

# Sample

**Impaired Cognition Supporting Documentation**  
**B2a - Short Term Memory Problem - Page 1**

Assessment Reference Date (ARD): \_\_\_\_\_

Month: \_\_\_\_\_ Year: \_\_\_\_\_

Observation Period Record day in box to right.	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
<b>B2</b> Short term memory is a problem*							
<i>This form is invalid without supporting documentation and initials. Check each shift ONLY where short-term memory is a problem, initial and describe below.</i>	<b>11/7</b>						
	<b>7/3</b>						
	<b>3/11</b>						
<b>Describe specific resident examples to support short-term memory problems noted above.</b>							
Day 1							
Day 2							
Day 3							
Day 4							
Day 5							
Day 6							
Day 7							

Initial	Full Staff Signature	Initial	Full Staff Signature

Resident Name	Medical Record Number	Room Number



**Impaired Cognition Supporting Documentation**  
**B4 - Daily Cognitive Decision Making - Page 2**

Assessment Reference Date (ARD): \_\_\_\_\_

Month: \_\_\_\_\_ Year: \_\_\_\_\_

Observation Period Record day in box to right.		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
<b>B4</b> Code then initial the appropriate response for daily cognitive decision making:** 0. Independent 1. Modified Independence 2. Moderately Impaired 3. Severely Impaired	<b>11/7</b>							
	<b>7/3</b>							
	<b>3/11</b>							
<i>This form is invalid without supporting documentation and initials.            Check each shift above with appropriate daily cognition decision making code and describe specific resident examples below.</i>								
Day 1								
Day 2								
Day 3								
Day 4								
Day 5								
Day 6								
Day 7								

- \*\*0. Independent - *decisions consistent/reasonable*  
 1. Modified Independence - *some difficulty in new situations only*  
 2. Moderately Impaired - *decisions poor; cues/supervision required*  
 3. Severely Impaired - *never/rarely made decisions*

Initial	Full Staff Signature	Initial	Full Staff Signature

Resident Name	Medical Record Number	Room Number

# Sample

## Impaired Cognition Supporting Documentation

### C4 - Making Self Understood - Page 3

Assessment Reference Date (ARD): \_\_\_\_\_

Month: \_\_\_\_\_ Year: \_\_\_\_\_

<b>Observation Period</b> Record day in box to right.		Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
<b>C4</b> Code the appropriate response then initial for making self understood:*** 0. Understood 1. Usually Understood 2. Sometimes Understood 3. Rarely/Never Understood	<b>11/7</b>							
	<b>7/3</b>							
	<b>3/11</b>							

This form is invalid without supporting documentation and initials.  
Check each shift above with appropriate "making self understood" code and describe specific resident examples below.

Day 1	
Day 2	
Day 3	
Day 4	
Day 5	
Day 6	
Day 7	

- \*\*\*0. Understood
1. Usually Understood - *difficulty finding words or finishing thoughts*
  2. Sometimes Understood - *ability is limited to making concrete requests*
  3. Rarely/Never Understood

Initial	Full Staff Signature	Initial	Full Staff Signature

Resident Name	Medical Record Number	Room Number



**Impaired Cognition Supporting Documentation**  
**B2a, B4, C4**

Assessment Reference Date (ARD): \_\_\_\_\_

Month: \_\_\_\_\_ Year: \_\_\_\_\_

Insert day in box at right. Day 7 is ARD.	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
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**Instructions:** For each of the three items, answer with **Y** for Yes or **N** for No then **initial** box. For all Yes responses, write the reason (example) you answered yes in corresponding box. Be specific. If additional room is needed, use back of form or reference location of documentation. Be sure to sign full name/title at bottom of page.

<b>B2a</b> Is a Short-term memory problem demonstrated?	11/7	/	/	/	/	/	/	/
	7/3	/	/	/	/	/	/	/
	3/11	/	/	/	/	/	/	/
<b>B4</b> Is difficulty making Daily Decisions demonstrated?	11/7	/	/	/	/	/	/	/
	7/3	/	/	/	/	/	/	/
	3/11	/	/	/	/	/	/	/
<b>C4</b> Is difficulty Making Self Understood demonstrated?	11/7	/	/	/	/	/	/	/
	7/3	/	/	/	/	/	/	/
	3/11	/	/	/	/	/	/	/

Day 1	
Day 2	
Day 3	
Day 4	
Day 5	
Day 6	
Day 7	

<b>Initial</b>	<b>Full Staff Signature</b>	<b>Initial</b>	<b>Full Staff Signature</b>

<b>Resident Name</b>	<b>Medical Record Number</b>	<b>Room Number</b>