Bureau of Human Services Licensing - Documentation of Medical Evaluation (DME)

INSTRUCTIONS FOR USE

Personal Care Home

Applicable Regulations

§ 2600.141

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 and certification of accuracy 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.

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Licensed Setting:
Personal Care Home

Resident Information			**Evaluation Information**		
Name:			Type (Check one) ☐ INITIAL ☐ ANNUAL ☐ STATUS CHANGE	Date of In Person Evaluation:	Date Form Completed:
Date of Birth:					
(1) - General Physical Examination					
Height:	Weight:	Pulse Rate:	Blood Pressure:		Temperature:

(2) - Medical Diagnoses, Physical / Mental	**(3) - Medical Information Pertinent to Diagnoses and Treatment, if applicable**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

For additional diagnoses, see **Diagnoses Addendum** on page 4.

(4) Poisonous Materials	**(5) - Advanced Directives**
☐ This resident CAN safely use or avoid poisonous materials ☐ This resident CAN NOT safely use or avoid poisonous materials	☐ Yes ☐ No Check One: ☐ Full Code ☐ DNR (Do Not Resuscitate)
(6) - Special Health or Dietary Needs	**(7) - Allergies**
☐ None ☐ Special Diet - Check all that apply ☐No Added Sodium ☐Low Cholesterol ☐Heart Healthy ☐Mechanical Soft Foods ☐Pureed Foods ☐No Concentrated Sweets ☐ Respiratory Care Describe: _____ ☐ Wound Care ☐ Other - See **Needs Addendum** on page 4	☐None ☐Unknown ☐Listed Below:

(8) - Medications	(9) - Immunization History	
☐ None **OR** See **Medication Addendum** on page 4	Are immunizations current? ☐Yes ☐No ☐Unknown	
Ability to Self-Administer Medications - Check all that apply: ☐ Can self-administer - no assistance from others. ☐ Can self-administer -assistance to store medication in a secure place ☐ Can self-administer - assistance in remembering schedule. ☐ Can self-administer - assistance in offering medication at prescribed times. ☐ Can self-administer some medications but not others - See **Medication Addendum** on page 4 **OR** ☐ Cannot self-administer medications.	Td/Tdap Date: Type:	Influenza Date:
	Pneumonia Date:	Covid Date:
	TB Test Date:_____ Type: ☐Skin ☐Blood Chest X-Ray Date:_____	
	Other Immunization - (List Date and Type):	

(10) - Body Positioning / Movement - Level of Assistance for Ambulation or Transfers	(11) - Health Status	(12) - Cognitive Functioning (Check All That Apply)
☐ None ☐ Assistive devices and/or wheelchair: Listed: _____ ☐ Supervision ☐ Cueing ☐ One person assist ☐ Two person assist ☐ Assist with repositioning ☐ Assist with turning ☐ Assist with transfers	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Actively Dying	☐ No impairment/Independent ☐ Short term memory deficits ☐ Long term memory deficits ☐ Needs assist with high level decision making ☐ Needs assist with all decision making ☐ Dementia diagnosis ☐ Brain injury

(13) Mobility Needs Assessment (For Ability To Evacuate In An Emergency)	☐ **Independent (Mobile)** Resident has **no** mobility needs and can evacuate independently in an emergency	☐ **Minimal (Mobile)** Resident requires **limited** physical or oral assistance to evacuate in an emergency	☐ **Moderate (Immobile)** Resident requires **moderate** physical or oral assistance to evacuate in an emergency	☐ **Total (Immobile)** Resident requires **total** physical or oral assistance to evacuate in an emergency from one or more staff persons

(14) Special Care Needs (For Secure Dementia Care Unit Admissions Only)

Dementia

Does resident require dementia - related care in a secured area?

☐ YES

☐ NO

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 of In Person Evaluation:	Date Form Completed:

Diagnoses Addendum

(2) - Medical Diagnoses, Physical / Mental	(3) - Medical Information Pertinent to Diagnoses and Treatment, if applicable
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

(6) Needs Addendum

Other (describe):

(8) Medication Addendum

Medication Name	Strength (Example: 100 mg.)	Dose (Example: 2 Tablets)	Frequency (Example: 2x / Day)	Purpose (Example: COPD)	Self-Administration* (Check One)
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐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.**

Medical Professional Information

By Signing Below, I certify that:

- ☐ I am a physician, physician assistant, or certified registered nurse practitioner whose license to practice is in good standing.
- ☐ The information on this form, the addendum sheet, and any attached list of medications was generated based on my evaluation.
- ☐ 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.

Check One Of The Options Below:

- ☐ The resident's needs can be met safely at the Personal Care Home.
- ☐ The resident is Nursing Facility Clinically Eligible (NFCE). Services to be provided at home or in a nursing facility. The resident's needs CAN NOT be met safely at the Personal Care Home.

Medical Professional Name:	**Medical Professional License #:**
Medical Professional Signature:	**Date Signed:**