Miscellaneous Forms

Nananom Assisted Living

Evacuation Drill Record

Residents and employees drill every 6 months.
(Must be full evacuation unless doctor orders evacuation to be harmful.)

Date of Drill: _____ Time of Drill:_____ Shift:_____
How was the alarm sounded? _____
Was the local fire department notified? ( ) Yes ( ) No
Employee Participants: _____
_____
Did all employees participate? ( ) Yes ( ) No If No, why not? _____
_____
Number of Residents: _____
Did all residents participate? ( ) Yes ( ) No If No, why? _____
_____
Describe the procedures followed for the Drill: _____
_____
_____
Amount of time required to complete entire Drill: _____

Key:*W/C (Wheelchair), WA (Walker), V/C (Verbal Cue), P/A (Physical Assistance)*

Identified Problems: _____
_____
_____
Possible Solutions to Problems: _____
_____
_____
_____

_____ _____
Manager/Designee Signature Date

Nananom Assisted Living

Disaster Drill Record

Employees drill every 3 months, each shift.

Date: _____Time: _____
Shift: ___ Morning___ Afternoon___ Night

Type of Disaster Scenario Discuss:

___ Fire ___ Water emergency
___ Power outage ___ Flood
___ Severe weather ___ Earthquake
___ Other: _____

Discussion:
_____
_____
_____
_____
_____

Name of Employees/Volunteers who participated: Position
_____ _____
_____ _____
_____ _____
_____ _____

The Disaster Plan is reviewed every 12 months by Nananom Assisted Living Management Team.

Review Date: _____ By: _____

Nananom Assisted Living

Disaster Plan Review
Annual Review

R9-10-818: A Disaster Plan is developed, documented and maintained in a location accessible to caregivers and assistant caregivers, and if necessary, implemented. The Disaster Plan is reviewed and documented at least once every 12 months.

Date: _____ Time: _____

Name of employees and/or volunteers participating:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Disaster Plan Review:

- Once the determination that the facility cannot be used is made, the caregiver on duty should contact the manager and title licensee (owner) and notify them of the disaster. The caregiver and/or manager will contact the location that will be receiving the residents and make arrangements to transfer the residents to that location.
- Transportation may be by the resident's representative, family member, facility personnel or by transportation services.
- Resident's medical records and medications are stored in a centralized location to ensure ease of access in the event of evacuation and will be available to individuals providing services to the resident during a disaster.
- Resident records will be relocated along with each resident.

Critique and Recommendations for Improvement:

- Caregivers providing services to residents will report for their scheduled shifts to the designated location while the disaster plan is in place.
- The manager will then contact each resident or resident's representative to determine if continued placement in one of these facilities is acceptable until repairs of the facility can be made. If not, the manager will make every effort to meet the desire of the resident or resident's representative including referring the resident or resident's representative to a referral/placement service for possible placement.
- Medications for each resident will be available to be administered during a disaster and is to be relocated with the residents.
- Food and water will be provided through the regular channels ifin the assisted living facility. The facility that will accept the residents are providing services, food and water to the relocated residents.

Reviewed by: _____, (Manager, Designee, Licensee)

Note: *This facilities Disaster Plan review will be done every 30th day of June each year.*

Nananom Assisted Living

Please review the following Policies and Procedures of different disasters.
Needs to be reviewed every three months.

Review date	Type of disaster	Manager review
	Severe weather	
	Bomb threat	
	Fire	
	Power outage	
	Water emergency	
	Flood	
	Earthquake	
	Other:	

Nananom Assisted Living

Incident Report Form

A licensure shall ensure that a manager of an assisted living facility shall provide the following information when there is an accident, incident or injury that affects the resident's health and safety.

Resident's Name: _____
Date and Time of Accident, Incident or Injury:_____
Notifications: ____ POA/Representative notified (date and time): _____
____Name of Rep/POA: _____
____ Assisted Living Manager: _____
____ Primary care provider (date and time):_____
____Name of PCP: _____
____ Emergency Response Team: _____
____ Resident Case Manager: _____

Describe the Accident, Incident or Injury:

_____
_____
_____
_____
_____
_____
_____

Identify individuals who observed the accident, incident or injury:
Name: _____ Name: _____
Name: _____Name:_____

Describe actions taken by employees, support staff, or volunteers:
_____
_____
_____

Describe action taken to prevent future occurrence of the accident, incident or injury:
_____
_____
_____
_____
_____

_____ _____
Signature/Title of Person Initiating Report Licensee/Manager Signature

Nananom Assisted Living

Relocation Instructions

Date: _____

I,_____, the manager and owner of Nananom Assisted Living made the following arrangements for this facility resident's and staff in the event of a disaster, emergency, or any other event that poses a need to evacuate this facility.

The evacuation location for this facility is:

_____

_____

_____

If a resident/representative wish for arrangements other than the above to be implemented, please discuss with Nananom Assisted Living manager/owner. Any information other than the above will need to be documented in the resident's file and all staff made aware of these changes.

The priority for the manager and staff of Nananom Assisted Living will be to remain calm, reassure our residents, and to make them as comfortable as possible, as quickly as possible.

Manager _____ Date _____

Nananom Assisted Living

Monthly Safety and Maintenance Checklist

Indoor Maintenance(monthly):	**Date:**	**Date:**	**Date:**	**Date:**	**Comments:**
Smoke detectors					
Air filter					
Vents					
Fire extinguisher					
Dishwasher vent					
Oxygen storage					
Medication storage					
Chemical storage					
Handicap appliances					
Ramps/grab bars					
Record hotwater temperature (90°-120° F)					
Kitchen sink					
Dishwasher					
Washing machine					
Bathroom 1					
Bathroom 2					
Appliances:					
Fridge:					
Microwave:					
Oven/Stove					
Toaster					
Blender					
Other:					
Water tank					
Flooring/walls/furniture					
Bathroom/tub/showers					
Check outlets/chords					
Bed/wheelchairs/DME					
AC/heating(HVAC)					
Pest control/yard maintenance					
Other:					

Nananom Assisted Living

Release of Responsibility

Release Statement:

My signature on the “Log Out” acknowledges my understanding and acceptance of responsibility for the resident. Nananom Assisted Living is not responsible for the resident during their leave of absence.

Nananom Assisted Living is not responsible for any injuries or accidents while in the vicinity of the property.

Nananom Assisted Living

Release of Responsibility

Release statement: My signature below acknowledges my understanding; Nananom Assisted Living is not responsible for the resident during this leave/absence, and I accept all responsibility.

Log-Out

Date	Resident Name	Time-Out	Time-In	Responsible Party	Caregiver on Duty

Nananom Assisted Living

Weekly Housekeeping Checklist

Date	Description	Yes	No	Initials
	Dusting:			
	Ceiling fans			
	Pictures on walls			
	Furniture			
	Above the door jams			
	Thermostats			
	Fire extinguishers			
	Windowsills			
	Base boards			
	Wall scratches			
	Vacuuming:			
	Move furniture & vacuum all areas			
	Cloth furniture			
	Mopping:			
	All floors			
	Bathrooms:			
	Scrub tubs/showers			
	Disinfect shower curtains			
	Clean toilets			
	Wipe down lights			
	Clean mirrors			
	Refill soap andpaper towels			
	Clean out drawers.			
	Outside:			
	Water plants			
	Sweep surroundings			
	Pull weeds, if necessary			
	Pick up trash			
	Remove clutter			
	Other:			

Manager Approval: _____ Date: _____

Nananom Assisted Living

Delegation of Authority

I, _____the manager of Nananom Assisted Living, give permission to

CAREGIVERS

_____ _____
_____ _____
_____ _____

who are 21 years or older, and a trained caregiver with 3 years experience, to act on my behalf and to sign all the documents as if I were physically present.

In case I should be gone for more than 30 consecutive days, I will appoint a new Assisted Living Manager to run Nananom Assisted Living.

The following residents are under our care:

1. _____

2. _____

3. _____

Manager: _____Date: _____

Nananom Assisted Living

Service Agreement

Please review this agreement carefully, as it sets forth the understanding between _____("Company") and Nananom Assisted Living("Facility") regarding the services requested and provided. If you have any questions, concerns or issues about the content of this Agreement please contact Nananom Assisted Living for clarification before signing it.

This Agreement made this _____ day of _____ (effective date) by and between Nananom Assisted Living and _____("Company").

Name of the Company's responsible person or representative: _____

_____

Street Address City State Zip Code

_____

Company phone number Cell Other

_____

Emergency contact name Relationship Phone number

Terms and Conditions set out below:

Term of Agreement. The term of this agreement will start on the effective date and will continue on an as-needed basis until the Agreement is terminated by either party, as provided hereunder.

Services Requested. We will provide and perform the services as follows:

_____

"Scope of Services"

The preferred day, time and duration of services will be mutually agreed upon by Nananom Assisted Living and/or your representative and the Company.

Schedule: _____

1. ***Rates, Fees & Deposits***. We will provide the services at the rates set out in the current Rate/Fee schedule enclosed.
2. ***Cancellations.*** Cancellations may be made up to ____ days in advance of a scheduled visit without charge. We reserve the right to charge for a scheduled visit if insufficient notice is not given.
3. ***Termination***. Either "Company" or "Facility" may terminate this agreement at any time, with a minimum of 14 days' written notice to the other party. If either party terminates this Agreement, all fees due at time of termination will be due and payable by you immediately. We will immediately refund any prepaid fees.
4. ***General Information*.** You will be provided with a list of contact names and numbers in the event you have any questions or concerns or should an emergency arise.

Your signature and/or your representative's signature below indicate that you and/or your representative have read, understand and are in agreement with the Terms and Conditions of this Service Agreement.

Company Representative Signature: _____ Date: _____
Facility Signature: _____ Date: _____

Nananom Assisted Living

Activities for Residents:

1. Sort poker chips.
2. Clip coupons.
3. Count tickets.
4. Rake leaves.
5. Use the carpet sweeper.
6. Read stories out loud.
7. Bake cookies (the premade cookie dough good to use).
8. Dye Easter eggs.
9. Read the newspaper out loud.
10. Fold laundry.
11. Listen to relaxing music.
12. Plant seeds.
13. Look at family photos.
14. Toss a ball.
15. Color pictures.
16. Make lemonade.
17. Wipe off the table.
18. Weed the flower bed.
19. Make peanut butter sandwiches.
20. Have a spelling bee.
21. Read from Reader's Digest.
22. Fold clothes.
23. Have a friend with a calm pet visit. (Ensure that all visiting pets follow policy/procedures.)
24. Cut pictures out of greeting cards.
25. Dress up: fancy or fun.
26. Bake homemade bread.
27. Say "tell me more" when they start talking about a memory.
28. Put silverware away.
29. Sort objects such as beads by color or shape.
30. Sing Christmas carols.
31. Make Valentines.
32. Play favorite songs and sing together.
33. Take a ride.
34. Make a pie.
35. Read aloud from the newspaper.
36. Feed the fish.
37. Match a basket of socks.
38. Take a walk.
39. Reminisce about the first day of school.
40. String Cheerios to hang outside for birds.
41. Make a fresh fruit salad.
42. Sweep the patio.
43. Color paper shamrocks green.
44. Fold towels.
45. Have afternoon tea.
46. Remember great inventions.
47. Play Pictionary.
48. Paint a sheet.
49. Cut out paper dolls.
50. Identify state capitols.
51. Make a family tree.
52. Color a picture of a flag.
53. Cook hotdogs outside.
54. Grow Magic Rocks.
55. Water house plants.
56. Reminisce about their first kiss.
57. Sing favorite hymns.
58. Make homemade ice cream.
59. Play horseshoes.
60. Dance.
61. Dress in favorite team on football Sunday.
62. Make Christmas cards.
63. Sort playing cards by color.
64. Write a letter to a family member.
65. Make a birthday cake.
66. Pop popcorn.
67. Name the Presidents.
68. Give a manicure.
69. Make paper butterflies.
70. Plant a tree.
71. Make a May basket.
72. Make applesauce.
73. Finish famous sayings.
74. Feed some ducks/birds.
75. Mold play dough.
76. Look at pictures in National Geographic.
77. Put a puzzle together.
78. Sand wood.
79. Rub on scented hand lotion.
80. Decorate paper placemats.
81. Arrange fresh flowers.
82. Remember famous people.
83. Straighten drawers.
84. Finish nursery rhymes.
85. Wipe off patio furniture.

Nananom Assisted Living

Residents' Discharge Log

Name of Resident:	Admission date:	Reason:	Disposition:	Discharge date:

Instructions:

1. To be completed by Nananom Assisted Living manager, when a resident is permanently discharged
from the facility.
2. To be retained in the business office.
3. Use the codes listed below to complete the appropriate sections.

Reason:

R-1 – Expired
R-2 – Transferred to another facility
R-3 – Hospitalized
R-4 – Non-payment
R-5 – Relative assumed care
R-6 – Long term care required
R-7 – No information given

Disposition:

D-1–Funeral home
D-2 – Group home
D-3 – Hospital
D-4 – Private home
D-5 – Nursing home
D-6 – Day care
D-7 – No information given

Nananom Assisted Living

Please update the following:

Resident's Name	Admission date	TB Test	Service Plan Level of Care	Flu/Pneumonia

Nananom Assisted Living

Resident Information

(*For staff members only*)

Resident's Name	Family Members Or Guardian	Case Manager	Doctor's Name	Pharmacy

In case of emergency call 911**(except for hospice residents).**
Please inform the following: Manager, immediate family member and PCP.

Nananom Assisted Living

Vital Sign Flow Sheet

Resident'sname:_____
Admission date: _____ Admission Weight: _____

Date	Time	BP	Temp	Weight	Signature of CG	Notes	Referred to PCP

Nananom Assisted Living

Report of Abuse, Neglect and Exploitation

Name of involved person:_____

Date and time of the report: _____ Date and time of the incident: _____

Person reporting: _____ Other witnesses: _____

Death or self-injury needing medical attention: YES _____ NO _____
(*If yes, report needs to be filed with DHS within 24 hours*.)

Description of the incident and injuries (Document any changes to the resident's physical, cognitive, functional or emotional condition.):
_____
_____
_____
_____
_____

Immediate action taken to stop the suspected abuse, neglect or exploitation:
_____
_____
_____
_____

Local Police Department notified: _____ Date:_____ Time:_____

APS notified: _____ Date: _____Time:_____

ADHS notified: _____Date:_____ Time:_____

Investigation findings:
_____
_____
_____

Action taken to prevent future abuse, neglect or exploitation:
_____
_____
_____

Submit findings to ADHS within 10 days of submitting the first report: Date:_____ Time:_____

Nananom Assisted Living manager signature: _____Date:
_____

(*Attach additional pages, if necessary.*)

Nananom Assisted Living

Transportation Liability Waiver

I, _____ (Manager) request and authorize to transport _____(resident's name) in the facility's vehicle or in another vehicle provided by or for the resident.

I understand that all Home Care Workers, who are employed by Nananom Assisted Living, who are assigned transporting duties, are required to have a valid drivers' license and carry relevant vehicle insurance including Personal Injury Protection.

I understand Nananom Assisted Living checks their employees' driving records to ensure they are free from infractions.

I understand that Nananom Assisted Living reviews the currency of employees' drivers' licenses and motor vehicle insurance coverage but does not perform safety inspections or monitor maintenance on employee-provided or employee-owned vehicles.

I understand Nananom Assisted Living does not provide vehicle insurance for employee-owned vehicles.

I acknowledge that driving is risky and can result in serious injury or death.

I assume the risk of riding in a motor vehicle of Nananom Assisted Living, or its employees and I forever discharge and release Nananom Assisted Living and its employees from any and all claims, including their own negligence, which may arise out of the operation of a motor vehicle in which I am riding.

I acknowledge that I am responsible for my own vehicle insurance during all times that Nananom Assisted Living employee uses my vehicle or any vehicle that I supply.

I have read and voluntarily agree to sign Nananom Assisted Living Transportation Liability Waiver.

_____

Printed name of resident/representative Signature of resident/representative

_____

Printed name of witness Signature of witness

Nananom Assisted Living

Resident Transportation Recording Form

Resident's name: _____

Date of relocation:_____ Time of discharge: _____

Where will the resident be transported:

____ Home ____ Rehab facility ____ Skilled nursing ____Group home

____ Hospice in-patient____ Behavioral facility ____ Other

Name of destination: _____

Address: _____

Phone number: _____Contact person: _____

Method of transportation:
____ Facility transport ____ Family/friend transport ____ Cab/taxi ____ Ambulance
____ Medical transport ____ Non-medical transport

Is an escort needed for transport? ____Yes ____No
Name of escort: _____

Is the resident bringing personal belongings? ____ Yes ____ No
If so, who is responsible for belongings and transportation of belongings? _____
Have all accounts been completed and closed for this resident? ____ Yes ____ No ___ On hold

**Send resident's TB test results and most recent Service Plan with the resident.*

Resident's signature: _____ Date: _____

Representative's signature: _____ Date: _____

Manager's signature: _____ Date: _____

Nananom Assisted Living

Caregiver Skills Documentation Form

Employee's name: _____ Start Date: _____

Skills:	**Competent:**		
Patient care:	Yes	No	N/A
Basic caregiver skills: Changing beds and linens, transfers, mobility, bed positioning, skin care toileting, and bowel/bladder management.	___	___	___
Activities of Daily Living: Grooming, hygiene, eating and feeding, dressing, bathing and shampooing.	___	___	___
Resident's Rights: Confidentiality, abuse, neglect, and exploitation, mandatory reporting, legal and ethical issues.	___	___	___
Advance Directives: Power of Attorney, Living Willand Do Not Resuscitate (DNR)	___	___	___
CPR/First Aid	___	___	___
Infection control: Hand washing, gloving,(Personal Protective Equipment) disinfecting, disposing of sharps and other waste.	___	___	___
Emergency preparedness: Disaster drill for employees. (Every 3 months on each shift) Evacuation drill for residents. (Every 6 months)	___	___	___
Service Plans: Initiating, changing and updating. (*Must be reviewed and signed by an RN within 14 calendar days.*)	___	___	___
Medication management: Self- administration, assistance in self-administration, Five Rights: (Resident, Medication, Dosage, Route, Time), MAR (Routine meds) PRN (As needed)	___	___	___
Proper documentation: Progress Notes and Incident Reporting	___	___	___

Caregiver's signature: _____ Date: _____

Manager's signature: _____ Date: _____

Nananom Assisted Living

Referral Agency Disclosure

Resident's name: _____ Representative: _____
Referral agency: _____ Phone: _____
Facility manager: _____ Phone: _____

R4-33-408. Referral requirements

A. A manager who is employed by an assisted living facility that pays a fee to an individual or entity for referral of a resident to the assisted living facility shall ensure that the assisted living facility:
   1. has on file a contract with the individual or entity making the referral.
   2. maintains a file of the names of the residents referred by the individual or entity.
   3. obtains at the time of admission and maintains a statement, signed by the resident or the resident's representative or legal guardian, which discloses that:
      a. a fee was paid for referring the resident to the assisted living facility.
      b. the resident or the resident's representative or legal guardian was informed of the fee arrangement.
      c. the resident or the resident's representative or legal guardian was informed of any ownership interest between the assisted living facility and the individual or entity making the referral.

B. A manger shall maintain the records required under subsection (A)(1) for five years and shall maintain the records required under subsections (A)(2) and (A)(3) for five years after the resident ceases to reside in the assisted living facility.

C. A manager shall make the records required under this Section available for review upon request by the Board.

HB 2529 36-446.14. **Referral agencies; requirements; civil penalty; definitions**

A. A referral agency shall disclose to any prospective resident or representative of a prospective resident at the time or before any referral is made for care at an assisted living facility both of the following:
   1. The existence of any current business relationship between the referral agency and the assisted living facility, including any common ownership or control and any other financial, business, management or familial relationship that exists between the referral agency and the assisted living facility.
   2. That the assisted living facility pays a fee to the referral agency in connection with the referral.

B. The referral agency shall disclose to a new resident or the resident's representative either before or at the time of the resident's admission date the amount of the fee or a good faith estimate of the fee to be paid by the assisted living facility to the referral agency.

C. Both the referral agency and the prospective resident or the prospective resident's representative shall sign and date or electronically acknowledge and date the disclosures required by subsections a and b of this section. the referral agency shall provide the prospective resident or the prospective resident's representative a copy of the disclosures either electronically or in a hard copy. the referral agency shall provide the assisted living facility a copy of the signed and dated or electronically acknowledged and dated disclosures at the same time the resident receives the disclosures, and the assisted living facility shall maintain a copy of the disclosures on file at the facility.

D. The assisted living facility may not pay any referral fee associated with a resident until the assisted living facility receives the disclosures required by subsections A and B of this section.

E. A referral agency that violates this section is subject to a civil penalty of up to one thousand dollars for each violation. the attorney general or a county attorney may institute a proceeding in superior court to recover the civil penalty under this subsection and to restrain and enjoin a violation of this section. Any civil penalty recovered pursuant to this subsection shall be deposited in the general fund of the jurisdiction that prosecuted the violation.

F. For the purposes of this section:

1. "electronically" includes an audio recording that conforms with the Arizona rules of evidence, that is maintained by the referral agency and that is transmitted to the assisted living facility and the resident or the resident's representative in a format that can be downloaded.
2. "referral agency":
    a. means a person or entity that provides referrals for a fee that is collected from either the patient or the assisted living facility.
    b. does not include either:
        i. an assisted living facility or its employees.
        ii. a resident, a resident's family member or a patron of an assisted living facility who refers a prospective resident to an assisted living facility and receives a discount or other remuneration from the assisted living facility.

I/We do hereby acknowledge the items above were disclosed.

Resident: _____ Date: _____

Representative: _____ Date: _____

Referral agency: _____ Date: _____

Manager/Designee: _____Date: _____

Nananom Assisted Living

Contracted Services

List of contracted services, to include the name of the business, the job they are contracted to complete, any license numbers, the business address and phone number.

Company: _____ Contact person: _____
Address: _____
Phone: _____E-mail:_____
License number: _____
Service/job:_____
Status: _____

Company: _____ Contact person: _____
Address: _____
Phone: _____E-mail:_____
License number: _____
Service/job:_____
Status: _____

Company: _____ Contact person: _____
Address: _____
Phone: _____E-mail:_____
License number: _____
Service/job:_____
Status: _____

Company: _____ Contact person: _____
Address: _____
Phone: _____E-mail:_____
License number: _____
Service/job:_____
Status: _____

Nananom Assisted Living

Equipment Inspection and Maintenance Log
(*Inspections are done at the beginning of each month.*)

Year: _____

Equipment or device name:	JAN	FEB	MAR	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC

List equipment and devices that need to be inspected or maintained such as Hoyer Lifts, oxygen concentrators, walkers, wheelchairs.

Name and initials of individuals performing the inspection or maintenance: _____
_____ _____ _____

Nananom Assisted Living

Urine Output Log

Resident's name:																			**Month/year:**												
Time:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
7AM																															
Output (ml)																															
Color																															
Odor																															
Appearance																															
7PM																															
Output (ml)																															
Color																															
Odor																															
Appearance																															

C=Clear CL=Cloudy Y=Yellow D=Dark R=Red B=Blood in urine S=Sediments O=Other: _____

Nananom Assisted Living

Turn/Reposition Log

Resident's name:																		**Month/year:**											
Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
0600																															
0700																															
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Turn every 2 hours and PRN for comfort and to prevent skin breakdown.

LS = Left side RS = Right side B = Back P = Prone WC = Wheelchair R = Recliner SC = Shower chair

Nananom Assisted Living

Incontinence Log

Resident's name:																				**Month/year:**										
Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
0600																															
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Check every 2 Hours and change as needed.

C = Checked CH = Changed

Nananom Assisted Living

Resident Weight Record

Resident's name: _____Admission date: _____
Admission weight: _____ Admission height: _____

Date:	Weight:	Date:	Weight:	Date:	Weight:	Date:	Weight:

Comments:_____
_____
_____

Nananom Assisted Living

Notification of Weight Changes

Fax to: _____

From: Nananom Assisted Living

Date:_____

This is to inform you that Mr./Mrs. _____ a resident of
Name of resident
Nananom Assisted Living has experienced:

- A weight **GAIN** of _____ pounds in the past thirty (30) days.
- A weight **LOSS** of _____ pounds in the past thirty (30) days.

_____	_____
Month/day/year	Preceding months weight
_____	_____
Month/day/year	Current weight

Nananom Assisted Living manager:_____ Date: _____

PCP recommendations:

_____

_____

_____

PCP signature: _____ Date: _____

Nananom Assisted Living

W E I G H T W A I V E R

R9-10-808(A)(3), a manager shall ensure that the service plan for a resident receiving directed care services includes: Documentation:

a. Of the resident's weight, or
b. From a medical practitioner stating that weighing the resident is contraindicated

Policy and Procedure

- A licensee shall provide to each resident receiving personal care services shall have documentation of a resident's weight for each resident receiving medication administration or nursing services. A resident's weight shall be recorded in the resident's service plan when a resident's service plan is developed or updated.

- A licensee of an assisted living facility providing services to a resident who is unable to direct self-care shall provide documentation of a resident's weight. A resident shall be weighed and the resident's weight recorded in the resident's service plan when a resident's service plan is developed or reviewed.

Physician Order and Resident Weight Waiver:

Above resident name is a patient under the care of _____.
This resident qualifies for exemption from the requirement for weighing because of the following:

___Resident cannot tolerate the movement required to be weighed.
___ Resident weigh is contraindicated
___(Precise and specific reason why the resident cannot be weighed)
___Arm circumference (equation or calculation formula to be given by RN)

Weight exemption is in effect until further notice or while he/she is receiving services from _____ (Hospice).

Hospice: _____ Phone: _____

Resident Name: _____

Facility Manager: _____ Phone: _____

_____ _____
Physician's Signature Date