4659.0140 SUBP. 2. INITIAL AND CONTINUING ASSESSMENTS

Assessment tool elements. Each facility must develop a uniform assessment tool. The facility may use any acceptable form or format for the tool, such as an online or hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. A uniform assessment tool must address the following:

A. The resident's personal lifestyle preferences, including:
   (1) sleep schedule, dietary and social needs, leisure activities, and any other customary routines that is important to the resident's quality of life;
   (2) spiritual and cultural preferences; and
   (3) advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life sustaining treatment" order;

B. Activities of daily living, including:
   (1) toileting pattern, bowel, and bladder control;
   (2) dressing, grooming, bathing, and personal hygiene;
   (3) mobility, including ambulation, transfers, and assistive devices; and
   (4) eating, dental status, oral care, and assistive devices and dentures, if applicable;

C. Instrumental activities of daily living, including:
   (1) ability to self-manage medications;
   (2) housework and laundry; and
   (3) transportation;

D. Physical health status, including
   (1) a review of relevant health history and current health conditions including medical and nursing diagnoses;
   (2) allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening;
   (3) infectious conditions;
   (4) a review of medications according to Minnesota Statutes, section 144G.71, subdivision 2,including prescriptions, over-the-counter medications, and supplements, and for each:
      (a) the reason taken;
      (b) any side effects, contraindications, allergic or adverse reactions, and actions to address these issues;
      (c) dosage;
      (d) frequency of use;
      (e) route administered or taken;
      (f) any difficulties the resident faces in taking the medication;
      (g) whether the resident self-administers the medication;
      (h) the resident's preferences in how to take medication;
      (i) interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications; and
      (j) provide instructions to the resident and resident's legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications;
   (5) a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post acute care facility;
   (6) a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months;
   (7) weight; and
   (8) initial vital signs if indicated by health conditions or medications.

E. Emotional and mental health conditions, including:
(1) review of history of and any diagnoses of mood disorders including depression, anxiety, bipolar disorder, and thought or behavioral disorders;
(2) current symptoms of mental health conditions and behavioral expressionsof concerns; and
(3) effective medication treatment and nonmedication interventions;

F. Cognition, including:
(1) review of any neurocognitive evaluations and diagnoses; and
(2) current memory, orientation, confusion, and decision-making status and ability;

G. Communication and sensory capabilities, including:
(1) hearing;
(2) vision;
(3) speech;
(4) assistive communication and sensory devices including hearing aids; and
(5) the ability to understand and be understood;

H. Pain, including:
(1) location, frequency, intensity, and duration; and
(2) effectiveness of medication and nonmedication alternatives;

I. Skin conditions;

J. Nutritional and hydration status and preferences;

K. List of treatments, including type, frequency, and level of assistance needed;

L. Nursing needs, including potential to receive nursing-delegated services;

M. Risk indicators, including:
(1) risk for falls including history of falls;
(2) emergency evacuation ability;
(3) complex medication regimen;
(4) risk for dehydration including history of urinary tract infections and current fluid intake pattern;
(5) risk for emotional or psychological distress due to personal losses;
(6) unsuccessful prior placements;
(7) elopement risk including history or previous elopements;
(8) smoking, including the ability to smoke without causing burns or injury to the resident or others or damage to property; and
(9) alcohol and drug use, including the resident's alcohol use or drug use not prescribed by a physician;

N. Who has decision-making authority for the resident, including:
(1) the presence of any advance health care directive or other legal document that establishes a substitute decision maker; and
(2) the scope of decision-making authority of a substitute decision maker under subitem (1); and

O. The need for follow-up referrals for additional medical or cognitive care by health professionals.