PRECIOUS CARE GROUP (PCG)

A subsidiary of Jecano Investment Ventures (JIV), Llc.

7345 Acacia Woods Court, Las Vegas, NV 89113

Phone: 702-998-5988 Direct: 702-580-6676 Fax: 702-998-2251

Admission Intake Form

Medical services needed/Receiving_____
Service provider: _____Phone #_____
Address: _____

Medication at Admission: _____

_____
_____
_____

_____

Uses (*circle all needed*): Walker Wheelchair Cane

Type and amount of supervision needed: _____

Medical information provided (***circle all provided***):

TB test Physical exam Mental Assessment Physical assessment other: _____

_____

Personal Property Received: _____

_____

_____

____ Pairs of paints/slacks _____ Tops/shirts _____Sweats suits _____ Pairs of socks

_____ Pairs of Underwear _____ Bras ____Pajamas/Nightgowns _____ Coats/Jackets

_____ Shoes/boots

(All clothing items marked with initials)_____

Referred By: _____

Admitted By: _____Date_____

Administrator's signature_____ _____ Date _____

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PHYSICAL ASSESSMENT

NAME: _____DATE OF BIRTH: _____ AGE: _____
SEX: _____MALE _____FEMALE DATE OF MOST RECENT_____
LENGTH OF TIME UNDER YOUR CARE_____ CODE STATUS: _____
PRIMARY DIAGNOSIS_____
ALLERGIES: _____

PHYSICAL HEALTH:

Height: _____ Weight: _____ Normal blood pressure: _____ Normal temperature: _____
Free of TB: ____ Yes ____ No Date of PPD test _____ Result _____ Chest X-ray _____
General Health: ____ Good _____Fair _____ Poor
Condition on stable and predictable course: _____Yes _____ No; Reason: _____
Auditory impairment: _____None _____Mild _____Severe
Special diet: _____No _____Yes. Explain: _____
Alcohol problem: _____None; _____ Occasional; _____Frequent
Respiratory limitations: _____Yes _____No; _____Oxygen _____ liters

MENTAL CONDITION:

Alert and oriented ____ Person ____ Place ____ Time/date; __ No, explain: _____
Mental status score if done (MMSE): _____
Able to follow orders: _____ Yes _____No _____ Moderately
Confused part of the time: _____Yes ____No _____ Moderately
Depressed: _____ Yes _____No _____Moderately

CAPACITY FOR SELF CARE:

Assistive devices: ___ Cane ___ Walker ___ wheelchair ___Hearing Aids ___Other
Able to care for all personal needs: _____ Yes _____ No _____With assistance
Can administer own medications: _____ Yes _____ No _____With assistance
Can transfer out of bed: _____ Yes _____ No _____With assistance
Can walk independently: _____ Yes -------- No _____With assistance
Ability to: Bath self: _____ Yes _____ No _____With assistance
Dress self: _____ Yes _____ No _____With assistance
Feed self: _____ Yes _____ No _____With assistance
Toileting _____ Yes _____ No _____With assistance
Bladder control: _____ Yes _____ No _____With assistance
Bowel Control: _____ Yes _____ No _____With assistance

CURRENT MEDICATIONS:	**DOSE**	**FREQUENCY**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician Signature: _____ Date: _____

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Standard Physician's Assessment

Resident's Name _____
Definitions:

Category 1 resident - refers to a person who is physically capable of moving without assistance from an unsafe area to an area of safety and who is mentally capable of recognizing danger and deciding appropriate action for self-protection.

Category 2 resident - refers to a person who requires the assistance of at least one person in transfer or to move from an unsafe area to an area of safety or who is mentally incapable of recognizing danger or deciding appropriate action for self-protection. A person is considered mentally incapable of recognizing danger if he is not oriented to at least two of three spheres: person, place and time and does not understand verbal or otherwise conveyed cues to move to an area of safety.

This resident is oriented to (*check all that apply*): ☐ **Person** ☐ **Place** ☐ **Time**

This resident is a (check only one): **Category 1 Resident** ☐ **Category 2 Resident** ☐

Please, attach information concerning past and present diagnosis or most recent history and physical (H&P) **. *(*if answer is yes, see prohibited medical condition section*)** **Yes** **No**

Is the Resident's physical and mental condition stable and following a predictable course? *☐ ☐

Should this resident be allowed to possess and manage his/her own medications? *☐ ☐

Are the resident's medications at a maintenance level**?** * ☐ ☐

Does the resident's medication require a daily assessment? *☐ ☐

Please, list the resident's current medical needs in accordance with the listed medical conditions section and whether the resident can perform self-care? **Yes** **No**

_____**self -care** ☐ ☐

_____**self-care** ☐ ☐

_____**self-care** ☐ ☐

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MEDICAL CONDITIONS:

(a) Oxygen therapy
(b) Intermittent Positive Pressure Breathing equipment therapy (IPPB)
(c) Colostomy or Ileostomy care
(d) Use of Enemas, Suppositories or Fecal Impaction removal
(e) Catheter care (f) Incontinence of bowel or bladder
(g) Contracture care (h) Diabetes
(i) Administration of Injections (j) Need for Protective Supervision
(k) Tracheostomy care (l) Wound care
(m) Pressure/Stasis Ulcer care
(n) Administration of Medications on an as needed or PRN (**pro re nata**) basis

PROHIBITED MEDICAL CONDITIONS:

(a) Bedfast -(a person who is incapable of changing his position in bed without the assistance of another person or a person who is immobile)
(b) Requires restraint - (either a psychopharmacologic drug that is used for convenience or a manual method of restricting a resident's freedom of movement or his normal access to his body or a device or material or equipment which is attached to or adjacent to a person's body that cannot be removed easily by the person and restricts the person's freedom of movement or his normal access to his body
(c) Requires confinement in locked quarters
(d) Requires skilled nursing or other medical supervision on a 24-hour basis
(e) Gastrostomy care (G-Tube)
(f) Staphylococcus infection or other serious infection
(g) Any other serious medical condition that has not yet been described here
(h) Requires medication which are not at a maintenance level
(i) Receives medication that requires a daily assessment

In accordance with **NAC 449.274(5)** before admission and each year after admission, or more frequently if there is a significant change in the physical condition of a resident, the facility shall obtain the results of a general physical examination of the resident by his or her physician. The resident must be cared for pursuant to any instructions provided by the resident's physician.

In accordance with **NAC 449.274(6)** the members of the staff of the facility shall:
(a) Ensure that the resident receives the personal care that he or she requires.
(b) Monitor the ability of the resident to care for his or her own health conditions and document in writing any significant change in his or her ability to care for those conditions.

In accordance with **NAC 449.2706** if a resident's condition deteriorates to such an extent that the residential facility is unable to provide the services necessary to treat the resident properly; or the resident no longer complies with the requirements for admission to the facility, the facility shall plan for the transfer of the resident pursuant to **NRS 449A.100 and 449A.103** to another facility that is able to provide the services necessary to treat the resident properly.

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STANDARD ASSESSMENT FOR COGNITIVE ABILITIES

Resident's Name: _____ Date _____

Score "1" for a response that indicates the resident understands the questions or **Score "0"** for a response that indicates the resident did not understand the question.

Score **Questions Asked of the Resident:**

_____ 1. How would you get out of the facility?

_____ 2. What would you do if you noticed a fire in your room?

_____ 3. Is the resident oriented to: ☐ ☐ ☐

Person Place Time (orientation to 2 or more appropriate)

_____ 4. If you needed help, what would you do?

Score answers either "1" for Yes or "0" for No

Score Questions Asked of the Caregiver familiar with the Resident: In your opinion

_____ 1. Is the resident cognitively able to evacuate on his/her own?

_____ 2. Is the resident cognitively able to use the phone?

_____ 3. Can you leave the front door of the facility open without worry that the resident may wander?

_____ 4. Is the resident cognitively able to go on an outing on his/her own?

_____

Total Score (Add all columns from questions asked of the resident & the caregiver)

If the **total score is less than 5** and the facility is licensed to care for **category 2 residents**, the resident requires further assessment for appropriate facility placement by physician.

If the total score **is less than 5** and the facility is licensed to care for **category 1 residents**, then conduct the evacuation test below; a) if the resident passes the test, the resident is to be further assessed for appropriate facility placement by a physician. b) If the resident fails the test, the facility must develop a plan for protecting the resident until he or she can be transferred to an appropriate facility. **If the total score is 6 or more, no additional assessment is necessary at this time.**

EVACUATION TEST

Allow facility staff to prepare and cue the resident to evacuate when the alarm sounds prior to the test. Then set the alarm off and determine if the resident is able to evacuate in 4 minutes with assistance

☐ Pass (Self evacuated in less than 4 mins)

☐ Fail (Self did not evacuate in less than 4 mins)

Assessor's Signature: _____ Date: _____

Please, print or type the Assessor's Name here: _____