



**pennsylvania**  
DEPARTMENT OF HUMAN SERVICES

JAN 24 2019

Mr. Jack Poplar,  
President/Chief Executive Officer  
Acadia Acquisition, Inc.  
1817 Olde Homestead Lane  
Lancaster, Pennsylvania 17601

RE: Acadia Acquisition 3  
1104/1114 Bentley Ridge Boulevard  
Lancaster, Pennsylvania 17602  
Certificate #: 331440

Dear Mr. Poplar:

As a result of the Department's Bureau of Human Services Licensing's annual licensing inspection on December 6, 2018, December 7, 2018 and December 10, 2018 of the above facility, the violations with 55 Pa.Code Ch. 2600 (relating to Personal Care Homes) specified on the enclosed violation report were found.

All citations specified on the enclosed violation report must be corrected by the dates specified on the violation report and continued compliance with 55 Pa.Code Ch. 2600 must be maintained.

In an effort to improve our licensing processes, the Bureau of Human Services Licensing is soliciting feedback about your recent human services licensing inspection experience. To participate in the online provider survey, launch your web browser and go to [https://www.surveymonkey.com/r/BHSL\\_Inspection](https://www.surveymonkey.com/r/BHSL_Inspection).

The survey is brief and will only take about 5 minutes to complete. Your participation in the survey is completely voluntary and all of your responses will be kept confidential. The responses will be reviewed as part of an aggregate of provider inspection responses. Thank you in advance for providing feedback.

Sincerely,

A handwritten signature in black ink, appearing to read "J. Rowe".

Jacqueline L. Rowe  
Director

Enclosure  
Violation Report

**VIOLATION REPORT  
PERSONAL CARE HOMES - 55 Pa.Code Chapter 2600**

PCH Name: ACADIA ACQUISITION 3		License Number: 33144
Address: 1104 1114 BENTLEY RIDGE BLVD, LANCASTER, PA 17602		County: Lancaster
Administrator: Kevenia Meredith		Region: CENTRAL
Legal Entity Name: ACADIA ACQUISITION INC		
Legal Entity Address: 1817 OLDE HOMESTEAD LANE, LANCASTER, PA 17601		
<b>Certificate(s) of Occupancy</b> Residential 08/26/2006 East Lampeter Township		
<b>Staffing Hours</b>		
Resident Support: 0	Total Daily Staff: 5	Waking Staff: 4
Type of Inspection: Full	BHA Docket Number:	Notice: Unannounced
<b>Reason(s) for inspection(s)</b> Renewal, Complaint		
<b>On-Site Inspections Dates and Department Representatives On-Site</b> 12/06/2018: McCloskey, Jason; Heemer, Laura 12/07/2018: McCloskey, Jason; Heemer, Laura 12/10/2018: McCloskey, Jason; Heemer, Laura		
<b>Off-Site Inspection Dates and Inspectors, if Applicable</b>		
<b>Other Details</b>		
Partial or Full Triggers:		Random Indicators:
<b>Resident Demographic Data as of Inspection Dates</b>		
Licensed Capacity: 6 Number of Residents Served: 5 Secured Dementia Care Unit in Home: No Area: Secured Dementia Unit Capacity, if Applicable: Number of Residents Served in Secured Dementia Care Unit, if applicable: Number of Current Hospice Residents: 0 Number of Hospice Residents in past year: 0	<b>Number of Residents who:</b> Receive Supplemental Security Income: 4 Are 60 Years of Age or Older: 1 Have Mental Illness: 2 Have an Intellectual Disability: 0 Have a Mobility Need: 0 Have a Physical Disability: 1	

Violation Report: 33144 - 12/06/2018 - McCloskey, Jason  
 PCH Name: ACADIA ACQUISITION 3

1. REGULATION 55 Pa.Code §2600  
 2600.25(a)(1) - Prior to admission, or within 24 hours after admission, a written resident-home contract (contract) between the resident and the home shall be in place.

2a. DESCRIPTION OF VIOLATION  
 Resident 1, admitted 5/21/18, did not have a resident-home contract completed until 6/13/18.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)  
*Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

See Attached Pages 7A and 7F

\*The administrator will complete an audit of all records current residents to assure that each resident has a signed contract in place. The audit shall be completed within 10 days from the receipt of this plan.  
 BAS 1/10/19

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kevenia Meredith, PCHA	Date 1/3/19
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**DEPARTMENT USE ONLY - HOMES MAY NOT WRITE BELOW THIS LINE!**

The above plan of correction is approved as of <u>1/10/19</u> (Date)	Plan of correction implementation status as of <u>1/10/19</u> (Date)
The above plan of correction was approved by <u>BAS</u> (Initials)	<input type="checkbox"/> Fully Implemented <input checked="" type="checkbox"/> Partially Implemented - Adequate Progress <input type="checkbox"/> Partially Implemented - Inadequate Progress <input type="checkbox"/> Not Implemented

Violation Report: 33144 - 12/06/2018 - McCloskey, Jason  
 PCH Name: ACADIA ACQUISITION 3

1. REGULATION 55 Pa.Code §2600  
 2600.26(a) - The home shall establish and implement a quality management plan.

2a. DESCRIPTION OF VIOLATION  
 The home does not have a quality management plan.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)  
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

SEE ATTACHED Pages 7A and 7C

\*The home's quality management plan will review all of the elements required by 2600.26b. At a minimum, the plan will include:

- (1) The date the administrator and executive staff will review the effectiveness of the reportable incident and condition reporting procedures developed as required by 2600.16b, and a plan to correct any errors or inefficiencies identified during a review or all incidents reported within the past year.
- (2) The date the administrator and executive staff will review all of the complaints received from residents within the past year, a plan to reduce future complaints, and a review of how the home addressed each complaint in accordance with the requirements of these regulations.
- (3) A plan to review all training provided to direct care staff within the past year, addressing which trainings were effective, which were not effective, and what additional training courses would be helpful.
- (4) A review of all of the violation reports received within the past year, and a complete self-inspection using the Department's licensing measurement instrument.

BAS 1/10/19

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <u>Kevenia Meredith, PCHA</u>	Date <u>1-3-19</u>
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Violation Report: 33144 - 12/06/2018 - McCloskey, Jason  
 PCH Name: ACADIA ACQUISITION 3

**1. REGULATION 55 Pa.Code §2600**  
 2600.132(b) - A fire safety inspection and fire drill conducted by a fire safety expert shall be completed annually. Documentation of this fire drill and fire safety inspection shall be kept.

**2a. DESCRIPTION OF VIOLATION**  
 The most recent fire safety inspection and fire drill observed by a fire safety expert was conducted on 11-1-18. The previous fire safety inspection and fire drill occurred on 6-30-17.

**3. PLAN OF CORRECTION (POC)** (Attach pages as necessary. Remember that you must sign and date any attached pages.)  
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

**SEE ATTACHED**

Pages 7B, 7D, and 7E

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page)

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) <u>Karenia Meredith, PCHA</u>	Date <u>1-3-19</u>
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Violation Report: 33144 - 12/06/2018 - McCloskey, Jason  
 PCH Name: ACADIA ACQUISITION 3

**1. REGULATION 55 Pa.Code §2600**  
 2600.224(a) - A determination shall be made within 30 days prior to admission and documented on the Department's preadmission screening form that the needs of the resident can be met by the services provided by the home.

**2a. DESCRIPTION OF VIOLATION**  
 The pre-admission screening form for Resident 1, admitted 5/21/18, is not dated.

**3. PLAN OF CORRECTION (POC)** (Attach pages as necessary. Remember that you must sign and date any attached pages.)  
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

See Attached Pages 7A and 7E

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page)



Printed Name and Title of Legal Entity Representative (Required on EVERY Page)	Date
Kerenia Meredith, PCHA	1/3/19

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Violation Report: 33144 - 12/06/2018 - McCloskey, Jason  
 PCH Name: ACADIA ACQUISITION 3

**1. REGULATION 55 Pa.Code §2600**

2600.225(a) - A resident shall have a written initial assessment that is documented on the Department's assessment form within 15 days of admission. The administrator or designee, or a human service agency may complete the initial assessment.

**2a. DESCRIPTION OF VIOLATION**

The initial assessment for Resident 1, admitted 5-21-18, was completed on 8-20-18.

**3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)**

*Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.*

See Attached

Pages 7A and 7F

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kevonia Meredith, PCHA	Date 1-3-19
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Violation Report: 33144 - 12/06/2018 - McCloskey, Jason  
 PCH Name: ACADIA ACQUISITION 3

1. REGULATION 55 Pa.Code §2600  
 2600.252 - Each resident's record must include the following information: (1) through (26)

2a. DESCRIPTION OF VIOLATION  
 The records for Residents 1, 2, and 3 do not include any information if the resident has identifying marks.

3. PLAN OF CORRECTION (POC) (Attach pages as necessary. Remember that you must sign and date any attached pages.)  
 Include steps to correct the violation described above and steps to prevent a similar violation from occurring again. If steps cannot be completed immediately, include dates by which the steps will be completed.

SEE ATTACHED  
 Pages 7A , 7G, and 7H

Repeat Violation: No	Date(s) of Previous Violation(s):		
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Signature of Legal Entity Representative  
 (Required on EVERY Page) 

Printed Name and Title of Legal Entity Representative (Required on EVERY Page) Kevenia Meredith, PCHIA	Date 1-3-19
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 (Date)

The above plan of correction was approved by BAS  
 (Initials)

Plan of correction implementation status as of 1/10/19  
 (Date)

- Fully Implemented
- Partially Implemented - Adequate Progress
- Partially Implemented - Inadequate Progress
- Not Implemented

**Kevenia Meredith**

1114/1104 Bentley Ridge Blvd  
Lancaster PA. 17603  
(717) 606-8030  
Kmeredith@acadiarchab.com

9th January 2018

**RE: Acadia Acquisition 3, Inspection Report**

To whom this may concern,

Attached is the plan of correction for Acadia Acquisition 3 Certificate#331440.

1. Regulation 2600.25(a)(1), Regulation 2600.224(a), Regulation 2600.225(a) Attached to the email is a form labeled Residential Admission Support Plan (RASP) which addresses these regulations. This check will be implemented immediately as of 1/3/19 to ensure all proper steps are followed when admitting a resident along with completing a resident's RASP annually or as required. This will ensure documents are dated properly, signed in the correct allotted time, and DME/physicals are completed at correct times. The checks will be completed by the PCHA of the residence as well as another administrator at the time the forms are completed to ensure the RASP and pre-admission screening are completed in its entirety going forward. To ensure these violations from reoccurring this process will be audited monthly by the PCHA and residence assistant for errors. Education and training will be provided to personnel involved in the intake and admission processes, including intake coordinator, case manager, as well as PCHA of other sites in consideration of internal acquisition transfers.

2. Regulation 2600.252, Attached I have included the form that our facility will include in our residents file, which has a description of the clients "identifying marks, in detail. The PCHA's will work with nursing to properly complete this form for each client in the residence and have this completed within the next 30days. The nurse will be responsible for completing the form upon admission of each client. PCHA will provide education to the nurse on a yearly basis or upon hire in the case of a new or additional nurse. PCHA will also review the forms to ensure that it has been completed in full on the day of admission. PCHA will conduct an audit of client files in order to ensure completion. The description of the identifying marks will include birthmarks, tattoos, scars, etc. in as much detail as possible.

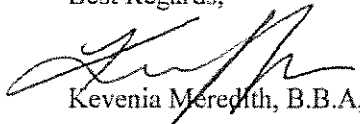
3. Regulation 26(a) Attached is the Quality Management plan that will be implemented by the PCHA of the residence listed above. The PCHA will meet with pertinent individuals, including the Director of Residential Services and DHS Compliance Specialist and update plan as necessary on a bi-annually (Jan-June and June-Dec) basis. This will ensure the best quality of care is being provided to residence. This plan will be finalized by the PCHA with assistance from the Residential Director. PCHA and Residential director will hold trainings and educational opportunities on going to inform staff of information listed in the Quality management plan. This process will be in place by January 31<sup>st</sup>, reviewed in July of 2019, and scheduled for review every 6 months following.

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4. Regulation 123. (b) Attached is letter from the fire safety official of Acadia Acquisition explaining the plan of correction for this regulation, along with the fire chief's card. This letter addresses the potential plan and agreement that will be signed at January 29<sup>th</sup>, 2019 meeting. Education and information will be provided to fire safety official in order to increase understanding of regulations and their purpose annually in preparation of inspections to be scheduled. DHS Compliance Specialist will be assigned responsibility of acquiring necessary inspections. PCHA will be responsible for auditing fire safety requirements on a quarterly basis to ensure 100% completion.

Please feel free to contact me if any additional information is required.

Best Regards,

 1-9-19  
Kevenia Meredith, B.B.A, PCHA  
Acadia, Inc.

Quality Management Plan

Date: 1/3/2018

Acadia Acquisition 3 (1104/1114 Bentley Ridge Blvd, Lancaster PA 17603)

Persons Involved with Plan: Residential Director, Night Shift Supervisor, Site Administrators/Supervisors, NRA supervisor/DHS specialist

**Discussed Agenda**

**B3: Staff training:** The 2019 projected staff training schedule was distributed.

- The 2019 projected in-service training is posted at the site. There will be a month by month schedule that will be posted each month of actually offered trainings.
- Medication Recertification will be set up for by DHS train the trainer staff & scheduled with staff to recertify each month as they are due. See Medication Recertification schedule
- American Heart courses & reviews are scheduled for each month as they are due for staff. See American Heart Recertification schedule.
- All annual DHS required in-service trainings scheduled within the year. See monthly in-service schedules and staff tracking sheets.
- There is a staff tracking guide to keep up with all annual staff trainings.
- Any additional staff required trainings will come out on the month to month schedule.
- There is an annual review on Mandate Reporting offered.

**Client complaint:** There is no reported client complaint at this point in time for the start of the year. All clients have the right to file a complaint, both formal and informal. The company policy for and complaint form should always be posted and available.

**Family counseling:** The whole treatment team of each particular client meets throughout the year to discuss client and family member's needs and client progress. This done through team and family meetings. A summary report is kept with the client's case manager and available to all individual clients. As well as a copy going to the client's designated person.

See attached and/or posted is violation report summary and plans of correction. (where applicable) There were no violations in the last two year at Acadia Acquisition 4.

**Reportable incidents and conditions reporting procedures:** All reportable incidents should be reported to the state within 24 hours of the incident. Follow up on extra training should take place where needed and with all parties involved. Record of all reportable incidents should be part of the client's records.

See reportable incidents and conditions reporting procedures in P&P as well as Regulation 16b-f.

**Specific to Site Topics (add in what applies):** Safety topics such as: Falls, Number DHS incident reports Per time period selected.

 1-3-19.

RED highlight will be information  
that is changed, yellow highlight will be

January 3, 2019

Bureau of Human Services Licensing  
Central Region  
625 Forster Street, Room 631  
Harrisburg, PA 17120

RE: Acadia Acquisition (3), Inspection Report

To whom it may concern,

This letter is to address our plan of correction regarding the violation for regulation 2600.132b. An agreement will be drawn with the local fire company that assures that we have an observed fire drill each year. The drills will be scheduled one year from the last completed date. This is with the understanding that there is a 15-day grace period if for some reason we are not able to complete the drill on the date scheduled. This document has not been signed at this time due to the holidays. Ian Wirls, DHS Compliance Specialist for Acadia, Inc., will be meeting with [REDACTED] on January 29<sup>th</sup> to have the above-mentioned agreement signed. We have also attached the business card of [REDACTED] along with this letter, listing his credentials.

Thank you,

Ian Wirls, DHS Compliance Specialist  
Acadia, Inc.

 1-3-19



1-3-19



Lafayette Fire Company

[Redacted]

Fire Chief

63 Lafayette Way - Lancaster, Pennsylvania 17602

Ph: [Redacted] Cell: [Redacted] - Fax: [Redacted]

EMERGENCY: DIAL 911 Email: [Redacted]

## Resident Admission Support Plan (RASP)

The primary purpose of a RASP form is to quickly, safely and accurately inform others of the needs of our clients and our plan on how to best meet those needs that have been identified through the assessment.

When completing a RASP please make sure you follow the steps below:

- Pre-admission screening dated and signed
- DME dated and signed
- Resident information all boxes completed (Part I)
- Assessment and Support Plan Information completed (Part II – III)
- Summary and Determination completed (Part IV)
- Client is present to review, sign and date the RASP after reviewing it.
- Resident and Supervisor's signature and date (Part V). If a resident refuses to sign, please make sure the box is checked and signed.
- Assure that all necessary boxes are checked, and everything is signed.
- Admissions agreement completed, dated and signed

All documents should be filed once everything is completed.

\_\_\_\_\_  
Client's name

\_\_\_\_\_  
Date of last RASP

\_\_\_\_\_  
PCHA/Site Supervisor

\_\_\_\_\_  
Assistant Site Supervisor

 1-3-19

# ADMISSION NURSING ASSESSMENT

## STATUS UPON ADMISSION

<b>Admission Notes</b>		<b>Allergies</b>
Date of admission _____ Time _____ a.m. p.m.		Meds _____
Transported by _____		Food _____
Accompanied by _____		Other _____
Age _____ Sex _____ Weight _____ Height: _____ Ft. _____ In.		
Vitals: T _____ P _____ ( <input type="checkbox"/> Reg <input type="checkbox"/> Irreg ) R _____ B/P _____		
Attending physician notified? <input type="checkbox"/> No <input type="checkbox"/> Yes, date/time _____ a.m. p.m.		
Diagnosis: _____ Date last chest x-ray or PPD _____		

**PAIN**

(As described by resident/representative)

**Frequency:**

No pain  Daily, but not constant

Less than daily  Constant

**Location:** \_\_\_\_\_

**Intensity:**

No pain  Severe pain

Mild pain  Horrible pain

Distressing pain  Excruciating pain

**Pain on admission:**

No  Yes, describe \_\_\_\_\_

\_\_\_\_\_

Identify Site on Diagram Below

Anterior      Posterior

**Skin Condition**

Using the diagrams provided, indicate all body marks such as old/recent scars (surgical and other), bruises, discolorations, abrasions, pressure ulcers, or questionable markings. Indicate size, depth (in cms), color and drainage.

**COMMENTS:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SPECIAL TREATMENTS & PROCEDURES:**

\_\_\_\_\_

\_\_\_\_\_

See Pressure Ulcer Record

CURRENT STATUS	
<p><b>General Skin Condition</b></p> <p>Check all that apply.</p> <p><input type="checkbox"/> Reddened <input type="checkbox"/> Pale <input type="checkbox"/> Jaundiced</p> <p><input type="checkbox"/> Cyanotic <input type="checkbox"/> Ashen</p> <p><input type="checkbox"/> Dry <input type="checkbox"/> Moist <input type="checkbox"/> Oily <input type="checkbox"/> Warm <input type="checkbox"/> Cold</p> <p><input type="checkbox"/> Edema, site _____</p>	<p><b>Physical Status (describe if applicable otherwise indicate NA)</b></p> <p>Paralysis/paresis-site, degree _____</p> <p>Contracture(s)-site, degree _____</p> <p>Congenital anomalies _____</p> <p>Prosthesis: _____</p> <p>Other _____</p>

Functional Status		
<p><b>TRANSFERS-ABLE TO TRANSFER</b></p> <p><input type="checkbox"/> Independently</p> <p><input type="checkbox"/> 1 person assist</p> <p><input type="checkbox"/> 2 person assist</p> <p><input type="checkbox"/> Total assist</p> <p><b>WEIGHT BEARING-ABLE TO BEAR</b></p> <p><input type="checkbox"/> Full weight</p> <p><input type="checkbox"/> Partial weight</p> <p><input type="checkbox"/> Non-weight bearing</p>	<p><b>AMBULATION-ABLE TO AMBULATE</b></p> <p><input type="checkbox"/> Independently</p> <p><input type="checkbox"/> 1 person assist</p> <p><input type="checkbox"/> 2 person assist</p> <p><input type="checkbox"/> With device</p> <p style="padding-left: 20px;">Type _____</p> <p><input type="checkbox"/> Wheelchair only</p> <p><input type="checkbox"/> Wheelchair/propels self</p> <p><input type="checkbox"/> Bedrest</p>	<p><b>SUPPORTIVE DEVICES USED:</b></p> <p><input type="checkbox"/> Elastic hose <input type="checkbox"/> Footboard</p> <p><input type="checkbox"/> Bed cradle <input type="checkbox"/> Air mattress</p> <p><input type="checkbox"/> Sheepskin <input type="checkbox"/> Eggcrate</p> <p><input type="checkbox"/> Hand rolls <input type="checkbox"/> Sling <input type="checkbox"/> Trapeze</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Other _____</p>

Drug Therapy			
DRUG	DOSE/FREQUENCY	DRUG	DOSE/FREQUENCY
1		6	
2		7	
3		8	
4		9	
5		10	

NAME-Last _____	First _____	Middle _____	Attending Physician _____
		Record No. _____	Room/Bed _____

CF58-3111 © 1997 BPR003, Des Moines, IA 50308 (800) 247-2543 www.BipageCorp.com  
 1-3-19

CURRENT STATUS - CONTINUED											
<b>Hearing</b>	Right	Left	R & L	<b>Vision</b>	Right	Left	R & L	<b>Communication</b>			
Adequate				Adequate				<input type="checkbox"/> Clear			
Adequate w/aid				Adequate w/glasses				<input type="checkbox"/> Aphasic <input type="checkbox"/> Dysphasic			
Poor				Poor				Language(s) Spoken: _____			
Deaf				Blind							
<b>Oral Assessment</b>				<b>Eating/Nutrition</b>							
Complete oral cavity exam: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, condition _____				<input type="checkbox"/> Dependent <input type="checkbox"/> Independent <input type="checkbox"/> Needs assist			Food likes _____				
Own teeth: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, condition _____				<input type="checkbox"/> Dysphagic; reason _____			Food dislikes _____				
Dentures: Upper <input type="checkbox"/> Comp <input type="checkbox"/> Part Lower <input type="checkbox"/> Comp <input type="checkbox"/> Part Do dentures fit? <input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Adaptive equipment (specify) _____			Bev. preference _____				
				Type/consistency of diet _____			HS snack preferred: <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>Sleep Patterns</b>				<b>Bathing/Oral Hyg.</b>		<b>Indep. Assist. Dep.</b>		<b>General Grooming</b>		<b>Indep. Assist. Dep.</b>	
Usual bed time _____ a.m./p.m.				Tub				Shave			
Usual arising time _____ a.m./p.m.				Shower				Grooming			
Usual nap time _____ a.m./p.m.				Bed bath				Dressing			
Other _____				Oral hygiene				Shampoo			
<b>Psychosocial Functioning</b>											
<b>FAMILY RELATIONSHIPS:</b>				<b>WHICH WORDS BEST DESCRIBE RESIDENT?</b> <input type="checkbox"/> Alert <input type="checkbox"/> Angry <input type="checkbox"/> Fearful							
Members visit (frequency) _____				<input type="checkbox"/> Noisy <input type="checkbox"/> Friendly <input type="checkbox"/> Cooperative <input type="checkbox"/> Lethargic <input type="checkbox"/> _____							
_____				<input type="checkbox"/> Non-questioning <input type="checkbox"/> Combative							
Closest relationship with _____				<b>ANSWERS QUESTIONS:</b> <input type="checkbox"/> Readily <input type="checkbox"/> Reluctantly <input type="checkbox"/> Inappropriately							
_____				<b>MOOD:</b> <input type="checkbox"/> Passive <input type="checkbox"/> Depressed <input type="checkbox"/> Elated <input type="checkbox"/> Quiet <input type="checkbox"/> Secure							
_____				<input type="checkbox"/> Questioning <input type="checkbox"/> Talkative <input type="checkbox"/> Homesick <input type="checkbox"/> Wanders mentally							
_____				<input type="checkbox"/> Hyperactive <input type="checkbox"/> _____							
<b>ORIENTED:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No, if No,				<b>COMPREHENSION:</b> <input type="checkbox"/> Slow <input type="checkbox"/> Quick <input type="checkbox"/> Unable to understand							
<b>DISORIENTED TO:</b> <input type="checkbox"/> Time <input type="checkbox"/> Place				<b>MOTIVATION:</b> <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor							
<input type="checkbox"/> Person				<b>PERSONAL HABITS:</b> Smokes? <input type="checkbox"/> Yes <input type="checkbox"/> No Uses alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No							
<b>RESIDENT GIVEN EXPLANATION OF/OR INVOLVED IN PLAN OF CARE?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No											
<b>RESIDENT ORIENTED TO FACILITY?</b> <input type="checkbox"/> Call light <input type="checkbox"/> Bathroom <input type="checkbox"/> Mealtime <input type="checkbox"/> Activities											
<b>Bowel and Bladder Evaluation</b>											
Uses: <input type="checkbox"/> Toilet <input type="checkbox"/> Urinal <input type="checkbox"/> Bedpan <input type="checkbox"/> Bedside commode											
<b>BOWEL HABITS:</b> Continent? <input type="checkbox"/> Yes <input type="checkbox"/> No Constipated? <input type="checkbox"/> Yes <input type="checkbox"/> No Laxative used? <input type="checkbox"/> Yes <input type="checkbox"/> No											
Enemas used? <input type="checkbox"/> Yes <input type="checkbox"/> No Last bowel movement _____ a.m./p.m.											
<b>BLADDER HABITS:</b> Continent? <input type="checkbox"/> Yes <input type="checkbox"/> No Dribbles? <input type="checkbox"/> Yes <input type="checkbox"/> No Catheter? <input type="checkbox"/> Yes, type _____ <input type="checkbox"/> No											
Urine color _____ Consistency _____ Time last voiding _____ a.m./p.m.											
<b>Restorative Programs Indicated</b>						<b>Therapy Indicated</b>					
Based on the foregoing assessment, check all that apply.											
<input type="checkbox"/> ROM			<input type="checkbox"/> Dressing/grooming training & skill practice			<input type="checkbox"/> Physical					
<input type="checkbox"/> Splint or brace assistance			<input type="checkbox"/> Eating/swallowing training & skill practice			<input type="checkbox"/> Occupational					
<input type="checkbox"/> Bed mobility training & skill practice			<input type="checkbox"/> Appliance/prosthesis training & skill practice			<input type="checkbox"/> Speech			Comments: _____		
<input type="checkbox"/> Transfer training & skill practice			<input type="checkbox"/> Communication training & skill practice						_____		
<input type="checkbox"/> Walking training & skill practice			<input type="checkbox"/> Scheduled toileting						_____		
			<input type="checkbox"/> Bladder retraining						_____		
Comments: _____											
_____											
<b>Completed by:</b>											
Signature/Title _____								Date _____			
NAME-Last			First		Middle		Attending Physician			Record No.	
										Room/Bed	

**ADMISSION NURSING ASSESSMENT**

*[Handwritten Signature]* 1-3-19