfer or bathing.

4. **Inappropriate social behavior** means behavior that is not generally accepted and may include, but is not limited to, any of the following: urinating in inappropriate locations; unwanted sexual advances or conduct such as touching other residents or staff in inappropriate places; disrobing; hoarding; or, rummaging through others' belongings.
5. **Occasional** means not daily, but at least two to three times per week.
6. **Regular** means that the resident demonstrates this behavior daily.
7. **Wandering** means moving about without purpose, looking for a non-existent place or trying to actively leave the facility.
8. **Cognitive impairment** means the loss of processes, including remembering and recalling, thinking, planning, organizing and interpreting information, and exercising judgment, that allow individuals to turn ideas, wishes, needs into goal-directed behavior. It includes the lack of judgment, planning, organization, self-control, and the persistence needed to manage normal demands of the resident's environment.
 - Examples of behaviors that may reflect impaired cognition or judgment may include, but are not limited to: touching a hot stove or surface, or going outside in cold weather without a coat without recognizing the potential danger.
 - Examples of unsafe behaviors may include, but are not limited to: trying to take a wheelchair down a flight of steps, wandering into dangerous areas without understanding the risks, in or outside of the facility.
 - Examples of behaviors that may present a risk to the individual or others may include, but are not limited to: unsupervised smoking, lighting fires in trash cans due to using the trash can as an ashtray, combative or aggressive behaviors (e.g., kicking, biting, hitting, scratching, or spitting).
9. **Medication** means a pharmacological agent, which includes over-the-counter (OTC) medications, taken to try to relieve or manage the risks or symptoms of a disease or a condition (e.g., nebulizer, anti-coagulants, or cardiovascular (heart) drugs).
10. **Treatment** means a nonpharmalogic approach or procedure used to manage the symptoms of a pathological condition or disease (e.g., oxygen for shortness of breath, wound care or pressure ulcer care, flushing of indwelling urinary catheters).

Examples include:

- Psychiatric interventions, other than medications, including resident or group therapy and ECT are considered treatments.

- Services that are physician ordered for a physical, occupational, and/or speech therapies that would require staff time and assistance to follow up on the treatment recommendations.
- Treatments that have been arranged for and delivered by any home health agency staff.

11. **Activities of Daily Living** means normal daily activities, including eating or being fed; grooming, bathing, oral hygiene including brushing teeth, shaving, and combing hair; mobility, transfer, ambulation, and access to the outdoors, when appropriate; toileting; and, dressing in clean, weather-appropriate clothing.

12. **Significant Change of Condition** means a shift in a resident's health, functional, or psychosocial conditions that either causes an improvement or deterioration in a resident's condition as described in Appendix A of the Resident Assessment Tool.

Guide to the Assisted Living Resident Assessment Tool

It is important to answer all items in the Assisted Living Resident Assessment Tool. Notations such as "see attachment" are not acceptable for scoring purposes. A health care practitioner may attach medical documentation to help provide and clarify details. These attachments, however, are not a substitute for completing any item on the Assisted Living Resident Assessment Tool.

Part I: The Health Care Practitioner Portion

Item 1: Current Medical and Psychiatric History

Briefly describe changes in health or behavioral status within the last six months. This may include, but is not limited to, acute episodes of medical or psychiatric illness, recent changes in function or behavior, symptom progression requiring changes in medications or treatments, falls with or without injury and any suicide attempts. Provide enough detail to indicate the course of the problem (resolved, improved somewhat, worse, etc.), any complications (for example, became dehydrated from repeated vomiting, or bruised left hip from fall because of balance problems due to a recent transient ischemic attack) and any new or changed treatments. A change in one's environment can be considered a risk factor. The change of environment and a recent onset of mood disturbance, such as a suicide attempt within the past six months may be a risk factor for depression or another suicide attempt. If available, the health care practitioner may attach any additional information (physician notes, hospital discharge summary, consultation forms, etc.) to help provide and clarify details.

Item 2: Briefly describe any past illness or chronic conditions.

Briefly describe any past illnesses (including hospitalizations) and long-term physical, functional, and psychological condition changes over the years. Some residents have had numerous types of illnesses or may have had numerous bouts of the same illness, operations, and injuries. Include all known chronic conditions with any bearing on their current condition (e.g., dementia, chronic renal failure, COPD (chronic obstructive pulmonary disease), hypertension, congestive heart failure, HIV/AIDS, hepatitis, diabetes mellitus, and suicide attempts). If available, the health care practitioner may attach any additional information (physician notes, hospital discharge summary, consultation forms, etc.) to help provide and clarify the details. These attachments are not a substitute for completing this item on the form.

Item 3: Allergies

List any allergies or sensitivities to food, medications, or environmental factors. Environmental factors may include cleaning products or air fresheners. A person's descriptions of "allergies" may actually reflect various reactions ranging from a disagreeable sensation or upset stomach to anaphylaxis. Therefore, as much as possible (and if known), identify the nature of any problems such as rash, anaphylactic reaction, GI symptoms, etc. Please be sure to also enter all medication or substance (food or environmental) allergies under Item 12.

Item 4: Communicable Illnesses

The Assisted Living Program regulations require that the resident be free from communicable tuberculosis (TB) and other active reportable airborne communicable diseases. Therefore, indicate whether the resident is *free* from active disease. Provide enough information in the indicated spaces about the basis for this conclusion. This requires either a negative PPD or chest X-ray or evidence that a positive converter or previous TB patient does not currently have active disease,³ whether or not they are symptomatic. Please contact your local health department for guidance to determine frequency of testing for residents and staff. As needed, provide additional information about required treatments or monitoring when answering Items 12 (c) and (d).

Item 5: History of Substance Abuse

Indicate whether the resident has any history or current problem related to abuse of prescription, non-prescription, or illegal drugs, alcohol, inhalants, or herbal supplements. If such a problem is present, then identify the substance(s) and the actual or approximate last known date of use (to the best of your knowledge). Indicate whether the resident is in a treatment program for substance abuse, and where the resident is receiving treatment. Monitoring by staff for compliance with therapeutic programs should be part of the service plan.

Item 6: Risk Factors for Falls and Injury

Many residents are at risk for falling. Falling is a major cause of disability and death in the elderly. Knowing that a resident is at risk for falls permits various interventions to prevent falling. Risk factors for falling may include but are not limited to: poor balance, low blood sugar, low blood pressure, dehydration, poor fluid intake, medication side effects (e.g., walking and balance

³ Active disease means a disease process that is present and flourishing, which may or may not demonstrate symptoms.

disturbances, dizziness, excessive fatigue, diuretics which would result in frequent urination, etc). The service plan should indicate the approach to monitor for, and address, these risk factors.

Item 7: Skin Condition(s)

Impaired skin integrity may require current treatment or may represent a risk factor for subsequent skin breakdown. Easy bruising may indicate a medical condition or a risk factor for injury. Identify any current or past history of ulcers (vascular, stasis, or pressure), rash, skin tears, easy bruising, and their causes. Monitoring for problems related to skin conditions should be addressed as part of the service plan.

Item 8: Significant Sensory Impairments Affecting Functioning

Sensory impairments can be significant risk factors, or may interfere with functioning or quality of life (for example, enjoying food or socializing). Sometimes, these impairments can be improved, which helps improve quality of life. Indicate all applicable impairments:

- (a) Hearing: Quality of hearing in each ear. Address the resident's nonuse of or refusal to use a hearing aid in Item 34 as well as in the service plan.
- (b) Vision: Quality of vision in each eye. Address the resident's nonuse of or refusal to use a visual aid in Item 34 as well as in the service plan.
- (c) Smell: Whether smell is intact or diminished. Address in the service plan due to resident risk in the event of a fire.
- (d) Taste: Whether taste is intact or diminished. Address in the service plan if this affects food intake.
- (e) Temperature Sensitivity: Whether the resident has any loss of significant sensitivity to temperature (for example, because of neuropathy or stroke).

Item 9: Current Nutritional Status

Understanding the resident's current nutritional status is very important, to enable monitoring for risks factors and for the management of current problems or conditions. Height and weight are clues to current nutritional status. Any forms or mechanism to document monitoring should be developed by the case manager/delegating nurse and the assisted living manager.

- (a) Identify the presence of any significant weight change in the past six months. This may mean a steady decline, a gain or loss of more than 10-percent of weight, or some other significant pattern.
- (b) Identify the amount and the period of time over which the weight change has occurred.
- (c) Monitoring necessary. Weight is a key indicator of a resident's health. It is appropriate and reasonable for a facility to monitor each resident's weight on at least a monthly basis. You do not need a physician's order for this routine monitoring. A physician should be notified if the resident has an unplanned or unanticipated weight loss or gain. An unanticipated weight gain may reflect

fluid retention. An unanticipated weight loss may reflect a loss of appetite due to a medical cause or medication effect, or overall decline in condition. Monitoring may include not only weights but a change in food or fluid intake, ability to feed oneself, chew and swallow food, or decreased ability to feed self or progression of cognitive impairment (e.g., forgets to eat when presented with a meal or during the course of a meal).

(d) Identify any evidence of malnutrition, or if the resident is a risk for under nutrition (for example, because of increasing confusion, forgetting how to eat or use utensils, poor oral intake, taking medications that affect appetite or sense of taste, or recent acute illness).

- Nutritional supplements such as Ensure, Boost, or Carnation Instant Breakfast should be noted in the resident's record.

(e) Identify any evidence of dehydration, or if the resident is at risk for dehydration (for example, because of poor oral intake, heart failure requiring use of higher doses of diuretics and ACE inhibitors, etc.).

(f) Monitoring of risk for malnutrition or dehydration will need to be addressed and the service plan should include the method and frequency of monitoring.

(g) Identify if medical or dental conditions are affecting chewing, swallowing, or eating (for example, a new or old stroke causing dysphagia, depression causing loss of appetite, or periodontal disease causing mouth pain and in turn affecting chewing). Some examples of problems that could cause chewing or eating problems may include loose teeth, unfilled cavities, and poorly fitting dentures. In the service plan, address use/need for assistive devices such as a weighted spoon, plate rim or special plate, or Geri-cup to prevent spilling. Use of assistive devices may enable the resident to maintain independence with eating and drinking as well as encourage the necessary food and fluid intake. The service plans should address management and monitoring requirements for a resident who is fed by a gastrostomy tube (GT).

(h) Special or therapeutic diets are to be noted in this section. For the resident who is on a restricted diet, such as renal or no concentrated sweets, the case manager/delegating nurse may help educate the assisted living manager in modifying meals.

If the resident is fed by a GT, the order must specify the formula to be used, rate of flow of the feeding per hour or gravity drip, and total volume to be given in a 24-hour period. Orders for water flush should include frequency and volume.

The service plan will need to address how the GT orders are to be carried out with documentation on forms designated or designed by the assisted living manager and the case manager/delegating nurse.

**Item 10:
Cognitive/Behavioral
Status**

Medical conditions heavily influence cognitive and behavioral status. Knowing more about the reasons for a resident's impaired cognition and behavior, and the frequency or scope of various disturbances of cognition, mood, and behavior will help the assisted living provider assist and monitor the resident.

- If the resident has dementia, indicate the diagnosis or cause(s), such as Alzheimer's Disease, multi-infarct dementia, Parkinsonism, or others. Since some residents have multiple causes, mark all that apply.
- Indicate the date and score of any Mini-Mental Status Exam, if tested. If alternative tests of cognitive function have been done, then write in the test name and the results.
- Section 10(e) lists a series of cognitive, communication, mood, and behavioral problems or conditions. For each item in the grid, indicate either the frequency or severity of the problem by *circling the most appropriate answer*. It is understood that some of these will be best estimates, while others can be based on direct observation or testing. This information will be very important for the assisted living provider to define the frequency and complexity of essential support needed for the impaired resident.
- Section 10(f) addresses a resident's ability to make decisions about his or her health care, including life sustaining treatment. Please note that it may be acceptable for others to make health care decisions if a resident is incapacitated and unable to make decisions.

Item 11: Ability to Self-Administer Medications

The answers to this section should be based upon the resident's ability to safely perform the task, not on the facility's policy on medication administration.

The ability of a resident to self-administer medications depends on a combination of factors:

- Physical ability to manipulate containers and take medications.
- Cognitive ability to know which medications to take and when.
- Enough intact judgment to know the general risks and dangers of missing medications, taking the wrong medications, or taking too many medications.

Based on the preceding review of the resident's functional capabilities, physical and cognitive status, and limitations, rate this resident's ability to take his or her own medications safely and appropriately. *This should be assessed at least every 90 days and at the time of a significant change in physical or cognitive status.*

(a) **Independently without assistance** means that the resident has the physical and cognitive ability to take medications without any support or assistance from others.

(b) **Can do so with physical assistance, reminders, or supervision only** means that the resident has some minor physical or cognitive limitations, but only to the point of requiring some cuing and coaching or minimal supervision. The resident may need help opening the medication containers or pouring the medications. However, the resident can take and swallow the medications and has some understanding of the reason for taking medications.

(c) **Needs to have medications administered by someone else** means that the resident lacks either physical or cognitive capabilities, or both, requiring that a staff member regularly identify, pour, and give the medications to that resident.

Assessment tools are available to help determine if the resident may safely self-administer, needs assistance or must have medications administered. Consult with the case manager/delegating nurse for these tools.

If (b) or (c) are checked this will need to be addressed in the service plan. For a facility that has residents requiring medication assistance, contact the Office of Health Care Quality to obtain the Cuing and Coaching Video and Workbook order form.

Item 12: Prescriber's Medication and Treatment Form, and Other Information

There is often a link between medical conditions, medications, and impaired function and behavior. This portion of the Health Care Practitioner's Resident Assessment was designed to serve as both a prescribing practitioner's order form and a way to help the assisted living provider understand the link between a resident's diagnoses and his/her medications and treatments.

Many assisted living residents have numerous medical conditions as well as functional and cognitive impairments, and they may take many medications. Most assisted living providers are not health care practitioners. Some of these medications may be considered high-risk medications. Assisted living providers need to know about a prospective or current resident's illnesses and conditions to understand the:

- Reasons for a resident's impaired function,
- Purpose of the resident's medications; and,
- Possible risks of the resident's treatments and medications, including high-risk medications.

Therefore, it is very important for the physician or other health care practitioner to indicate clearly and as fully as possible:

- (a) The resident's active diagnoses;

(b) What medications the resident is taking in relation to that diagnosis;

- If crushing of medications or liquid form is needed, it should be noted in Item 12(a).
- Over the counter herbal supplements of "alternative medicine" should be listed in Item 12(a) due to the risk of possible interaction with conventional prescription and non-prescriptions medications.

(c) What treatments are ordered in relation to diagnoses or conditions;

(d) What the assisted living provider needs to monitor or report to the health care practitioner related to the condition, the medication, or the treatment. Examples could be reporting blood pressure over 150/100, a finger stick result under 60 or greater than 120, two or more consecutive days of pulse below 60 and cardiac or blood pressure medication having been held.

The service plan should reflect conditions or problems that impact a resident's functioning. This includes any additional monitoring or safety issues related to high-risk medications. For example, diagnosis of osteoporosis (brittle bones) may require additional attention to risk factors for falling.

High-risk medications or supplements include, but are not limited to the following examples:

(1) Digoxin or Lanoxin;

(2) Theo-dur (theophylline);

(3) Anti-seizure medications, such as Dilantin;

- These medications would require laboratory blood testing for therapeutic levels.

(4) Coumadin (Warfarin), Plavix, or any other anti-coagulant (blood thinner) medications;

- Warfarin would require laboratory blood testing for therapeutic levels.
- This does not include Aspirin as part of a prophylactic regimen for past history of stroke or cardiac problems.

(5) Over the counter herbal supplements (e.g., St. John's Wart, Kava, Valerian, Echinacea or Gingko);

- (6) Herbal or green teas because of potential interaction with prescribed medications; and,
- (7) A resident's medication regimen may present a high risk for that individual. Consultation with attending physician, the case manager/delegating nurse and pharmacist can help the provider identify these risks. Numerous resources are available via drug books, the Physicians Desk Reference (PDR), and on the Internet.

Procedure for Item 12. Use the following procedure to complete this section.

List all of the medications, including OTC and dietary supplements and/or herbal supplements in Column A. Also, list any medications that the resident is taking but which are not associated with a specific diagnosis or condition.

List all related diagnoses, problems, or conditions in Column B.

List all treatments, including the frequency in Column C (e.g., lab testing for protime/INR for anticoagulant therapy, standing orders for routine skin creams, or prescribed lotions).

In Column D, indicate any monitoring associated with the diagnosis or treatment, including any need to report information to the physician. For example, "monitor finger sticks twice a day and notify physician if results are over 300;" "figure sticks to monitor the diet controlled diabetic;" "check pulse prior to giving heart medications and hold if pulse is below 60;" observation of and dressing to skin tears or ulcers and cleaning around GT site.

There may be several medications and treatments for one diagnosis. If the medications are being given for several purposes (for example, an ACE inhibitor for both congestive heart failure and hypertension) list those diagnoses together but only list the medication once.

Having completed the form, the physician or prescribing practitioner should sign it and complete the other requested information. The form may be used as an Admission Order Form.

The service plan should address any monitoring by the assisted living staff or outside testing requirements and how the outside services will be provided.

Part II: The Assisted Living Manager Portion

Items 13 - 21: Activities of Daily Living

Activities of daily living (ADLs) are considered to be essential functions needed to help a resident survive, be safe, and meet social and personal expectations. They include processes related to personal care such as eating, waste elimination, and dressing. An assisted living provider must assist a resident with significant ADL deficits to maximize the resident's functioning and quality of life, and to protect health and safety.

For each item choose and mark the one response that best describes the resident's ability to perform or participate in the task. As much as possible, determine the resident's ADL function by direct observation. When this cannot be done, you may complete this portion of the assessment based on evaluation by a health care provider, or by direct discussion with someone who has seen the resident and can accurately describe and define his or her functional capabilities and limitations.

Because ADLs are important in determining the resident's overall level of care, each ADL function has been assigned a score. Based on assessment, write the score for each item in the blank space provided. Then, add together the resident scores for items 13 through 21, and place that total ADL score in the blank space provided in Item 21(a).

**Item 21(a): Scoring
for ADLs**

Add the scores of Items 13 - 21, and enter the total in the blank space. Then transfer the score to the Scoring Tool (Section 5).

**Items 21 - 27:
Instrumental Activities
of Daily Living**

Instrumental activities of daily living (IADLs) include capabilities related to the tasks of everyday social and personal life such as cooking, chores, or keeping personal space clean, using the telephone, managing money for daily personal needs, and shopping.

While the IADLs do not figure in the Level of Care scoring, they are significant in identifying a resident's strengths and needs, and may need to be included in the service plan.

**Items 28 - 36:
Behaviors/
Communication**

For Items 28 - 35, choose and check as many answers as applicable that best describe the resident, his or her behaviors, and ability to communicate. There may be more than one answer for each item. If there are multiple answers for each question, use the highest scoring value. For example, if question 29 is scored as occasional, regular and continuous, then the scoring value is continuous.

Residents who have the cognitive ability to make informed decisions about their care may exercise their right to refuse elements of care without being considered resistive or uncooperative. For example:

- The resident who refuses to take a pain pill for joint or other type of pain because they would rather tolerate the pain than take a pill.
- The resident who refuses regularly scheduled daily bath or shower and will take only one bath or shower twice a week.

Note: The resident with dementia who refuses to bathe or shower when first approached, but will take the bath or shower upon being approached again in a few minutes or at a later time that same morning or evening should not be considered as refusing.

Items 28 - 35 will need to be transferred to the Scoring Tool for the purpose of determining level of care. Any response other than "never" for items 28 - 35 needs to be addressed in the service plan to ensure a safe environment for the resident and others residing in the home.

While Item 36 is not included in the Scoring Tool, it will need to be addressed in the resident's service plan.

**Items 37 - 43: Daily
Social and
Recreational Needs**

The following items do not impact on scoring, but will need to be addressed in the resident's service plan.

Item 37: Family Support and Personal Relationships. Check all responses that apply to the resident. Briefly explain the nature of any family problems. For example: "Four children, three local and one out-of-town who is the responsible party. Husband very ill and cannot visit often. Contact limited because of significant family conflicts". Include anything such as social isolation or problems that impact getting along with others.

Item 38: Spiritual Needs and Status. Briefly describe noteworthy information about the resident's spiritual status, preferences, and needs. For example: "Likes to attend religious services, wants to attend Mass daily."

Item 39: Education/Work History. There is more than one possible answer for this section. The educational level and past occupation may assist you in planning and understanding any problems that might be pertinent to the resident's current situation (e.g., employed as a night watchman in warehouse, former police officer or fire fighter, which may have an impact on how to handle a resident with wandering problems.)

Item 40: Interests and Hobbies. Briefly describe what is known about the resident's past and present interests and hobbies. These past interests and hobbies should be incorporated into the resident's service plan whenever possible.

Item 41: Activity Status. Briefly describe what is known about the resident's interest and ability to participate in (a) structured and group activities and (b) self-directed activities such as reading, computer use, or watching television. Maintaining participation in program activities will need to be addressed in the resident's service plan based upon interests and hobbies noted in Item 40.

Item 42: Current Daily Routine. Briefly describe what is known about the resident's current daily routine such as usual wake-up time, bedtime, and meal preferences. Things noted here could have a potential impact on resident care and need to be included in the service plan.

Item 43: Interest in Programs Away from the Facility. Briefly describe what is known about the resident's interest in attending, or need to attend, programs away from the facility, such as senior centers, adult day care, or rehabilitation programs. Making arrangements for transportation to attend those programs should be included as part of the resident's service plan.

Residents Who May Not Be Admitted to Assisted Living

An assisted living program may not provide services to a resident who, at the time of initial admission, as established by the initial assessment, require : ⁴

- (1) More than intermittent nursing care;
- (2) Treatment for stage three or stage four skin ulcers;
- (3) Ventilator services;
- (4) Skilled monitoring, testing, and aggressive adjustment of medications and treatments where there is the presence of, or risk for, a fluctuating acute condition;
- (5) Monitoring of chronic medical conditions that are not controllable through readily available medications and treatments;
- (6) Treatment for a disease or condition that requires more than contact isolation.

These provisions do not apply to a resident under the care of a general hospice program licensed by the Department.

⁴ COMAR 10.07.14.22(I).

The Scoring Tool

The Scoring Tool has been developed to link information about the resident, recorded on the Resident Assessment Tool, to the amount of care and service likely to be required to meet those needs. Points have been assigned to items based on how they impact the scope (number or amount) and frequency of provider services.

Match each item on the Resident Assessment Tool to the corresponding item on the Scoring Tool. Record the number of points in the space provided. When each section is finished, total the score for that section and place the total in the indicated box marked "Score for this Section".

Calculating Level of Care Score

Add together the total score from each section of the tool and enter into the blank at the bottom of page two of the Level of Care Scoring Tool.

The Levels of Care are identified as follows:

- Level 1 = a total score of 0 - 20;
- Level 2 = a total score of 21 - 40; and,
- Level 3 = a total score of 41 or higher.

Assessment of Condition

Assisted living programs are required to conduct a full reassessment of a resident within 30 days before admission. Assisted living programs are also required to conduct a full assessment annually on each resident and within 48 hours, but no later than required by nursing practice and the resident's condition, after a significant change of condition and after each nonroutine hospitalization. Please refer to Appendix A for more information regarding how to identify a significant change of condition.

In addition, a review of the resident's assessment should be conducted every six months for those who do not have a change in condition. This timeframe coincides with the regulatory requirement for the review of a resident's Service Plan. The assessment that is reviewed should be updated for only those questions where there is change. If there is a score change in any of the following areas: 10(e), 11, or 28 - 35 further evaluation by the health care practitioner is required and changes need to be made to the Service Plan.

Resident-Specific Waiver. If, upon reassessment, the resident's level of care exceeds the level of care for which the assisted living program has authority to provide or if the resident requires care that falls into one of the six prohibited categories (as noted in COMAR 10.07.14.22(I)) the assisted living program

must request a resident-specific waiver from the Office of Health Care Quality in order to continue to provide services to the resident.

In requesting a resident-specific waiver, the assisted living program must demonstrate that it has the capability of meeting the needs of the resident and that the needs of the other residents of the program will not be jeopardized.

Service Plan Development

A service plan is an ongoing and evolving document that reflects the current needs of a resident. An assisted living manager is required to develop a resident's service plan in a manner that enhances the principles of dignity, privacy, resident choice, resident capabilities, individuality, and independence without compromising the health or reasonable safety of other residents.⁵

The assisted living manager must have a written service plan recorded in the resident's record which, at a minimum, addresses the following:

- Services, based on the assessment of the resident, to be provided;
- When and how often services are to be provided; and,
- How and by whom the services are to be provided.

The resident's service plan is required to be developed within 30 days of admission to the assisted living program and must be reviewed by staff at least every six months and updated, if needed, unless the resident's condition and preferences significantly change. (See Reassessment Section)

The resident's service plan, for example, may include the use of adaptive eating devices, such as built up spoons, forks, plate guards, or Geri-Cups, requiring that medications be crushed or in liquid form due to swallowing problems for residents who are at risk of aspiration, requirements for additional or specific monitoring, etc., if needed.

On-Site Nursing and Awake Overnight Staff

On-Site Nursing. Assisted Living Program regulations require the case manager/delegating nurse to oversee and manage resident care. The case manager/delegating nurse has the responsibility to make recommendations regarding clinical care and the assisted living manager has the responsibility for implementing those recommendations.

⁵ COMAR 10.07.14.26.

The case manager/delegating nurse, based on the needs of resident, has the authority to issue a nursing or clinical order. The assisted living manager must implement the nursing or clinical order. If an assisted living manager determines that a nursing or clinical order should not or cannot be implemented, the manager, delegating nurse, and resident's physician should discuss any alternatives that could address the resident's needs. The outcome of this discussion shall be documented in the resident's record. If there are alternatives that could address the needs of the resident, the assisted living manager must notify the resident or the resident's legal representative of the change to the order.

An assisted living manager cannot simply choose not to implement a nursing or clinical order from a case manager/delegating nurse without any consideration given to appropriate alternatives. If an assisted living manager does so, the case manager/delegating nurse must notify the OHCQ, the resident's physician, and the resident or the legal representative of the resident.

Awake Overnight Staff. If any of the "triggers" or specific elements, as noted in Table One, are identified on the Resident Assessment Tool, **it is presumed that a resident requires awake overnight staff.** If the physician or assessing nurse, in their clinical judgment, does not believe that a resident requires awake overnight staff, the physician or assessing nurse must document the decision and rationale on the Level of Care Scoring Tool.

Use of Technology In Lieu of Overnight Staff. An assisted living program may request a waiver for the requirement to provide awake overnight staff in order to substitute a monitoring device. The Department will review the request and evaluate for approval. Approval may be dependent upon matching the proposed technology to the resident, the setting, and the population served by the program. Approval may also be conditional and reassessment would be required based on the resident's change of status.

Table One. "Triggers" for Awake Overnight Staff from the Resident Assessment Tool	
No.	Item
1	Current medical and psychiatric history (e.g., recent changes in function or behavior or symptom progression which may require monitoring or treatment by awake overnight staff) ;
2	Past illness or chronic conditions (including hospitalizations), past suicide attempts, and physical functional and psychological conditions or changes that require monitoring or treatment by awake overnight staff;
6	Risk factors for falls and injury;
7	Skin conditions (specifically those requiring overnight attention);
8	Sensory impairments affecting functioning (specifically those requiring overnight attention);
9e	Evidence of dehydration or risk for dehydration;
10	Cognitive/behavioral status: a - Is there evidence of dementia, c - Diagnosis (cause of dementia), e - behavioral elements if at level B , C, or D if this diagnosis impacts the resident's behavior at night;
11	Ability to self-administer medications - b or c, if medications are required at night;
13	Resident must be fed or needs tube feeding, if required at night;
14	Resident mobility - 2 or 3 ⁶ ;
15	Resident transfer to bed, chair, or toilet - 2 or 3 ⁷ ;
16	Bed mobility - how resident moves to and from lying position, turns side to side, and positions body in bed - 2 or 3 ⁸ ;
17	If bathroom is on different floor from bedroom;
18	Resident continence - 1, 2, or 3 ⁹ ;
29	Wanders - C or E at regular or continuous;
30	Sleep disturbance - A at regular or continuous;
31	Verbally inappropriate - B at regular or continuous, if behaviors occur at night;
32	Disruptive behaviors - C, D, or E at regular or continuous, if behaviors occur at night;
33	Combative behaviors - at regular or continuous, if behaviors occur at night;
34	Resistive/uncooperative behaviors - D or g at regular or continuous; if behaviors occur at night; and,
35	Communication - C or D at regular or continuous (unable to communicate needs).

⁶ Numbers indicate score of prevalence.

⁷ Id.

⁸ Id.

⁹ Id.

APPENDIX A: HOW TO IDENTIFY A SIGNIFICANT CHANGE OF CONDITION

HOW TO IDENTIFY A SIGNIFICANT CHANGE OF CONDITION

A significant change of condition is a shift in a resident's health, functional, or psychosocial condition that either causes an improvement or deterioration in a resident's condition. The American Medical Directors Association (AMDA) issued Clinical Practice Guidelines regarding Acute (or significant) Change of Condition in the Long Term Care Setting. These guidelines provide essential information on how to identify a resident's significant change of condition in any setting, including assisted living.

Should an assisted living manager have any questions regarding these guidelines or how to identify a significant change of condition, the manager should contact the assisted living case manager/delegating nurse.

A. Physical Symptoms.

(1) Respiration. Observe the resident for the following symptoms:

- Respiratory rate > 28 breaths/min (normal in younger adults is 12 - 15 breaths/min; in elderly 16 - 25 breaths/min, with approximate 2:1 inspiration/expiration ratio).
- Marked change from usual respiration pattern or rhythm.
- Irregular breathing, long pauses between breaths, audible noises related to breathing.
- Struggling to breathe (e.g., gasping for breath, using accessory muscles of the neck).

(2) Temperature.

- A range of 98.2 °F to 99 °F (36.8 °C to 37.7 °C) oral temperature is considered normal. A resident's normal temperature will vary by up to 0.9 °F (0.5 °C) daily. As quickly as possible after admission, try to establish the resident's normal temperature range.
- A sudden or rapid change from normal temperature may suggest a significant change of condition. One temperature reading above 100 °F, two readings above 99 °F, or an increase of 2 °F in the upper end of the resident's normal range may indicate a significant change of condition.
- After an isolated temperature reading that is outside the resident's normal range is obtained, repeated temperature readings approximately every 4 hours for up to 24 hours and seek other signs and symptoms to determine whether a significant change of condition exists.
- Hypothermia (temperature below normal range) may also indicate a possible significant change of condition.
- An electronic thermometer is the preferred method for taking temperature.
- Assess the resident for factors that may affect temperature, such as medications.

(3) Blood Pressure.

- As soon as possible after admission, establish the resident's usual blood pressure (BP) range. (Normal range is approximately systolic 100 - 140 mmHg, diastolic 60 - 90 mmHg.)
- An electronic BP machine is the preferred method - includes pulse. (See Item 4 below)
- A change in BP is more often a symptom than a cause of a significant change of condition. Isolated BP elevations generally are not significant. Sustained elevations in systolic pressure should trigger further assessment. A BP change alone should not trigger a call to the practitioner without additional signs or symptoms (e.g., sustained elevation, new neurological symptoms.)
- A decrease in systolic BP ≥ 20 mmHg when moving from a prone to a seated position or from a seated to a standing position signals orthostatic hypotension.
- Any significant decrease in BP may signal a significant change of condition (e.g., systolic BP < 100 mmHg if baseline is 110 mmHg, decline in BP accompanied by other symptoms such as dizziness, decline ≥ 15 mmHg in systolic BP, combination of pulse > 100 beats per minute (BPM) and/or systolic BP < 100 mmHg).

(4) Pulse. Normal pulse ranges from approximately 60 - 100 BPM (beats per minute), but this can vary by about 10%. The following clinical presentations may indicate a significant change of condition and should be assessed further:

- Sustained change from normal range.
- Change in usual pulse rhythm or regularity.
- Pulse > 120 BPM or < 50 BPM
- Pulse > 100 BPM combined with other symptoms (e.g., palpitations, dyspnea, or dizziness).

(5) Pain. The following may indicate a significant change of condition and should be assessed further:

- Pain worsening in severity, intensity, or duration, and/or occurring in a new location.
- New onset of pain associated with trauma.
- New onset of pain greater than 4 on a 10-point scale.¹⁰

¹⁰ For more information about pain scales, refer to AMDA's clinical practice guideline for Pain Management in the Long-Term Care Setting.

(6) Weight/Eating Patterns.

- At a minimum, weights should be taken monthly. A patient's health condition may require more frequent weights, for example if a patient is on dialysis.
- An abrupt change in appetite may indicate a significant change of condition before a significant change in weight occurs.
- Rate of weight gain or loss may be a more important indicator of a possible significant change of condition than amount of weight gain or loss.
- A change in intake patterns (e.g., consuming >75% of all meals in 24 hours or < 25% of any one meal) should trigger additional evaluation for a possible significant change of condition.
- In documentation of intake, identify both solid and liquid intake in as much detail as possible.
- Evaluate signs and symptoms that may suggest fluid imbalance (e.g., edema or change in edema).
- Acute, rapid weight gain may indicate a significant change of condition that is accompanied by fluid accumulation (e.g., acute CHF).
- Acute, rapid weight loss over several days should trigger concern about a hydration emergency.¹¹

(7) Level of Consciousness.

- Level of consciousness (LoC) should be distinguished from aspects of cognition such as orientation and memory.
- The levels of consciousness are alert, drowsy/lethargic, stuporous, and comatose.
- The following may indicate a significant change of condition and should be assessed further:
 - ¾ Frequent fluctuations in LoC.
 - ¾ A reduction of one level or more in LoC (e.g., from alert to lethargic, or from lethargic to stuporous).
 - ¾ Hypersomnolence (more sleepy than usual or sleepy for most of the day).

(8) Weakness.

- New onset of weakness or significant change from baseline may indicate a significant change of condition and should be assessed further.
- Classify weakness as generalized or localized and describe in detail.

(9) Falls. The following may indicate a significant change of condition and should be assessed further.

- Repeated falls on the same day.

¹¹ For more information about fluid imbalance, refer to AMDA's 2001 clinical practice guideline for Dehydration and Fluid Maintenance.

- Recurrent falls overall several days to weeks.
- New onset of falls not attributed to a readily identifiable cause.
- A fall with consequent change in neurological status, or findings suggesting a possible injury.

(10) Change in Elimination Patterns.

- Appearance of blood in stool, urine, or vomit.
- Abrupt change in frequency of urination or defecation.
- Frequent loose stools (three or more in 24 hours).
- Worsening incontinence of bowel or bladder.

B. Behavioral Symptoms.

- Significant change in nature or pattern of usual behavior.
- New onset of resistance to care.
- Abrupt onset or progression of significant agitation or combative behavior.
- Significant change in affect or mood.
- Violent/destructive behaviors directed at self or others.

C. Cognitive Symptoms.

- Abrupt onset of or increase in confusion.
- Onset of hallucinations, delusions, or paranoia.
- Significant fluctuations in level of confusion during the day or over several days.

D. Functional Symptoms.

- Sudden or persistent decline in function (i.e., ability to perform ADLs).