

COMMONWEALTH OF KENTUCKY
Cabinet for Families and Children
Department for Community Based Services

DSS-277

(R 4-99)

FAMILY CARE HOME SEMI-ANNUAL ASSESSMENT

A. IDENTIFYING DATA

Facility Name _____ Number of Beds _____ Telephone _____
Address _____ Operator _____
Relief Person _____

B. HOME ASSESSMENT INFORMATION (Circle appropriate response)

1. Does documentation reflect that medicines are being given as ordered? Yes No
2. Do menus reflect meals are well-balanced? Yes No
3. Have you observed a meal? Yes No
4. Have there been changes in the number of people (residents and family members) residing in the home? Yes No
If yes, explain _____

5. Any obvious changes in the operator's physical, emotional or social status that might affect the care? Yes No
If yes, describe _____

6. Any changes from the usual in physical environment/housekeeping? Yes No
If yes, describe _____

7. Activities available in the home to residents? Yes No

8. Activities available outside the home to residents? Yes No

List: _____

9. Since last assessment:
Any DSS-284's? Yes No

Any Protective Service Investigations? Yes No

10. Residents moved since last assessment? Yes No

If yes, give name and reason for move _____

11. Deaths of residents since last assessment? Yes No

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C(1). RESIDENT ASSESSMENT (Circle appropriate responses)

NAME _____ DOB/AGE _____

1. Is resident satisfied with placement? Yes No
If no, what are the resident's concerns? _____

2. Describe resident's emotional/mental status. _____

3. Noticeable change in resident weight? Yes No
If yes, explain _____

4. Problems with grooming/hygiene? Yes No
If yes, describe _____

5. Is the resident:
Ambulatory? Yes No Mobile Nonambulatory? Yes No
Needing Assistance? Yes No Bedfast Waiver Resident? Yes No

6. Did the resident have physician contact, hospitalization, home health services since the last assessment?
Yes No If yes, explain _____

7. Medication changes since the last assessment? Yes No
If yes, List: _____

8. Is the resident restrained? Yes No
If yes, explain _____

9. Activity participation (List) _____
If none, explain _____

COMMENTS AND RECOMMENDATIONS: _____

C(2). RESIDENT ASSESSMENT (Circle appropriate responses)

NAME _____ DOB/AGE _____

1. Is resident satisfied with placement? Yes No
If no, what are the resident's concerns? _____

2. Describe resident's emotional/mental status. _____

3. Noticeable change in resident weight? Yes No
If yes, explain _____

4. Problems with grooming/hygiene? Yes No
If yes, describe _____

5. Is the resident:
Ambulatory? Yes No Mobile Nonambulatory? Yes No
Needing Assistance? Yes No Bedfast Waiver Resident? Yes No

6. Did the resident have physician contact, hospitalization, home health services since the last assessment?
Yes No If yes, explain _____

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7. Medication changes since the last assessment? Yes No
If yes, List: _____
8. Is the resident restrained? Yes No
If yes, explain _____
9. Activity participation List: _____
If none, explain _____
- COMMENTS AND RECOMMENDATIONS: _____

C(3). RESIDENT ASSESSMENT (Circle appropriate responses)

NAME _____		DOB/AGE _____
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1. Is resident satisfied with placement? Yes No
If no, what are the resident's concerns? _____

2. Describe resident's emotional/mental status. _____

3. Noticeable change in resident weight? Yes No
If yes, explain _____

4. Problems with grooming/hygiene? Yes No
If yes, describe _____

5. Is the resident:

Ambulatory?	Yes	No	Mobile Nonambulatory?	Yes	No
Needing Assistance?	Yes	No	Bedfast Waiver Resident?	Yes	No

6. Did the resident have physician contact, hospitalization, home health services since the last assessment?
Yes No If yes, explain _____

7. Medication changes since the last assessment? Yes No
If yes, List: _____

8. Is the resident restrained? Yes No
If yes, explain _____

9. Activity participation List: _____

COMMENTS AND RECOMMENDATIONS: _____

D. NEXT REVIEW DATE _____

E. WORKER'S SIGNATURE _____ DATE _____

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FAMILY CARE HOME SEMI-ANNUAL ASSESSMENT

The purpose of the FCH Semi-Annual Assessment, DSS-277, is to provide a periodic uniform assessment of the home, operator and residents and to assist the SSW in identifying problems or service needs.

PROCEDURES:

The Initial Assessment and Profile (DSS - 278) shall establish baseline information about the family care home and the residents. Six months after the worker receives notification of licensure of the family care home the first semi-annual assessment is to be completed and a new assessment every six (6) months thereafter. Some information gathered on the initial visits shall be more descriptive of current status than of change, since the SSW may not have previously assessed the home. In subsequent visits, changes noted by SSW are of particular importance. The SSW shall assess the physical and emotional condition of the residents. The SSW shall also assess conditions in the home but shall not function as a licensing or regulatory agent. However, if the SSW observes conditions which appear to be in violation of FCH regulations, a DSS-284 is to be completed and forwarded to Licensing and Regulations.

ALL SECTIONS ARE TO BE COMPLETED AT EACH ASSESSMENT

- A. **IDENTIFYING INFORMATION** - Enter appropriate information. The relief person is the person responsible for supervising residents when operator is out of the home. Unless there have been changes in this section since last visit, provide only facility's full name.
- B. **HOME ASSESSMENT** - Answer as indicated using the following Guidelines:
1. Compare instructions on prescription containers against medication sheets. All medicines, including OTC (over-the-counter) require a doctor's order. Operator or resident may have some awareness of why medicine is ordered and any special precautions. This information may be found on prescription label.
 2. Check posted menus.
 3. The SSW may want to visit at mealtime or during food preparation to determine quality and quantity of food. However, if there are complaints or other concerns regarding meals, SSW shall visit during mealtime or during meal preparation.
 4. Be alert for changes that effect residents' care/comfort such as children or grandchildren moving into home resulting in crowding or loss of privacy.
 5. Be alert for any changes in health of operator or family members that affect ability to care for residents. Caregiving ability may be affected by such events as death, divorce, social isolation, hospitalization or financial stress.

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6. Changes may be positive or negative and may effect the safety or comfort of both residents and the operator. Negatives might be such things as unlocked weapons, kerosene heaters, unvented space heaters, broken windows, broken steps, handrails or ramps in disrepair, uncomfortable temperatures, deterioration of housekeeping standards. Positives may be such things as air conditioners, new furniture, remodeling, cable TV or fenced yard.
7. List in-home activities. Examples: TV, radio, indoor games, magazines, newspapers, pets, yard games, gardening.
8. List outside activities. Examples: Shopping trips, park/picnic trips, sheltered workshops, community mental health programs, senior citizens programs, church.
9. Indicate if any protective service investigations or DSS-284's have been completed.
10. Enter names of residents who have moved since last assessment and the reason(s).
11. Deaths shall be recorded regardless of whether or not the resident died in the home or in the hospital. State cause(s), if known.

The SSW may provide follow-up services aimed at alleviating any problems identified.

C. RESIDENT ASSESSMENT - Answer as indicated using the following guidelines:

Complete the resident assessment on each resident unless the resident objects. Objections shall be documented. Efforts shall be made to talk privately with each resident.

1. The SSW's goal is to determine resident's satisfaction with the living arrangement. Responses may indicate problem areas which the worker may wish to discuss with resident and operator to determine if action is needed. Responses may indicate the need for counseling, resident relocation, or mental health services.
2. Through face-to-face contact determine if resident is oriented to person, place and time. Describe if resident is alert, confused, forgetful, sad, happy, hostile, or withdrawn. When appropriate, obtain observations from others regarding emotional/mental status.
3. Note or describe resident's weight or note any obvious weight change. Obesity, thinness or noticeable change in weight may indicate dietary, dental/denture, medical/health or emotional problem(s). Try to determine reason(s) for weight change.
4. Discuss problems with grooming or hygiene with the resident and operator.
5. Residents in family care homes are to be ambulatory or mobile non-ambulatory. This means they able to get in and out of bed or chair without assistance of another person. If assistance of another person is required to walk or transfer, notify Licensing and Regulation for purposes of

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assessment. "Family Care Home", "Mobile Non-Ambulatory" and "Ambulatory" and "Bedfast Waiver", definitions are in the appendix.

6. List any health services received.
7. The SSW may want to consult with the primary physician, if the resident appears over sedated, hyperactive or there are several medicines prescribed by different doctors.
8. Restraints shall be ordered by a physician.
See Resident Rights, Appendix
9. Answer as indicated. List in-home and outside activities in which the resident participates.

COMMENTS AND RECOMMENDATIONS

Enter any additional information considered relevant to care of residents or enter continuation of information from Sections B and C of this form. Attach additional pages when necessary to adequately document visit.

D. Enter next review date.

E. Sign and date.

Distribution

Original: Local File

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