apd agency for persons with disabilities State of Florida

CNSI AND KEPRO ARE NOW Acentra HEALTH

Annual Group Home Resident Medical Review

Name of Nurse Reviewer:	Case ID:	APD Region:
Date of Review:	Time of Review:	
Name of Group Home (GH):	Name of GH Primary Contact:	
GH Address:	GH Primary Contact Phone #:	
Name of Resident:	DOB:	Age:
iConnect #:	Admission Date (*if known*):	
Name of Waiver Support Coordinator:		
Number of staff on duty at time of review:		
Name of Guardian (s):		
Name of Primary Care Provider(PCP):		PCP Phone #:
Diagnoses (*List all*):		
Describe onsite observation of resident (detail physical appearance, behavior and affect):		

1. Healthcare Visits

Visit Type	Documented Visit within Last Year?	Provider Name *(if different from PCP)*	Date *(Most Recent)*	Details *(information regarding a missed visit, provider comments, or recommendations)*
Wellness Visit				
Additional PCP				
Specialty Care				
Dental				
Vision				
Labs				
Were all healthcare visit recommendations followed *(including any recommendations from any screenings)*?				

2. Diagnostic and Age-Appropriate Exams

Name of Screenings	Yes	No	Not Applicable	Unable to Verify
Falls Screening				
Prostate Cancer Screening				
Colorectal/Colonoscopy Screening				
Cervical Cancer Screening (PAP)				
Breast Cancer Screening (Mammogram)				
DEXA Scan				
Osteoporosis Screening				
Other:				
Details *(include follow-up recommendations from screenings, provide reasons for unable to verify, missed screening, and/or not applicable outcomes)*:				

3. Wellness and Therapeutic Supports

Therapy	Not Ordered	Daily	Every other day	Twice a week	Three times a week	Other
Physical Therapy						
Occupational Therapy						
Speech Therapy						
Respiratory Therapy						
Dialysis						
Nursing Services						

Name of nursing provider *(if applicable)*:

Nursing orders *(if applicable)*:

List of nursing duties/type of nursing provided *(if applicable)*:

Are there any other recommended therapeutic services or supports?

Describe any discrepancy between what has been ordered and what the individual is receiving:

Describe whether service recommendations/changes are updated in the medical record and provided for the individual:

4. Nutrition

Unexplained/concerning weight change: ☐ Yes ☐ No If yes, explain (weight/date/intervention):_________		Most recent documented weight: Date:
Food Allergies:		

Diet Status/Interventions *(check all that apply)*:			
Oral Feeding		Special Diet-Chopped	
GastricTube		Special Diet-Soft	
Jejunostomy Tube		Special Diet-Puree	
Gastrojejunostomy Tube		Special Diet-Thickened Liquids	
Enteral Medication Administration		Enteral Formula Administration	
Other type of Enteral Feeding		Enteral Water Flush	

Prescribed Enteral Formula Administration (PEFA) Validation
If tube is used for feeding, list the name of validated PEFA staff on duty at time of review: PEFA Validation Date : __________ PEFA Expiration Date : ___________

Special Diet/Safety/Concerns
Documented history of choking or swallowing issues (coughing, eating fast, etc.): Yes No If yes, describe issues and choking prevention strategies in place:
Describe other special diets or feeding or any noncompliance (*and any additional feeding preventions or interventions*):

5. Functional Status

Activity	Independent	Stand-by Assist	Stand-by and Cueing	Hands on Physical Assistance	Total Physical Assistance
Bathing					

Dressing					
Toileting					
Grooming					
Eating					
Ambulation					
Positioning					
Transfers					

6. Adaptive Needs

Equipment/Adaptation Utilized by Resident	Operable	Inoperable
Bedside Commode		
Elevated toilet seat		
3 in 1 (*bedside commode, raised toilet seat, and shower chair*)		
Bedpan		
Urinal		
Shower bench/chair		
Handheld shower		
Grab bars		
Transfer board		
Hospital bed		
Mechanical lift		
Gait belt		
Walker		
Cane		
Braces		
Crutches		
Motorized wheelchair		
Transfer Board		
Trapeze bar		
Protective helmet		
Ramp		
Shower		
Appropriate clearance for wheelchair/walkers		
Describe any other adaptive equipment:		

Equipment/Adaptation Utilized by Resident	Operable	Inoperable
Describe any medical or safety concerns (*include details for all instances where "inoperable " was chosen*):		

7. Meaningful Day Activity

Activity	Yes	No	Rating
Adult Day Training			
Employment			
Companion Services			
School			
Volunteer Activities			
Rating Scale for Estimating the Time Spent by the Person in an Activity **1**: Person performs or participates in the activity less than 1 day a month. **2**: Person performs or participates in the activity 1 to 3 days per month. **3**: Person performs or participates in the activity 1 to 2 days per week. **4**: Person performs or participates in the activity 3 to 7 days per week.			

8. Behavior Analysis Services (BAS)

Does the resident receive behavior analysis services?

Yes	No

Only show below if yes to previous question

List maladaptive behaviors being addressed: Add drop down		
Behavioral Analysis Documentation	**Yes**	**No**
Is there a current behavior plan?		
Is there documented tracking of behavior services?		
Is there a safety plan (ALL individuals with a history of sexually inappropriate behavior should have a safety plan)		
Describe any Behavioral Findings:		

9. **Health and Safety**

Hospitalizations within last 12 months If yes, list the date and reason for each admission		
ER visits within the last 12 months If yes, list the date and reason for each ER visit		
Falls within the last 12 months If yes, list date of each fall, injuries, and any intervention		
Skin condition issues documented within the last 12 months		
Skin condition issues documented within the last 12 months (ulcers, breakdowns, wounds),If yes: Date of initial onset: Location of skin breakdown: Treatment and interventions (orders): Name of wound care provider:		

10. **Medication**

Documented Medication Allergies:
Name of Pharmacy:
Name of validated Medication Assistance Provider (MAP) on duty at time of review:
Primary Route Validation Date: ________ Validation Expiration Date: ________

Medication Administration Summary	Met	Not Met	N/A	Unable to Verify
Consent - Authorization for medication administration (Must be signed MD/DO/PA/APRN)				
Consent - Informed consent from individual for medication administration *(not applicable for clients that self-administer without supervision)*				
Resident's medication, including over-the-counter (OTC) medication, are maintained in their original containers, intact original label, with name of individual, name of medication, directions for administration, prescribing provider's name				
Current prescriptions, prescribing provider's orders, or pharmacy profile per rule *(includes resident's name, name of medication, dosage, medication schedule, route, instructions, reason)*				
Provisions for medication requiring refrigeration are present				
Medication Administration Record (MAR) is current & documented correctly for all medication including: Individual's name				
Food or drug allergies				
Name of each medication				
Strength (i.e., 5mg/tsp, 20 mg)				
Name of prescribing physician for each medication				

Dosage (i.e., 1 tab)				
Scheduled time of administration for each medication				
Prescribed route of administration for each medication				
Instructions for mixing, diluting if applicable				
Date each medication was administered				
Initials & signature of MAP or licensed person who administered medication				
Refused or missed medication documented per Rule Chapter 65G-7, F.A.C				
If a medication error is identified at time of review, in the current MAR, was a medication error report submitted				
MAR reconciled within 24 hours of discharge from any inpatient, ER, or urgent care facility				

Insulin Administration	Yes	No
Does this resident receive insulin?		
If yes: Type of diabetes Name of insulin: Who administers:		

Additional Health Interventions	Yes	No
Oxygen		
C-PAP		
Blood Glucose Monitoring		
Other (Please provide name of intervention)		

Medication Concerns
Details of any medication administration concerns (*including details for all instances where "not met" and/or "unable to verify" were chosen*):

11. Summary of Findings

Medical Review Outcome	No Findings	Findings – No Additional Reporting	Findings – Report to APD same day	Findings – Immediate Report to Abuse Hotline & APD
1. Onsite Observation				
Describe any findings:				
2. Healthcare Visits, Exams, and Screenings				

Medical Review Outcome	No Findings	Findings – No Additional Reporting	Findings – Report to APD same day	Findings – Immediate Report to Abuse Hotline & APD
Describe any findings:				
3. Behavioral Analysis and Meaningful Day Activity				
Describe any findings:				
4. Functional Status				
Describe any findings:				
5. Therapeutic and Wellness Support				
Describe any findings:				
6. Health and Safety				
Describe any findings:				
7. Diet and Nutritional Status				
Describe any findings:				
8. Medications				
Describe any findings:				

12. Summary of Recommendations

Recommendations for group home follow up regarding findings from onsite medical review:

Nurse Reviewer's Electronic Signature: