QUESTIONS	ANSWERS
What documentation is necessary for a facility assessment?	The following documents are required for a facility assessment: • Release of Information (ROI) • Face Sheet • Guardianship/ Power of Attorney (POA) documentation • History & Physical (H&P) and/or Discharge Summary • Current MD orders • MD progress notes for last 72hours (as available) • Nurses Notes for the last 72hrs (as available) • Active Medication Summary-include date/time prn's received in the for the last 7 days (for example sliding scale insulin) • Initial Therapy evaluation (PT, OT, ST) • If currently receiving therapy Progress notes for last 3 visits • Treatment Administration records for the last 7 days (include oxygen, wound care, tube feedings, IV's) • Activities of Daily Living (ADLs) flow sheets for the last 7 days
What is the Assessor's role?	Prior to starting the assessment, the RN Assessor will need to obtain verbal permission from the individual. If the individual is unable to give permission, then permission will need to be obtained from a POA, guardian, or family surrogate. The Assessor will review the documentation provided, then ask to speak with the individual being assessed, along with a facility staff member who is familiar with the individual's current care needs.