

**POLICY: Resident Pre-Admission Appraisal**

The Administrator will gather data on each potential resident to determine the need and type of services to be provided.

**Procedure**

1. The Administrator meets with the resident and responsible party prior to admission.
2. The Resident Appraisal is completed.
3. The Administrator begins the pre-placement meeting with proper introductions and explanations to promote a milieu of trust, comfort, and honesty. Open-ended questions are encouraged. Consent is obtained for the appraisal.
4. Explain the purpose of the appraisal is to determine the level and type of services that will be available for the resident at the time of move-in, as well as to meet state licensing requirements. Assure the resident and/or family that honesty and detail regarding care needs is in the best interest of the resident.
5. Communicate acceptance by use of proper body posture, nods of understanding and allowing the resident ample opportunity to answer questions.
6. The Administrator reviews the Physician Report for any prohibited conditions or communicable illness.
7. The verification of absence of TB must be evidenced by a MD or chest x-ray within the last six months. Should verification be unavailable, the Administrator may apply and read a PPD upon proper screening and with a physician order.
8. The resident and/or responsible party are questioned about skin breakdown.
9. The medication review will include the following:
10. Ask the resident to show you all of the medications currently used. If the medications are not physically present, ask the resident/responsible party to provide a list and dosing of the medications.

- a. NOTE: A physician order is obtained prior to admission day, verifying medications and dosing schedule.
11. Specifically ask about the use of OTC (Over-The-Counter) medications. Note any preferred OTC medications to ensure physician orders are secured prior to admission.
  12. NOTE: This is an opportunity for resident teaching regarding the storage and use of OTCs, related to regulatory guidelines.
  13. Should a resident desire to retain his/her OTC medications, a physician order is obtained indicating the resident may self-store and self-administer medications.
  14. When OTC medications are centrally stored, a physician order is required for all routine medications prior to assisting with the medication.
  15. When the OTC is a PRN and centrally stored, the following must be included in the physician order:
    - a. Name of drug
    - b. Strength of drug
    - c. Dosage
    - d. Exact time frames between doses
    - e. Maximum dose in a 24 hour period
    - f. Symptoms for which the medication is used
  16. Information regarding alcohol consumption is obtained.
  17. Discuss and note any problematic drugs the resident has used in the past.
  18. Prohibited health conditions and/or residents significantly at risk are identified. See chart on page 6 for exception requirements related to prohibited health conditions.