CABINET FOR HEALTH
AND FAMILY SERVICES
Office of the
Inspector General

OIG-20:480-A, **March 2023 [~~November 2022~~]**

Functional Needs Assessment (FNA)

Resident Name: _____ Living Unit #: _____ Date: _____

Reason for FNA:

- ☐ Initial/Move-in: Individual is seeking admission to a social model (ALC), basic health model (ALC-BH), or a facility with a secured dementia unit (ALC-DC).
- ☐ Change in resident's condition and/or hospitalization.
- ☐ Annual update.

Staff Person Completing FNA: _____ Title: _____

Facility Name: _____

RESIDENT CRITERIA:

1. Is the individual/resident ambulatory? ☐ Yes ☐ No

   KRS 194A.700(2) defines "ambulatory" as "able to walk, transfer, or move from place to place with or without hands-on assistance of another person, and with or without an assistive device, including but not limited to a walker or wheelchair".

2. If applicable, what supportive devices are required for the individual/resident to transfer or move from place to place? _____

3. If the individual/resident is nonambulatory, is it due to a temporary condition? ☐ Yes* ☐ No **(Disqualify)**

   "Temporary condition" is defined by KRS 194A.700(26) as a condition that affects a resident as follows:
   - The resident is not ambulatory before or after entering a lease agreement with the ALC but is expected to regain ambulatory ability within six (6) months of loss of ambulation, as documented by a licensed health care professional, and the ALC has a written plan in place to mitigate risk; *or*
   - The resident is not ambulatory after entering a lease agreement with the ALC but is not expected to regain ambulatory ability, hospice services are provided by a hospice program licensed under KRS Chapter 216B or other end-of-life services are provided by a licensed health care provider in accordance with KRS 194A.705, as documented by a licensed hospice program or other licensed health care professional, and the ALC has a written plan in place to mitigate risk.

   ***If yes, attach a copy of:**
   - **Documentation from a licensed health care professional that the resident is expected to regain ambulatory ability within six (6) months of loss of ambulation; or**
   - **Verification that the resident is receiving hospice or other end-of-life services from a licensed hospice provider or other licensed health care professional respectively.**

   ***If yes, attach the facility's plan to mitigate risk to a nonambulatory resident who has a temporary condition.**

4. Is the individual/resident able to self-evacuate without hands-on assistance? ☐ Yes ☐ No*

KRS 194A.717(5) states the following:

When a resident requires hands-on assistance of another person to walk, transfer, or move from place to place with or without an assistive device, the assisted living community shall have a policy that describes how priority will be given by staff sufficient to assist that resident during times of emergency when evacuation may be necessary.

***If no, attach a copy of the facility's policy that describes how priority will be given by staff sufficient to assist the resident during an evacuation.**

EXCLUSIONS:

1. Are there open wounds that are not maintained independently by the individual/resident, a home health agency, or the facility? ☐ Yes ☐ No

2. Does the individual/resident have a communicable disease that could be transmitted to other residents or staff? ☐ Yes ☐ No

3. Does the individual/resident require 24-hour nursing or psychiatric care? ☐ Yes ☐ No

4. Does the individual/resident pose a danger to self or others? (Consider any significant history of physically or sexually aggressive behavior.) ☐ Yes ☐ No

5. Has the individual/resident ever left their residence and become lost or disoriented? ☐ Yes ☐ No

6. If the individual/resident requires cueing, are they easily agitated and unwilling to take instructions? ☐ Yes ☐ No

7. Does the individual/resident have a recent history of frequent falls **with major injuries** that would put them in *constant* danger? ☐ Yes ☐ No

8. Does the individual/resident have special dietary needs that the facility is unable to meet? ☐ Yes ☐ No

9. If incontinent (bowel or bladder), is the **facility able to provide assistance to the** individual/resident **to manage incontinence** **[~~incapable of self-managing with minimal assistance~~]**? ☐ Yes ☐ No

If "yes" to any questions above, do not consider for admission. *(If "yes" to question #5, the individual may be considered for admission to an **ALC-BH or** ALC-DC if the individual meets other criteria for admission.)*

MEDICAL EXAMINATION REQUIRED PRIOR TO ADMISSION

In accordance with KRS 216.765(1), a prospective resident must have a medical examination prior to admission to an ALC, ALC-BH, or ALC-DC. The medical examination is separate from this FNA and must include a:

- Medical history;
- Physical examination; and
- Diagnosis.

If completed within fourteen (14) days prior to admission, the medical evaluation may include a copy of the individual's discharge summary or health and physical report from a physician, hospital, or other health care

facility.

ACTIVITIES OF DAILY LIVING (ADL)	Performs Independently	Needs assistance, but has minimal ability to verbally direct or physically participate in the activity	Comments/Instructions Related to Reminders, Hands-on Assistance, or Standby Assistance
PERSONAL CARE			
Bathing			
Dental/Mouth Care			
Hair Care			
Shaving			
Toe/Fingernail Care			
Dressing			
MOBILITY			
Ambulatory - Able to get around			
Transfer To/From Bed			
Transfer To/From Chair			
Transfer To/From Wheelchair			
Safely evacuates the facility with minimal assistance			Yes □ No □ Comments:
TOILETING			
Bladder/Bowel Control			
DIETARY			
Eats Meals Daily			
Recent Weight Gain/Loss			Yes □ No □ Comments:
Special Diet Followed			Yes □ No □ Comments:
Food Allergies			**Yes □ No □ Comments:**

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL) – The following services shall be included in the monthly rate at no additional charge to the resident. The facility may complete any or all of the IADLs, even if the resident is capable of performing an activity independently.	**Performs Independently**	**Needs assistance, but has minimal ability to verbally direct or physically participate in the activity**	**Comments**
Housekeeping/Chores			
Shopping			
Laundry			
Clerical Assistance			
Ability to Use Phone			
Handles Finances/Household Budgeting			

TRANSPORTATION	Can drive self**:** Yes □ No □	Can leave facility with assistance**:** Yes □ No □	Comments:

MEDICATION	Self-administer: Yes □ No □	Needs assistance with self-administration**:** Yes □ No □ Comments:	Needs medication **<u>administration</u>[~~management~~]:** Yes □ No □ Comments:

TO BE COMPLETED BY STAFF PERSON COMPLETING THE FNA:

In your [~~professional~~] opinion, can this individual's needs be met in the ALC, ALC-BH, or ALC-DC, which is not a nursing facility or psychiatric facility? ☐ Yes ☐ No

_____ _____

Signature of Staff Person Completing the FNA Date

<u>The FNA shall be completed by a staff person who meets the qualifications of 902 KAR 20:480, Section 7(1)(c)2.</u>

ACKNOWLEDGEMENT

I acknowledge that I have received a copy of this form and that it is an accurate account of my need for assisted living services.

_____ _____

Resident Signature Date

_____ _____

Signature of Designated Contact Person or Legal Representative Date