

# Adult Residential Licensing - Documentation of Medical Evaluation (DME) INSTRUCTIONS FOR USE

## Applicable Regulations

**§ 2600.141(a)(1)** - A resident shall have a medical evaluation by a physician, physician's assistant or certified registered nurse practitioner documented on a form specified by the Department, within 60 days prior to admission or within 30 days after admission.

**§ 2600.141(a)(2)** - The medical evaluation shall include the following:

- (1) A general physical examination by a physician, physician's assistant or nurse practitioner.
- (2) Medical diagnosis including physical or mental disabilities of the resident, if any.
- (3) Medical information pertinent to diagnosis and treatment in case of an emergency.
- (4) Special health or dietary needs of the resident.
- (5) Allergies.
- (6) Immunization history.
- (7) Medication regimen, contraindicated medications, medication side effects and the ability to self-administer medications.
- (8) Body positioning and movement stimulation for residents, if appropriate.
- (9) Health status.
- (10) Mobility assessment, updated annually or at the Department's request.

**§ 2600.141(b)(1)** - A resident shall have a medical evaluation at least annually.

**§ 2600.141(b)(2)** - A resident shall have a new medical evaluation if the medical condition of the resident changes prior to the annual medical evaluation.

It's important to remember that the primary focus of these requirements is the need for residents to be evaluated by a physician, physician's assistant or certified registered nurse practitioner – **NOT that a form be completed**. The Department specifies a form simply to ensure that all of the required elements of the evaluation are performed during the evaluation.

## Homes are PERMITTED to:

- Complete all or a portion of the DME prior to the in-person evaluation, except for the "Medical Professional Information" section, and present the DME to the physician, physician's assistant or certified registered nurse practitioner for signature at the time of the examination.
- Complete all or a portion of the DME after an in-person evaluation that was performed within the timeframes specified by this regulation, except for the "Medical Professional Information" section, and present the completed form to the physician, physician's assistant or certified registered nurse practitioner for signature in person, by facsimile, or via electronic mail.
- Correct a DME upon discovering that the physician, physician's assistant or certified registered nurse practitioner has recorded inaccurate information or omitted information, IF a registered nurse (RN) or licensed practical nurse (LPN) contacts the person who performed the evaluation, AND receives permission from that person to correct the DME, AND documents the date, time, and person spoken to on the DME next to the correction.

## Homes are PROHIBITED from:

- Completing the "Medical Professional Information" section, unless the home employs a physician, physician's assistant or certified registered nurse practitioner.
- Completing all or a portion of the DME without an in-person evaluation by a medical professional.
- Completing all or a portion of the DME after an in-person evaluation that was performed outside of the timeframes specified by this regulation.
- Changing the content of a DME without the consent of the person who performed the evaluation. After obtaining consent, the DME must be changed by a registered nurse (RN) or licensed practical nurse (LPN).

It is strongly recommended that homes carefully review DME forms completed by a physician, physician's assistant or certified registered nurse practitioner to verify that all of the required information was recorded. Although the evaluations must be completed by medical professionals, homes are responsible for ensuring that the evaluations were complete and that the DMEs were filled out in their entirety.

## Adult Residential Licensing - Documentation of Medical Evaluation (DME)

Resident Information		Evaluation Information		
Name:	Type (Check one)		Date Resident Evaluated:	Date Form Completed:
Date of Birth:	<input type="checkbox"/> INITIAL <input type="checkbox"/> ANNUAL <input type="checkbox"/> STATUS CHANGE			
<b>(1) - General Physical Examination</b>		Height:	Weight:	Pulse Rate:
Blood Pressure:		Temperature:		
<b>(2) - Medical Diagnoses, Physical / Mental</b>		<b>(3) - Medical Information Pertinent to Diagnoses and Treatment, if applicable</b>		
1.				
2.				
3.				
FOR ADDITIONAL DIAGNOSES, SEE "DIAGNOSES ADDENDUM" BELOW				
<b>(4) Special Health or Dietary Needs</b>		<b>(6) - Immunization History</b>		
<input type="checkbox"/> None <input type="checkbox"/> This resident <b>CAN</b> safely use or avoid poisonous materials Secured Dementia Care (For SDCU admissions only) <input type="checkbox"/> Other - SEE "NEEDS ADDENDUM" BELOW		Are immunizations current? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
		Td/Tdap Date:	Influenza Date:	
<b>(5) - Allergies</b>		Other Immunizations (List Date and Type):		
<input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Listed Below:				
<b>(7) - Medications</b>		Ability to Self-Administer Medications - Check all that apply:		
<input type="checkbox"/> None <b>OR SEE "MEDICATION ADDENDUM" BELOW</b>		<input type="checkbox"/> Can self-administer - no assistance from others <input type="checkbox"/> Can self-administer - assistance to store medications in a secure place <input type="checkbox"/> Can self-administer - assistance in remembering schedule <input type="checkbox"/> Can self-administer - assistance in offering medications at prescribed times <input type="checkbox"/> Can self-administer - assistance in opening container or locked storage area <input type="checkbox"/> Can self-administer some medications but not others - See MED. ADDENDUM <b>OR</b> <input type="checkbox"/> Cannot self-administer medications		
<b>(8) Body Positioning / Movement</b>		<b>(9) - Health Status</b>		<b>Cognitive Functioning</b>
<input type="checkbox"/> None <input type="checkbox"/> Listed Below:		<input type="checkbox"/> Excellent <input type="checkbox"/> Poor <input type="checkbox"/> Good <input type="checkbox"/> Actively Dying <input type="checkbox"/> Fair	<input type="checkbox"/> Excellent <input type="checkbox"/> Poor <input type="checkbox"/> Good <input type="checkbox"/> None <input type="checkbox"/> Fair	
<b>(10) Mobility Needs Assessment</b>	Independent (Mobile) Resident has <b>no</b> mobility needs and can evacuate independently in an emergency <input type="checkbox"/>	Minimal (Mobile) Resident requires <b>limited</b> physical or oral assistance to evacuate in an emergency <input type="checkbox"/>	Moderate (Immobile) Resident requires <b>moderate</b> physical or oral assistance to evacuate in an emergency <input type="checkbox"/>	Total (Immobile) Resident requires <b>total</b> physical or oral assistance to evacuate in an emergency from one or more staff persons <input type="checkbox"/>
<b>Medical Professional Information</b>	<b>By signing below, I certify that:</b> <ul style="list-style-type: none"> <li>• I am a physician, physician's assistant or certified registered nurse whose license to practice is in good standing.</li> <li>• The information on this form, the addendum sheet, and any attached list of medications was generated based on my evaluation</li> <li>• The above-named resident requires assistance or supervision with Activities of Daily Living, Instrumental Activities of Daily Living, or both, as defined by 55 Pa. Code Chapter 2600</li> </ul>			
<b>Medical Professional Name:</b>			<b>Medical Professional License #:</b>	
<b>Medical Professional Signature:</b>			<b>Date Signed:</b>	

**Documentation of Medical Evaluation (DME) - Addendum Sheet**  
**This sheet may be copied as needed if additional space is required**

Resident Information		Evaluation Information	
Name:		Date Resident Examined:	Date Form Completed:

**Diagnoses Addendum**

(2) - Medical Diagnoses, Physical / Mental	(3) - Medical Information Pertinent to Diagnoses and Treatment, if Applicable
4.	
5.	
6.	
7.	
8.	
9.	
10.	

**(4) Needs Addendum**

<input type="checkbox"/> Special Diet - Check all that apply <input type="checkbox"/> No Added Sodium <input type="checkbox"/> Low cholesterol <input type="checkbox"/> Mechanical Soft Foods <input type="checkbox"/> Heart Healthy <input type="checkbox"/> Pureed Foods <input type="checkbox"/> No Concentrated Sweets	Other (describe):	<input type="checkbox"/> Special Health Needs - Include Description
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**(7) Medication Addendum**

Medication Name	Strength (Example: 100 mg.)	Dose (Example: 2 Tablets)	Frequency (Example: 2x / Day)	Purpose (Example: COPD)	Self-Administration* (Check One)
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

\* Residents may be able to self-administer some medications, but not others. The resident's ability to self-administer each medication should be assessed. If the resident can self-administer a medication, check "Yes." If a resident cannot self-administer a medication, check "No." If nothing is checked, the Department will assume that the resident cannot self-administer the medication.