NOTICE FOR EXPEDITED REVISIONS TO AGENCY FORMS

Proposed Expedited Revision Number **2022-4** Form Number **(Not applicable)**

1. Agency Name & Address:

Dept. of Health & Human Services
Health Facilities Administration
129 Pleasant Street, Brown Building
Concord, NH 03301

2. RSA Authority: **RSA 151:5-a**
3. Federal Authority:

4. Short Title: **Expedited Revision to the "Care Assessment for Residential Services Tool"**

5. Explanation of the reason for the proposed readoption with amendment of the form:

The Department of Health and Human Services (Department) is proposing to readopt with amendment through the expedited revision to forms process, pursuant to RSA 541-A:19-c, the form "Care Assessment for Residential Services Tool", January 2022 edition, incorporated by reference in He-P 804.16(d) and He-P 805.16(d).

The "Care Assessment for Residential Services Tool" (CARES tool) is designed to determine if an individual is compatible with the level of care the health facility is licensed to provide and to assist in identifying if the needs of an individual have exceeded the level of care the facility is licensed to provide.

The CARES tool is being revised to better reflect the intention of RSA 151:5-a by updating formatting, making amendments to Section I. on medical nursing, Section II. on ADL functions, Section III. on safety, and Section IV. on communication, and by deleting Section V. on legal.

6. Contact person for copies and questions about the proposed form:

Name:	**Allyson Zinno**	Title:	**Administrative Rules Coordinator**
Address:	**Dept. of Health & Human Services** **Administrative Rules Unit** **129 Pleasant Street, Brown Bldg.** **Concord, NH 03301**	Phone #:	**(603) 271-9604**
		Fax#:	**(603) 271-5590**
		E-mail:	**Allyson.E.Zinno@dhhs.nh.gov**
			TTY/TDD Access: Relay NH 1-800-735-2964 or dial 711 (in NH)

7. Deadline for submission of materials in writing or in the electronic format specified:
Thursday, April 7, 2022.

☒Fax ☒E-mail ☐Other format (specify):

CONSENT

Readopt with amendment "Care Assessment for Residential Services Tool" (January 2022), incorporated by reference in He-P 804.16(d), effective 1-29-22 (Document #13339) and in He-P 805.16(d), effective 1-25-22 (Document #13333), to read as follows:

Care Assessment for Residential Services Tool

~~Trained personnel may complete all sections of this assessment. Collaboration or consulting with health care professionals, their examinations or progress notes is essential to ensure the assessment is accurately completed.~~

Resident Name:
Date of Assessment:

Resident DOB:
Date of Admission:

Initial/Admission Assessment ☐ Six-Month Assessment ☐ ~~Change in Status~~After significant change Assessment ☐

INSTRUCTIONS:

- **Attach current list of diagnoses and medications.**
- **Each check mark in a shaded box must have a care plan or list A, B, C, or D why the need does not require a care plan. See acceptable reasons for not care planning below.**
- **All questions must be answered if prompted.**
- **Trained personnel may complete all sections of this assessment. Collaboration or consulting with health care professionals, their examinations or progress notes is essential to ensure the assessment is accurately completed.**
- **If any shaded box in Section I is checked, a nurse shall determine if a nursing assessment and care plan is required.**
- **One care plan may contain numerous needs that have a check mark in a shaded area.**

ACCEPTABLE REASONS FOR ABSENCE OF CARE PLAN FOR A NEED IN A SHADED BOX:

- **Reason A = This need is met for all residents as part of the basic services and all staff provide this need per their job description, responsibilities and / or facility policy.**
- **Reason B = This need is met by other health care professionals not employed by the facility but with oversight provided by facility staff.**
- **Reason C = The facility, and others, have exhausted all reasonable attempts to meet this need. The resident, legal agent and family are aware and agree this need will not have a care plan.**
- **Reason D = Other. Must provide explanation.**

Section I. MEDICAL/NURSING

~~**Current Diagnoses**~~

~~**Initial/Admission Assessment- Attach current diagnosis list**~~.

~~**Six-Month or Change of Status Assessment-** Write in new or discontinued diagnoses. Attach new diagnosis list **if more than five** changes.~~

~~Diagnosis~~	~~Date~~	~~Diagnosis~~	~~Date~~

~~**Current Medications/Treatments**~~

~~Initial/Admission Assessment- Attach active medication/treatment list.~~

~~Six-Month or Change of Status Assessment- Write in new or discontinued medications/treatments. Attach new medication/treatment list if~~

~~more than four changes.~~

	~~Yes~~	~~No~~	~~Comment:~~
~~Provider orders signed and dated for current medications and treatments~~			

~~Medication/Treatment changes since last C.A.R.E.S Assessme~~	~~Date~~

If any shaded box in this section is checked, a nurse shall determine if a nursing assessment and care plan is required.

~~Yes No Comment:~~

Nutritional Status	Yes	No	Care Plan?	Reason/Comments:	Nursing Assessment?
1. Special dietary need. If yes, specify.					
2. Requires adaptive eating utensils. If yes, specify.					
3. Weight change of 5% or more in the past 30 days. If yes, specify.					

~~Yes No Comment:~~

Medication Administration	Yes	No	Care Plan?	Reason/Comments:	Nursing Assessment?
1. Resident self-administers medication without assistance~~Responsible for self-administration. (If resident requires self-direct medication administration, note in comments.)~~(Must pass bi-annual evaluation and have annual order from licensed practitioner)				~~Annual Physician order for self-administration? YES or NO~~ ~~Bi-Annual Evaluation Complete? YES or NO~~	
2. ~~Requires supervised self-administration.~~Resident self-directs medication administration. (Must pass bi-annual evaluation and have annual order from licensed practitioner verifying their physical limitation)					
3. ~~Requires nurse or other licensed personnel to give all medications.~~Resident self-administers medication with assistance					
4. Requires nurse or personnel to administer medications.					
5. Requires someone to order medications.					
6. Is resident receiving treatment/medication for pain?					

Health Maintenance	Yes	No	Care Plan?	Reason/Comments:	Nursing Assessment?
1. Frequent urinary tract infections.					

2. Chronic constipation					
3. Indwelling catheter					
4. Receives nutrition through feeding tube					
5. Ostomy – identify type					
6. Requires monitoring of new/changed/or deteriorating medical condition. If yes, specify					

~~Yes No Comment:~~

Hospice Services	Yes	No	Care Plan?	Reason/Comments:	Nursing Assessment?
1. Currently receiving hospice services. ~~(If no, skip to next section)~~					
~~2. Hospice admitted orders signed and dated.~~					
~~3. Hospice Provider Contact Information:~~					

~~Yes No Comment:~~

Wound Care	Yes	No	Care Plan?	Reason/Comments:	Nursing Assessment?

1. Currently receiving wound care services. ~~(If no, skip to next section)~~					
~~2. Wound care orders signed and dated.~~					
~~3. Wound Care Provider Contact Information:~~					

COGNITIVE, MENTAL AND BEHAVIORAL HEALTH STATUS	Yes	No	Care Plan?	Reason/Comments:	Nursing Assessment?
1. Active diagnosis of cognitive/memory impairment, including dementia. (If yes, list in comment section. Example: Early, Mid, Late)					
2. Displays exit-seeking behaviors.					
3. Active diagnosis of mental health condition, including depression, anxiety, schizophrenia, etc. (If yes, list)					
4. Actively pursuing or currently receiving mental health treatment or services. (If yes, list in comment section.)					
5. Has attempted suicide in the past six months.					
6. Has been verbally, physically or behaviorally aggressive in the past six months.					

Section II. ADL Functions

~~Yes No Comment:~~

~~Requires assistance with incontinent products.~~	Yes	No	Care Plan?	Reason/Comments:~~If yes, circle level of assistance required: SET UP or ONE PERSON~~
1. Incontinence of bladder, bowel, or both. Please circle.~~Requires assistance with toileting.~~				~~If yes, circle level of assistance required: SET UP or ONE PERSON~~
2. Requires assistance with incontinence products. If yes, circle level of assistance required: SET UP or ONE/TWO PERSON~~Requires assistance with dressing.~~				~~If yes, circle level of assistance required: SET UP or ONE PERSON~~
3. Requires assistance with toileting. If yes, circle level of assistance required: SET UP or ONE/TWO PERSON~~Requires assistance with bathing.~~				~~If yes, circle level of assistance required: SET UP or ONE PERSON~~
4. Requires assistance with bathing. If yes, circle level of assistance required: SET UP or ONE/TWO PERSON~~Requires assistance with dental care. (Circle: FULL PARTIAL BRIDGE)~~		-		~~If yes, circle level of assistance required: SET UP or ONE PERSON~~
5. Resistant to maintaining hygiene. If yes, circle bathing, grooming, dental care				
6. Requires assistance with dressing. If yes, circle level of assistance required: SET UP or ONE/TWO PERSON				
7. Requires assistance with dental care.				

If yes, circle level of assistance required: SET UP or ONE/TWO PERSON				

Section III. SAFETY

~~Yes No Comment:~~

~~WALKING/~~**AMBULATION/TRANSF ERS~~FERS~~**	Yes	No	Care Plan?	Reason/Comments:
1. Independent with ambulation. If no, circle level of assistance required: SUPERVISION or ONE/TWO PERSON				~~If no, circle level of assistance required: SUPERVISION or ONE PERSON~~
2. Walks with assistive equipment~~ for ambulation~~. (If yes, list equipment.)				
3. Independent with stair navigation. If no, circle level of assistance required: SUPERVISION or ONE/TWO PERSON				~~If no, circle level of assistance required: SUPERVISION or ONE PERSON~~
4. Needs physical assistance to transfer. If yes, circle level of assistance required: SUPERVISION or ONE/TWO PERSON				~~If yes, circle level of assistance required: ONE PERSON or TWO PERSON~~
5. ~~Requires Hoyer lift or other lift~~Requires lift equipment to transfer. (If yes, list equipment.)				
6. Does resident require the use of a wheelchair?				

~~Yes No Comment:~~

FALLS	Yes	No	Care Plan?	Reason/Comments:
1. Diagnosis of gait or balance impairment.				
~~For six-month or change of status assessment **only**.~~ 2. Documented falls in last three~~six~~ months. (If yes, ~~write in~~ how many.)				

~~Yes No Comment:~~

EVACUATION (Select level of assistance necessary for safe evacuation.)	Yes	No	Care Plan?	Reason/Comments:
1. Evacuates building independently.				
2. Evacuates building with verbal assist.				
3. Evacuates building with physical assist. If yes, circle level of assistance required: ONE PERSON or TWO PERSON				~~If yes, circle level of assistance required: ONE PERSON or TWO PERSON~~

~~**Section IV. COGNITIVE, MENTAL AND BEHAVIORAL HEALTH**~~

~~Yes No Comment:~~

~~**COGNITIVE, MENTAL AND BEHAVIORAL HEALTH STATUS**~~					

~~1. Active diagnosis of cognitive/memory impairment, including dementia. (If yes, list in comment section.)~~					
~~2. Displays exit-seeking behaviors.~~					
~~3. Active diagnosis of mental health condition, including depression, anxiety, schizophrenia, etc. (If yes, list in comment section.)~~					
~~4. Actively pursuing mental health treatment or services. (If yes, list in comment section.)~~					

Section IV. COMMUNICATION

~~Yes No Comment:~~

COMMUNICATION	Yes	No	Will you Care Plan?	Reason/Comments:
1. Requires corrective lenses or reading glasses. **(Circle one: Daily Reading Both Refuses)**				~~(Circle one: Daily Reading Both)~~
2. Requires hearing aids. **(Circle one: Right Left Both Refuses)**				~~(Circle one: Right Left Both)~~
~~1.~~3. Effective verbal communication. (If no, list barriers. Example: Aphasia)				

Section V. LEGAL

	Yes	No	Comment:
1. Advanced Directives Completed.			
2. Activated DPOA-HC, or Guardian. (If yes, list Activated DPOA-HC or Guardian.)			
3. POLST Completed.			
4. Code Status. (Circle one: FULL CODE or DNR) (Circle one: If DNR, PINK form in facility - YES or NO)			

~~**ACCEPTABLE REASONS FOR ABSENCE OF CARE PLAN FOR A NEED IN A SHADED BOX**~~

~~Reason A = This need is met for all residents as part of the basic services and all staff provide this need per their job description, responsibilities and / or facility policy.~~

~~Reason B = This need is met by other health care professionals not employed by the facility but with oversight provided by facility staff.~~

~~Reason C = The facility, and others, have exhausted all reasonable attempts to meet this need. The resident, legal agent and family are aware and agree this need will not have a care plan.~~

~~Reason D = Other. Provide explanation below.~~

Comments:

_____

_____

_____

Completed by: _____ _____ _____ _____

Name (printed) Signature Date Title

All assessments must be completed and reviewed in collaboration with resident or their guardian, agent, or personal representative, if any.

Reviewed by: _____ _____ _____ _____

Name (printed) Signature Date Relationship

Reviewed by: _____ _____ _____ _____

Name (printed) Signature Date Relationship