Introduction

The previous tool known as the LOCA (Level of Care Assessment) has now been replaced by the LCD (Level of Care Determination).

Information contained in the LCD is essential to determining a level of care. Some information previously found in the LOCA has been moved to the Needs Assessment Tool (NAT) because the information was found to be most correct when identifying individual's needs used in the development of a service plan. Federal reporting requirements through the National Aging Program Information Systems (NAPIS) necessitate the retention of some information that may not appear relevant to level of care. *(Note: Questions that include NAPIS information are indicated with an * before the question.)* There is no longer any reference to locus of care and placement preferences with the exception of Nursing Facility Ineligible (NFI) determinations.

The Short Portable Mental Status Questionnaire has been replaced with the VAMC Saint Louis University Mental Status (SLUMS) Examination. The SLUMS has been placed before the medical condition section and must be completed. Placing the mental examination before the medical section enables the assessor to determine the cognitive ability of the individual to answer questions pertaining to medical diagnoses and functional ability. In the event of identified cognitive impairment, the assessor should share the results with the individual and informal supports. The assessor should also recommend that the attending physician be contacted and the results of the SLUMS exam be shared with the physician.

The Decision Narrative has been removed. Summary documentation to support the level of care determination is now included in Section 13.A.4.

The tool also has an algorithm to assist with clinical eligibility determinations. Certain responses on the tool will facilitate the correct clinical eligibility determination to trigger further thought processes for the assessor. The tool will improve documentation and the results can be utilized by the Department for quality initiatives and general data collection regarding the people that are served.

Use of the LCD will improve consistency with documentation in the assessments by decreasing text entries. Medical conditions now display drop down boxes for each type of diagnoses. The category of *Other* for selections of diagnoses not provided and a Notes section for expanded documentation in each section are available. Each section also contains a question on the individual's ability to manage their care based on the functional limitations of their diagnoses. This is paramount to determining a level of care.

The LCD is recorded directly in SAMS. Information will later transfer to the Needs Assessment Tool (NAT) using the SAMS copy feature (refer to SAMS Instructions).

Therefore, it is important that information documented in the LCD is complete, accurate and spelling is correct.

The assessors, registered nurses, and supervisors must ensure that when logging into SAMS/OMNIA, they use their individually assigned User ID and password. The signature in SAMS will indicate that the data recorded is complete and accurate. This is also important because SAMS/OMNIA will use the User ID to record an electronic signature for the individual completing their correct portion of the assessment tool. The electronic signature replaces the need for hard copy signatures.

1. INTRODUCTION

1.A. INDIVIDUAL'S IDENTIFICATION

Question 1: DATE when the AAA received the referral for the Level of Care Assessment:

Using the MM/DD/YYYY format, document the date that the agency received a referral for a level of care assessment.

Question 2: Individual's Last Name

Document the last name of the individual as it appears on his/her birth certificate or social security card.

Question 3: Individual's First Name

Document the first name of the individual as it appears on his/her birth certificate or social security card.

Question 4: Individual's Middle Initial

Document the individual's middle initial as it appears on his/her birth certificate or social security card.

Question 5: Individual's Name Suffix (if applicable)

Document name suffix (e.g. Sr. or Jr.).

Question 6: Individual's Nickname / Alias

Document the individual's nickname or alias (e.g. Josephine, alias Jay).

***Question 7: Individual's Date of Birth (DOB)**

Using the MM/DD/YYYY format, document the individual's date of birth.

***Question 8: Individual's Gender**

Document if the individual is a male or a female.

***Question 9: Individual's Ethnicity**

Document the individual's ethnicity as described by the individual. Select only one response (box).

***Question 10: Individual's Race:**

Document the individual's race as described by the individual. Select only one response (box).

Question 11: Individual's Social Security Number (SSN)

Enter the individual's SSN. The individual must present their SSN to apply for services in the community or nursing facility.

Question 12a: Does the individual have a Medicaid number?

Answer No, Yes or Pending. If Yes, enter the number in 1.A.12b.

Question 12b: Indicate Medicaid recipient number

Enter the individual's Medicaid recipient number if applicable.

Question 13a: Does the individual have Medicare?

Answer No or Yes. If Yes, enter the number in 1.A.13b.

Question 13b: Indicate the Medicare recipient number

Enter the individual's Medicare recipient number if applicable.

Question 14a: Does the individual have any other insurance?

Answer No, Yes, or Don't know. If Yes, enter the number in 1.A.14b.

Question 14b: Indicate other insurance information

Document the name of the individual's supplemental insurance if applicable.

1.B. ASSESSMENT INFORMATION

Question 1: PSA number conducting assessment

Document the Agency PSA number.

Question 2: Indicate type of assessment

Document the type of assessment completed. Select only one response (box).

Question 3: Where was the individual interviewed?

Document the location where the individual was interviewed. Select only one response (box).

Question 4: Date of visit/chart review:

Using the MM/DD/YYYY format, enter the date of the fact to face visit. In instances when the individual has been discharged or expired, enter the date of the chart review.

Question 5: Did the individual participate in the assessment?

Answer No or Yes. If the response is No, document in the Notes why they did not participate.

Question 6: If anyone else participated during the time of the determination, please document the relationship. (Document Name in Notes)

Document all persons present at the interview. Select all response boxes that apply. List the name(s) and their relationship(s) in the Notes section.

Question 7: Identify who referred the individual

Document all referral sources. Select all response boxes that apply, as there may be more than one referral source.

1.C. INDIVIDUAL'S DEMOGRAPHICS

***Question 1: Type of PERMANENT residence in which the individual resides**

Document the type of residence the individual lives in. Select only one response (box).

***Question 2: What is the individual's PERMANENT living arrangement? (Include in the "Lives Alone" category, individuals who live in an Assisted Living, Dom Care, or PCH, pay rent and have NO ROOMMATE.)**

Document the appropriate primary living arrangement. If the individual lives in Assisted Living, Dom Care, or PCH, pays rent and has no roommate, select the "Lives Alone" box and indicate in the Notes section the type of living arrangement.

***Question 3: Individual's marital status**

Document the marital status of the individual. Select one response (box).

***Question 4a: Is the individual a Veteran?**

Select No, Yes, or Unable to Determine. Select one response (box). If Yes, skip to 1.C.5a. If Unable to Determine, describe in the Notes section.

Question 4b: Is the Individual the spouse or child of a Veteran?

Select No, Yes, or Unable to Determine. Select one response (box). If Unable to Determine, describe in the Notes section.

***Question 5a: Does the individual require communication assistance?**

Select No, Yes, or Unable to Determine. Select one response (box). If No, skip to 1.C.6a. If Yes, complete 1.C.5b. If Unable to Determine, describe in the Notes section.

Question 5b: What type of communication assistance is required?

Document the type of assistance that the individual requires for communication. If the individual is unable to communicate, the assessor should check the response (box) entitled Unable to communicate.

Use the Notes section to clarify type of language assistance, such as interpreter or mechanical assistance (e.g. letter board).

Question 6a: Does the individual use sign language as their PRIMARY language?

Indicate No or Yes. Select one response (box). If No, skip to 1.C.7.
If Yes, complete 1.C.6b.

Question 6b: What type of sign language is used?

Document the individual's type of sign language used. Select one response (box). If not listed, select *Other* and document details in the Notes section.

***Question 7: What is the individual's PRIMARY language?**

Document the primary language understood and used by the individual. If not listed, select *Other* and document the primary language in the Notes section.

1.D. INDIVIDUAL'S PERMANENT RESIDENTIAL ADDRESS INFORMATION - MUNICIPALITY IS REQUIRED

Question 1: Is the individual's postal/mailing address exactly the same as the residential address?

Indicate Yes or No. If No, complete Section 1.E. (Individual's Postal/Mailing Address Information). Ask the individual, "Where do you get your mail?" Indicate Yes, if it is the same address where the individual is residing.

Question 2a: Residential County

Select the name of the County the individual lives in.

Question 2b: Residential Street Address

Indicate the Street Address where the individual resides.

Question 2c: Residential Address Second Line (Apt or Room #, Building or Complex Name, etc.)

Document the Apartment # or Room # and the name of the building or complex (if applicable) where the individual resides (e.g. Apt #3 Independence Court).

***Question 2d: Residential Municipality-REQUIRED (usually a Township or Boro where individual votes, pays taxes)**

This is the Township or Borough where the individual votes and pays taxes.

Question 2e: Residential City/Town

Document the City/Town where the individual resides.

Question 2f: Residential State

Document the State where the individual lives.

Question 2g: Residential Zip Code

Document the Zip Code where the individual lives.

Question 3: Directions to the individual's home

Document the directions to the individual's home.

***Question 4: Does individual reside in a rural area?**

This will automatically populate based on the address documented.

Indicate No or Yes.

Question 5a: Primary Phone Number

Document the primary phone number of the individual.

Question 5b: Mobile Phone Number

Document the individual's mobile phone number (if applicable).

Question 5c: Other Phone Number (Enter number where individual can be reached.)

Document any other ancillary phone number where an individual may be reached.

Question 5d: E-mail Address

Document the individual's e-mail address.

***Question 6: What was the outcome when the individual was offered a voter registration form? REQUIRED**

Select one response (box). It is not the AAA's responsibility to provide voter registration forms to an individual in a nursing facility. This is the nursing facility's responsibility as outlined in the Code of Federal Regulations (CFR). Assessors do not need to be repetitive. Documenting nursing facility in the Notes section will suffice.

1.E. INDIVIDUAL'S POSTAL/MAILING ADDRESS INFORMATION

Question 1a: Postal Street Address

Document the street address of the individual's residence.

Question 1b: Postal Address Line 2 (optional)

Document the apartment # or room # and the name of the building or complex if applicable (e.g. Apt #3 Independence Court).

Question 1c: Postal City/Town

Document the city or town where the individual resides.

Question 1d: Postal State

Document the State where the individual resides.

Question 1e: Postal Zip Code

Document the postal zip code where the individual resides.

1.F. EMERGENCY CONTACT

Question 1: Name of Emergency Contact

Document the name of the emergency contact for the individual.

Question 2: Relationship of Emergency Contact

Document the relationship of the emergency contact to the individual.

Question 3: Telephone Number of Emergency Contact

Document the telephone number of emergency contact.

Question 4: Work Telephone Number of Emergency Contact

Document the work telephone number of the emergency contact.

2. USE OF MEDICAL SERVICES

2.A. HOSPITAL, NURSING FACILITY, ER, INPATIENT PSYCHIATRIC VISITS/STAYS

Admission categories exist that include inpatient admission or outpatient observation status. Inpatient admission is when an individual is formally admitted to a hospital with a doctor's order. Outpatient observation is not considered a hospital admission. An outpatient receives emergency department services, observation services, outpatient surgery, lab tests, X-rays, or any other hospital services, and the doctor has not written an order to admit the individual to a hospital as an inpatient. In these cases, an individual is considered an outpatient even if the individual spends the night at the hospital.

Question 1: What is the individual's current level of consciousness?

Select the correct response. If Conscious, complete the assessment. If Comatose or in a Persistent Vegetative State, skip to 13.A.

Comatose: A coma is a state of unconsciousness lasting more than six hours, in which a person cannot be awakened; fails to respond normally to painful stimuli, light, or sound; lacks a normal sleep-wake cycle; and, does not initiate voluntary actions. A person in a state of coma is described as being comatose.

Conscious: The individual is awake and responsive to stimuli, keenly aware, fully appreciating the importance of something, intentional, considered and deliberate, or done with critical awareness.

Persistent Vegetative State: A persistent vegetative state is a disorder of consciousness in which patients with severe brain damage are in a state of partial arousal rather than true awareness. It is a diagnosis of some uncertainty in that it deals with a syndrome. After four weeks in a vegetative state (VS), the patient is classified as in a persistent vegetative state. This diagnosis is classified as a permanent vegetative state (PVS) after approximately one year of being in a vegetative state.

Question 2: Has the individual stayed in the HOSPITAL in the last 12 months?

Select No, Yes, or Unable to Determine. If No, skip to 2.A.4. If Yes, complete 2.A.3. If Unable to Determine, describe in the Notes section.

Note: Stayed means admitted to the hospital.

Question 3: The approximate number of times the individual has stayed overnight in the HOSPITAL in the last 12 months.

Indicate in the number of times the individual stayed overnight in the hospital in the last 12 months. Document the details in the Notes section.

Note: Number of times does not mean days in the hospital. It means times stayed in the hospital.

Question 4: The approximate number of times the individual has visited the ER in the last 12 months and was NOT admitted.

Indicate the number of times the individual visited the ER and was not admitted. Document the details in the Notes section.

Question 5: The approximate number of times the individual was admitted to a NURSING FACILITY in the LAST 12 MONTHS.

Indicate the number of times the individual stayed in a nursing facility in the last 12 months. Document the details in the Notes section.

Question 6: The approximate number of times the individual was an inpatient in a PSYCHIATRIC facility in the LAST 24 MONTHS.

Indicate the number of times the individual has had inpatient psychiatric visits/stays in the last 24 months. Document the details in the Notes section.

2.B. PRIMARY PHYSICIAN INFORMATION

Question 1: Does the individual have a PRIMARY Care Physician?

Answer No or Yes. If No, describe in the Notes section.

Question 2: PRIMARY Physician's Name

Enter the name of the primary physician in the space provided.

Question 3: PRIMARY Physician's Street Address

Enter the primary physician's street address in the space provided.

Question 4: PRIMARY Physician's City or Town

Enter the primary physician's city or town in the space provided.

Question 5: PRIMARY Physician's State

Enter the primary physician's state in the space provided.

Question 6: PRIMARY Physician's Zip Code

Enter the primary physician's zip code in the space provided.

Question 7: PRIMARY Physician's Business Phone Number. (Requires 10 digits to transfer to SAMS, optional 1-5 digit extension.)

Enter the primary physician's 10-digit telephone number in the space provided. It is optional to enter a 1-5 digit extension.

Question 8: PRIMARY Physician's FAX Number

Enter the primary physician's fax number in the space provided.

Question 9: PRIMARY Physician's E-MAIL ADDRESS

Enter the primary physician's e-mail address in the space provided.

Question 10: Additional Physicians:

Enter names and contact information for any additional physicians the individual has in the space provided (if applicable). Utilize the Notes section as needed.

3. SAINT LOUIS UNIVERSITY MENTAL STATUS (SLUMS)

The Saint Louis University Mental Status Examination (SLUMS) was designed as an alternative screening test to the widely used Mini-Mental State Examination (MMSE). The MMSE is not reliable at diagnosing people with very early Alzheimer's symptoms, which are sometimes referred to as Mild Cognitive Impairment (MCI) or Mild Neurocognitive Disorder (MNCD). These impairments occur as people progress from normal aging to early Alzheimer's disease. Alzheimer's diagnosis can be significant because early detection allows for treatment and symptom management to begin sooner. As with any Alzheimer's test, the SLUMS is a screening test and does not substitute for a full diagnostic work-up for Alzheimer's disease.

The SLUMS identifies the subtle symptoms of dementia and allows individuals to seek medical intervention early for the treatment of dementia. Early intervention may affect the disease process. The SLUMS consists of 11 items, and measures aspects of the cognition that include, orientation, short-term memory, calculations, naming of animals, a clock drawing, and recognition of geometric figures.

Scores range from 0 to 30. Scores of 27-30 are considered normal in a person with a high school education. Scores between 21 and 26 suggest Mild Neurocognitive Disorder, and scores between 0 and 20 indicate dementia.

Prior to conducting the SLUMS Examination, the assessor needs to determine that the individual is alert and that they are fully awake and able to focus. This is determined by asking and documenting questions 3.A.1-4. The assessor would not do the exam if the individual presents with the following:

- Extremely ill,
- Falling asleep,
- Blind,
- Unable to write, or
- Drowsy/Confused/Distracted/Preoccupied.

When the individual currently has a diagnosis of Dementia, the SLUMS exam is not necessary. Remember it is a screening test for early dementia.

The assessor needs to be prepared for the exam by having the following materials available:

- A watch with a second hand.
- The form with clock outline and geometric figures.

Cognitive: Refers to brain processes such as thinking, attention, perception, learning, memory, reasoning, problem solving, decision-making, and planning. Cognitive processes are distinguished from emotional processes (feelings) and behavioral processes (actions).

Orientation: Refers to the cognitive ability of an individual to know who they are, where they are, and what day and year it is. Assessment of orientation is an important part of any mental status examination, as it helps to evaluate the changes that a disease process may have brought about.

Cognitive Symptoms: Refers to problems with the processes mentioned above in the cognition definition, such as thinking, memory, and learning.

Mild Neurocognitive Disorder (MNCD): Occurs as people progress from normal aging to early Alzheimer's disease.

Mild Cognitive Impairment (MCI): Refers to the type of memory loss once considered normal that now may be seen as an early sign of disease.

3.A. SLUMS PREPARATION

Question 1: Determine if the individual is alert. Alert indicates that the individual is fully awake and able to focus.

Select the response that best indicates the individual's current level of alertness. Select one response (box).

Note: If the individual answers No to Question 2 or 3, be aware of the fact that many people with dementia will answer that question by indicating No. This is because a common symptom of persons with dementia is that they suffer from anosognosia (the literal translation is that "they do not know that they do not know"). Therefore, if an individual says No, one cannot conclude that they are free of cognitive impairment. The SLUMS should be completed by all residents unless they refuse to answer the questions.

Question 2: Do you have trouble with your memory?

Select No or Yes. Select one response (box).

Question 3: May I ask you some questions about your memory?

Select No, Yes, or Other. If No or Other, document the details in the Notes section.

Question 4: Is the individual able to complete the SLUMS Exam?

Select No or Yes. If No, document the details in the Notes section.

If the individual refuses to take the test, document in the Notes section and proceed to Section 4.

3.B. SLUMS QUESTIONNAIRE

Question 1: What DAY of the week is it?

Document the results of the individual's response to the question: Correct answer response or incorrect or not answered.

Note: Remember that the answer is incorrect if the individual does not answer.

Question 2: What is the YEAR?

Document the results of the individual's response to the question: Correct answer response or incorrect answer.

Question 3: What is the name of the STATE we are in?

Document the results of the individual's response to the question. Select one response (box) only.

Question 4: Please remember these five objects, I will ask you what they are later. Apple, Pen, Tie, House, Car

Recite the five objects to the individual clearly and slowly. Ask the individual to repeat them back to you and tell them that you will ask them again later. The assessor may repeat the objects as many times as it takes for the individual to repeat them back correctly.

The response to this question is recorded in question #7.

Question 5a: You have $100.00 and you go to the store and buy a dozen apples for $3 and a tricycle for $20. How much did you spend?

Document the results of the individual's response to the question: Correct answer response, incorrect answer or unanswered.

Question 5b: How much do you have left?

Document the results of the individual's response to the question: Correct answer response, incorrect answer or unanswered.

The assessor may repeat the question once and must not give any hints to the answer.

Question 6: Please name as many animals as you can in one minute.

Select the appropriate response. The assessor may accept names of animals only and not categories. Names of birds and fish are acceptable answers. Give the individual one minute to answer and be sure to time them.

Question 7: What were the five objects I asked you to remember? One point for each one correct response.

Select each response (box) that the individual answers correctly.

Question 8: I am going to give you a series of numbers and I would like you to give them to me backwards. For example, if I say four-two, you would say two-four.

Select each response (box) that the individual answers correctly. The assessor should state each number by its individual name. 87 is pronounced eight, seven; 649 is pronounced six, four, nine; 8537 is pronounced eight, five, three, seven.

Question 9: This is a clock face. Please put in the hour markers and the time at ten minutes to eleven o'clock.

This is the clock drawing. The assessor will need to utilize the form with clock face and geometric figures. The hour hand must be shorter than the minute hand. The minute hand must point at the 10 and the hour hand point at the 11.

Document the results of the individual's response to the question.

Question 10a: Please place an X in the triangle:

Document the results of the individual's response to the question.

The assessor will utilize the same form as the clock diagram or enlarge the diagrams on a separate sheet of paper to accommodate those with visual impairments.

Question 10b: Which of the figures is the largest?

The assessor asks the individual to place an X in the triangle. Then the assessor asks the individual "Which of the above figures is largest?"

Document the results of the individual's response to the question.

Question 11: I am going to tell you a story. Please listen carefully because afterwards, I am going to ask you some questions about it.

Jill was a very successful stockbroker. She made a lot of money on the stock market. She then met Jack, a devastatingly handsome man. She married him and had three children. They lived in Chicago. She then stopped work and stayed at home to bring up her children. When they were teenagers, she went back to work. She and Jack lived happily ever after.

Select each response (box) that the individual answers correctly.

The assessor should not repeat the story but read it slowly and make sure the individual is paying attention. The answer of Chicago as the State gets no credit, but the assessor may prompt the individual once by repeating the question.

3.C. SLUMS RESULTS

Question 1: SLUMS Consumer's Total Score

The scores for this exam will be automatically calculated in the LCD.

Question 2: Record the highest grade (1-12) the individual completed in school.

Indicate the number of years the individual attended high school.

Question 3: Identify the highest educational degree that the individual obtained.

Select the correct response.

Question 4: Assessor's conclusion after completion of the individual's SLUMS Exam:

Select the correct response based on the SLUMS score and the education level.

4. DIAGNOSES

The purpose of this section is to document four important questions.

- Are the individual's diagnoses or conditions specified in each question?
- Is the individual being treated for the medical conditions?
- Is the individual able to self-manage the care of their conditions?
- Does the diagnosis affect the individual's ability to function?

Self-manage: Defined as having the knowledge, awareness, and capability to manage their care with the supports that are currently available, as it pertains to a diagnosis or disability. This includes treatments or any prescribed medical measures for the diagnosis as directed by the individual's physician.

All questions must be answered. There may be more than one diagnosis in each section. Select the correct boxes for each diagnosis and document additional information about the diagnosis in the Notes section. In the event that there are no selections listed for the diagnosis, select the *Other* box and document in the Notes section.

Note: Utilize the boxes to document as much as possible as the tool has an algorithm embedded and the boxes trigger the algorithm, (the Notes do not trigger the algorithm).

Ascites is listed as a diagnosis under numerous medical sections in the tool. The term may not be familiar to you.

> Ascites: An abnormal accumulation of fluid in the abdomen, which results from high pressure in the blood vessels of the liver (portal hypertension) and low levels of a protein called albumin. Diseases that can cause severe liver damage can lead to ascites. These include long-term hepatitis C or B infection and alcohol abuse over many years. People with certain cancers in the abdomen may develop ascites. These cancers include cancer of the colon, ovaries, uterus, pancreas, and liver. Other conditions that can cause ascites include clots in the veins of the liver (portal vein thrombosis), Congestive Heart Failure, pancreatitis, thickening and scarring of the sac-like covering of the heart, and kidney dialysis.

4.A. RESPIRATORY

Question 1: Select all RESPIRATORY diagnoses:

Select the appropriate response(s) for all diagnoses. If None, skip to 4.B.1. If not listed, select *Other* and document details in the Notes section.

Question 2: Current treatments for RESPIRATORY diagnoses:

Select the appropriate response(s) for all treatments the individual is receiving. If Medications is selected, list the medication in 9.D. If the treatment is not listed, select *Other* and document details in the Notes section.

Question 3: Does the RESPIRATORY diagnosis affect the individual's ability to function?

Answer No or Yes. If Yes, document details in the Notes section.

Question 4: Is the individual able to self-manage care of the RESPIRATORY condition(s)?

Answer No, Yes, or Unable to Determine. If No or Unable to Determine, you must document details in the Notes section.

4.B. HEART AND CIRCULATION

Question 1: Select all HEART/CIRCULATORY system diagnoses:

Select the appropriate response(s) for all diagnoses. If None, skip to 4.C.1. If not listed, select *Other* and document details in the Notes section.

Question 2: Current treatments for HEART/CIRCULATORY system diagnoses:

Select the appropriate response(s) for all treatments the individual is receiving. If Medications is selected, list the medications in 9.D. If the treatment is not listed, select *Other* and document details in the Notes section.

Question 3: Does the HEART/CIRCULATORY diagnosis affect the individual's ability to function?

Answer No or Yes. If Yes, document details in the Notes section.

Question 4: Is the individual able to self-manage care of the HEART/CIRCULATORY system condition(s)?

Answer No, Yes, or Unable to Determine. If No or Unable to Determine, you must document details in the Notes section.

4.C. GASTROINTESTINAL

Question 1: Select all GASTROINTESTINAL diagnoses:

Select the appropriate response(s) for all diagnoses. If None, skip to 4.D.1. If not listed, select *Other* and document details in the Notes section.

Question 2: Current treatments for GASTROINTESTINAL diagnoses:

Select the appropriate response(s) for all treatments the individual is receiving. If Medications is selected, list the medications in 9.D. If the treatment is not listed, select *Other* and document details in the Notes section.

Question 3: Does the GASTROINTESTINAL diagnosis affect the individual's ability to function?

Answer No or Yes. If Yes, document details in the Notes section.

Question 4: Is the individual able to self-manage care of GASTROINTESTINAL condition(s)?

Answer No, Yes or Unable to Determine. If No or Unable to Determine, you must document details in the Notes section.

4.D. MUSCULOSKELETAL

Question 1: MUSCULOSKELETAL diagnoses and/or signs and symptoms of MUSCULOSKELETAL diagnoses:

Select the appropriate responses for all diagnoses. If None, skip to 4.E.1. If not listed, select *Other* and document details in the Notes section.

Question 2: Current treatments for MUSCULOSKELETAL diagnoses:

Select the appropriate response(s) for all treatments the individual is receiving. If Medications is selected, list the medications in 9.D. If the treatment is not listed, select *Other* and document details in the Notes section.

Question 3: Does the MUSCULOSKELETAL diagnosis affect the individual's ability to function?

Answer No or Yes. If Yes, document details in the Notes section.

Question 4: Is the Individual able to self-manage care of MUSCULOSKELETAL condition(s)?

Answer No, Yes or Unable to Determine. If No or Unable to Determine, you must document details in the Notes section.

4.E. SKIN

Wound: A break in the continuity of soft parts of body structures caused by violence or trauma to tissues. It may be a result of an accident or disease. Wounds are not staged.

Ulcer: An open sore or lesion of the skin or mucous membrane accompanied by sloughing or inflamed necrotic tissue. Ulcers are usually caused by irritation as in the case of bedsores. Ulcers are staged.

***Stage I, Stage II, Stage III, and Stage IV ulcers are defined at the end of the Resources section.*

Unstageable Ulcer: A full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green, or brown) and/or eschar (tan, brown, or black) in the wound bed.

***An unstageable ulcer is defined at the end of the Resources section.*

Question 1: Select all SKIN diagnoses:

Select the appropriate response(s) for all diagnoses. If None, skip to 4.F.1. If not listed, select *Other* and document details in the Notes section.

Question 2: Check ALL affected SKIN location(s):

Select all appropriate response(s). If not listed, select *Other* and document details in the Notes section.

Question 3: Identify the highest known ULCER STAGE:

Select the appropriate response. The assessor may have to refer to a medical professional or the medical record to obtain the correct stage of an ulcer.

Question 4: Current treatments for SKIN diagnoses:

Select the appropriate response(s) for all treatments the individual is receiving. If Medications is selected, list the medications in 9.D. If the treatment is not listed, select *Other* and document details in the Notes section.

Question 5: Does the SKIN diagnosis affect the individual's ability to function?

Answer No or Yes. If Yes, document details in the Notes section.

Question 6: Is the individual able to self-manage care of the SKIN condition(s)?

Answer No, Yes or Unable to Determine. If No or Unable to Determine, you must document details in the Notes section.

4.F. ENDOCRINE/METABOLIC

Question 1: Select all ENDOCRINE/METABOLIC diagnoses:

Select the appropriate response(s) for all diagnoses. If None, skip to 4.G.1. If not listed, select *Other* and document details in the Notes section.

Question 2: Select all the current treatments for ENDOCRINE/METABOLIC diagnosis:

Select the appropriate response(s) for all treatments the individual is receiving. If Medications is selected, list the medications in 9.D. If the treatment is not listed, select *Other* and document details in the Notes section.

Question 3: Does the ENDOCRINE/METABOLIC diagnosis affect the individual's ability to function?

Answer No or Yes. If Yes, document details in the Notes section.

Question 4: Is the individual able to self-mange care of the ENDOCRINE/METABOLIC condition(s)?

Answer No, Yes or Unable to Determine. If No or Unable to Determine, you must document details in the Notes section.

4.G. GENITOURINARY

Question 1: Select all GENITOURINARY diagnoses:

Select the appropriate response(s) for all diagnoses. If None, skip to 4.H.1. If not listed, select *Other* and document details in the Notes section.

Urinary incontinence usually results from an underlying treatable medical condition. If an individual is incontinent of urine, do not assume that it is caused by a bladder disorder such as neurogenic bladder, overactive bladder, or urinary retention. Incontinence has many causes. Try to find out the underlying diagnosis that is causing the incontinence.

Neurogenic bladder dysfunction: Sometimes referred to as neurogenic bladder, it is a dysfunction of the urinary bladder due to disease of the central nervous system or peripheral nerves involved in the control of micturition (urination). Neurogenic bladder usually causes difficulty or full inability to pass urine without use of a catheter or other method.

Question 2: Current treatments for GENITOURINARY diagnoses:

Select the appropriate response(s) for all treatments the individual is receiving. If Medications is selected, list the medications in 9.D. If the treatment is not listed, select *Other* and document details in the Notes section.

Question 3: Does the GENITOURINARY diagnosis affect the individual's ability to function?

Answer No or Yes. If Yes, document details in the Notes section.

Question 4: Is the individual able to self-manage care of the GENITOURINARY condition(s)?

Answer No, Yes or Unable to Determine. If No or Unable to Determine, you must document details in the Notes section.

4.H. INFECTIONS/IMMUNE SYSTEM

Question 1: Select all INFECTION/IMMUNE System diagnoses:

Select the appropriate response(s) for all diagnoses. If None, skip to 4.I.1. If not listed, select *Other* and document details in the Notes section.

Question 2: If HIV or AIDS is indicated in 4.H.1, has the individual ever had lab results of CD4 count under 400?

Select No, Yes or Unknown.

Question 3: Current treatments for INFECTION/IMMUNE system diagnoses:

Select the appropriate response(s) for all treatments the individual is receiving. If Medications is selected, list the medications in 9.D. If the treatment is not listed, select *Other* and document details in the Notes section.

Question 4: Does the INFECTION/IMMUNE system diagnosis affect the individual's ability to function?

Answer No or Yes. If Yes, document details in the Notes section.

Question 5: Is the individual able to self-manage care of the INFECTION/IMMUNE system conditions?

Answer No, Yes or Unable to Determine. If No or Unable to Determine, you must document details in the Notes section.

4.I. CANCER

Question 1: Does the individual have any current CANCER diagnoses?

Answer Yes or No. If No, skip to 5.A.1.

Question 2: If Yes, identify the CANCER stage:

Select the correct box. The assessor may have to refer to the medical record or the individual's physician to obtain the correct stage of cancer.

> Staging: Describes the extent or severity of an individual's cancer. Knowing the stage of disease helps the doctor plan treatment and estimates the person's prognosis. Staging systems for cancer have evolved over time and continue to change as scientists learn more about cancer. The TNM staging system is based on the size and/or extent (reach) of the primary tumor (T), whether cancer cells have spread to nearby (regional) lymph nodes (N), and whether metastasis (M), or the spread of the cancer to other parts of the body, has occurred. Physical exams, imaging procedures, laboratory tests, pathology reports, and surgical reports provide information to determine the stage of a cancer.

Question 3: Select all current CANCER diagnoses:

Select the appropriate response(s) for all diagnoses. If not listed, select *Other* and document details in the Notes section.

Question 4: Current treatments for CANCER diagnoses:

Select the appropriate response(s) for all treatments the individual is receiving. If Medications is selected, list the medications in 9.D. If the treatment is not listed, select *Other* and document details in the Notes section.

Question 5: Does the CANCER diagnosis affect the individual's ability to function?

Answer No or Yes. If Yes, document details in the Notes section.

Question 6: Is the individual able to self-manage the CANCER conditions?

Answer No, Yes or Unable to Determine. If No or Unable to Determine, you must document details in the Notes section.

5. NEUROLOGICAL (MANDATORY completion of Section 8 if Neurological diagnosis)

5.A. NEUROLOGICAL

Question 1: If there is a NEUROLOGICAL diagnosis, select all types & completion of Section 8 Behaviors is MANDATORY.

Select the correct response(s). If None, skip to 6.A.1. If not listed, select *Other* and document details in the Notes section.

Question 2: Current treatments for NEUROLOGICAL diagnosis:

Select the appropriate response(s) for all treatments the individual is receiving. If Medications is selected, list the medications in 9.D. If the treatment is not listed, select *Other* and document details in the Notes section.

Question 3: Is the individual ABLE to communicate?

Select the correct response. If No, document details in the Notes section.

Question 4: What characteristics describe the individual's cognitive state?

Select the correct response(s). If not listed, select *Other* and document details in the Notes section.

Question 5: Does the NEUROLOGICAL diagnosis affect the individual's ability to function?

Answer No or Yes. If Yes, document details in the Notes section.

Question 6: Is the individual able to self-manage care of the NEUROLOGICAL condition(s)?

Select the correct response. If No or Unable to Determine, document details in the Notes section.

6. INTELLECTUAL DEVELOPMENTAL DISABILITY (IDD) (MANDATORY completion of Section 8 if IDD diagnosis)

6.A INTELLECTUAL DEVELOPMENTAL DISABILITY (IDD)

Question 1: Does the individual have a diagnosis of Intellectual Developmental Disability (IDD) from birth to 22nd birthday or known to the IDD system?

Select the correct response. If No, skip to 7.A.1. If Yes, Section 8 - Behaviors are MANDATORY.

Question 2: Is the individual able to self-manage care of the IDD condition?

Select the correct response. If No or Unable to Determine, document details in the Notes section.

Question 3: Does the IDD diagnoses affect the individual's ability to function?

Select the correct response. If Yes, document details in the Notes section.

7. MENTAL HEALTH (MANDATORY completion of Section 8 if Psychiatric diagnosis)

7.A. PSYCHIATRIC

Determine whether or not the individual has any type of psychological disorder/mental illness.

> Mental Illness: A mental or bodily condition marked primarily by sufficient disorganization of personality, mind, and emotions to seriously impair the normal psychological functioning of the individual. The illness may result in a disruption in a person's thinking, feeling, moods, and ability to relate to others.

Prompting questions may include:

- Have you ever seen a psychiatrist?
- Have you ever been told that you have any psychiatric problems?
- Did you receive treatment?

Question 1: If there is any PSYCHIATRIC diagnosis, select all types & completion of Section 8 Behaviors is mandatory.

Select the appropriate response(s) for all diagnoses. If None, skip to 8.A.1. If not listed, select *Other* and document details in the Notes section.

Question 2: Current treatments for PSYCHIATRIC diagnosis:

Select the appropriate response(s) for all treatments the individual is receiving. If Medications is selected, list the medications in 9.D. If the treatment is not listed, select *Other* and document details in the Notes section.

Question 3: Does the PSYCHIATRIC diagnosis affect the individual's ability to function?

Answer No or Yes. If Yes, document details in the Notes section.

Question 4: Is the individual able to self-manage care of the PSYCHIATRIC conditions?

Answer No, Yes, or Unable to Determine. If No or Unable to Determine, you must document in the Notes section.

8. BEHAVIORS - MANDATORY if Neurological, IDD or Psychiatric Diagnosis

8.A. BEHAVIORS

Question 1: Does the individual present with any BEHAVIORAL signs/symptoms? This Section is REQUIRED if a Neurological, IDD or Psychiatric diagnoses was noted in Section 5, 6 or 7.

Select No, Yes, or Unable to Determine. If No, skip to 9.A.1. If Yes or Unable to Determine, complete all of Section 8.

Question 2a: Does the individual exhibit PHYSICAL behavioral symptoms toward OTHERS?

Select the correct response. If No, skip to 3a. If Yes, complete 2b and 2c.

Question 2b: Specify ALL types of aggressive PHYSICAL behavior toward OTHERS (If not listed, document in Notes.)

Select the correct response(s). If not listed, select *Other* and document details in the Notes section.

Question 2c: Does the aggressive PHYSICAL behavior toward OTHERS interfere with the individual's ability to function daily?

Answer No or Yes. If No, document why the behavior does not interfere in the Notes section. If Yes, document how the behavior interferes in the Notes section.

Question 3a: Does the individual exhibit aggressive PHYSICAL behavioral symptoms towards SELF?

Answer No or Yes. If No, skip to 4a. If Yes, complete 3b and 3c.

Question 3b: Specify ALL types of aggressive PHYSICAL behavior towards SELF (If not listed, document in Notes.)

Select the correct response(s). If not listed, select *Other* and document details in the Notes section.

Question 3c: Does the aggressive PHYSICAL behavior toward SELF interfere with the individual's ability to function daily?

Answer No or Yes. If No, document why the behavior does not interfere in the Notes section. If Yes, document how the behavior interferes in the Notes section.

Question 4a: Does the individual exhibit aggressive VERBAL behavior symptoms toward OTHERS?

Answer No or Yes. If No, skip to 5a. If Yes, complete 4b and 4c.

Question 4b: Specify ALL types of aggressive VERBAL behavior towards OTHERS (If not listed, document in Notes.)

Select the correct response(s). If not listed, select *Other* and document details in the Notes section.

Question 4c: Does the aggressive VERBAL behavior toward OTHERS interfere with the individual's ability to function daily?

Answer No or Yes. If No, document why the behavior does not interfere in the Notes section. If Yes, document how the behavior interferes in the Notes section.

Question 5a: Does the individual exhibit any GENERAL aggressive VERBAL behavior symptoms not specifically directed toward self or others?

Answer Yes or No. If No, skip to 6a. If Yes, complete 5b and 5c.

Question 5b: Select ALL GENERAL aggressive VERBAL behaviors (If not listed, document in Notes.)

Select correct response(s). If not listed, select *Other* and document details in the Notes section.

Question 5c: Does the GENERAL aggressive VERBAL behavior interfere with the individual's ability to function daily?

Answer No or Yes. If No, document why the behavior does not interfere in the Notes section. If Yes, document how the behavior interferes in the Notes section.

Question 6a: Does the individual exhibit any OTHER behavioral symptoms?

Answer Yes or No. If Yes, complete 6b and 6c. If No, skip to Section 9.

Question 6b: Specify ALL OTHER types of behaviors reported (If not listed, document in Notes.)

Select correct response(s). If not listed, select *Other* and document details in the Notes section.

Question 6c: Do the OTHER types of behaviors interfere with the individual's ability to function daily?

Answer No or Yes. If No, document why the behavior does not interfere in the Notes section. If Yes, document how the behavior interferes in the Notes section.

9. OTHER MEDICAL INFORMATION

9.A. INFORMATION

Question 1: Has the individual exhibited ELOPEMENT behavior in the PAST 6 MONTHS? If so, indicate the FREQUENCY.

Select the correct response. If *Other*, document details of the elopement behavior in the Notes section.

Elopement: An individual who is cognitively, physically, mentally, emotionally, and/or chemically impaired; wanders away, walks away, runs away, escapes, or otherwise leaves their environment unsupervised or unnoticed.

Supervision is defined as the action or process of watching and directing what someone does or how something is done.

Note: Supervision may be required in order to monitor existing health conditions or to promote the safety of an individual within their living environment. Supervision is determined by the information documented elsewhere in the assessment and must support the response to the supervision the individual requires. The assessor determines this by considering the compilation of information obtained during the assessment and the individual's ability to be independent with the current available resources.

Question 2: Does the individual require supervision?

Answer No or Yes. If No, skip to 9.A.4. If Yes, complete 9.A.3.

Question 2a: How long can the individual be routinely left alone?

Select the correct response.

Question 3: Why does the individual require supervision?

Select the correct response(s). There may be more than one correct response. In the Notes section, document the reason(s) why the individual needs the type and duration of supervision selected.

Question 4: Can the Individual evacuate their home in the event of a fire?

Answer No or Yes. If No, document details in the Notes section.

9.B. FRAILTY SCORE

The term frail is intended to identify individuals at greatest risk of adverse outcomes that include falls, worsening disability, institutionalization, and death. Frailty is a term commonly used among health care professionals to label the condition of an older person who has health problems, has lost functional abilities, and is likely to deteriorate further. It is thus a syndrome, describing a health state that could occur as the result of a number of underlying health conditions.

Someone is frail if they meet 3 or more of the 5 criteria, which include:

- Weight loss,
- Exhaustion,
- Weak grip strength,
- Slow walking speed, and
- Low physical activity.

The following simple test measures frailty. If the individual has 3 negative responses to the following questions, they meet the definition of frail, which is an indicator that they could deteriorate further.

Note: Negative responses are underlined.

Question 1: Are you tired?

Select correct response No or Yes.

Question 2: Can you walk up a flight of stairs?

Select correct response No or Yes.

Question 3: Can you walk a city block (250-350 feet)?

Select correct response No or Yes.

Question 4: Do you have more than 5 illnesses?

Select correct response No or Yes.

Question 5: Have you lost more than 5% of your weight in the last year?

Select correct response No or Yes.

Question 6: Individual shows symptoms of being frail?

Frailty score: 3 of 5 indicators = frail.

A true or false response is generated by the algorithm.

9.C. DEPRESSION / LIFE SATISFACTION

This depression screen has been recommended by PDA and DPW's Medical Director. When the individual has 3 or more negative responses, they have an indicator for depression. Depression incidences in older individuals have been known to increase institutionalizations (e.g. hospitalizations and nursing facility admissions).

Note: Negative responses are underlined.

Question 1: Are you basically satisfied with your life?

Answer No or Yes.

Question 2: Do you often get bored?

Answer No or Yes.

Question 3: Do you often feel hopeless?

Answer No or Yes.

Question 4: Do you prefer to stay at home, rather than going out and doing new things?

Answer No or Yes.

Question 5: Do you ever have feelings of worthlessness?

Answer No or Yes.

Question 6: Individual shows symptoms of being depressed?

Depression/Life Satisfaction score: 3 of 5 indicators = possible depression

A true or false response is generated by the algorithm.

9.D. MEDICATION MANAGEMENT

The purpose of this section is to document the name of the medication prescribed, dose, type, route, and frequency. It also describes the individual's ability level to manage medication.

Over-the-Counter (OTC) medications are recorded under Over-the-Counter (OTC) Medications unless the individual is in a facility. If an individual is in a facility, the Over-the-Counter medications are recorded under Prescribed Medications. When evaluating an individual in a facility, evaluate the ability of the individual to administer medications, not that the medication is administered to the individual by the facility. Information on facility residents' ability is essential to be considered for Level of Care determination, especially if the person is interested in returning home in the near future.

Central Venous Catheter: Is also referred to as central line, CVC, central venous line, or central venous access catheter. It is a long thin flexible catheter placed into a large vein in the neck (internal jugular vein), chest (subclavian vein or auxiliary vein), or groin (femoral vein) that is used to give medicines, fluids, nutrients, or blood products over a long period of time, take frequent blood samples, to receive kidney dialysis for kidney failure, give long-term medicine treatment for pain, infection, or cancer, or to supply nutrition. A central venous catheter can be left in place far longer than an intravenous catheter (IV).

Question 1: Does the individual take any PRESCRIBED medications?

Answer No or Yes. If No, skip to 9.D.5.

Question 2: Does the individual have a central venous line?

Answer No or Yes. If Yes, document the type and details in the Notes section.

Question 3: List all PRESCRIBED medications taken by the individual:

The assessor must document:

- The name of the medication
- The dose of the medication ordered
- The form (route of administration as coded)
- The frequency of the medication taken

Question 4: Does the individual take all medications as prescribed?

Answer No or Yes. If No, document details in the Notes section

Question 5: List all OVER THE COUNTER (OTC) medications taken by the individual:

The assessor must document:

- The name of the medication
- The dose of the medication ordered
- The form (route of administration coded)
- The frequency of the medication taken

Question 6: Does the individual have any allergies or adverse reactions to any medication?

Answer No or Yes. If Yes, document details in the Notes section.

Question 7: What is the individual's ability level to manage medication?

Select the correct response. If Independent, skip to 9.E.

Question 8: If limited assistance, indicate all types needed for MEDICATION MANAGEMENT:

Select correct response(s). If *Other*, document details in the Notes section.

Question 9: Who assists the individual with medication administration?

Select the correct response. Document details for all responses in the Notes section.

9.E. HEIGHT/WEIGHT

An individual's weight is an important factor for an assessor to know, especially if the individual has lost 10 pounds or more in the past 6 months. Weight loss could possibly be indicative of an illness or eating disorder.

Utilize the BMI calculation to determine weight type.
http://www.nhlbi.nih.gov/guidelines/obesity/BMI/bmicalc.htm

Prompting questions for weight loss or gain may include:

- Have you recently (last six months) lost or gained weight without any changes to your diet or exercise?
- Do you know why your weight has gone up or down?

Question 1: What is the individual's height?

Indicate the height of the individual.

Question 2: What is the individual's weight?

Indicate the weight of the individual.

Question 3: What is the individual's weight type?

Select the correct response.

9.F. PAIN

This section will address if the individual is experiencing pain, the location of the pain, the level of pain, the frequency of pain, and whether or not the individual's pain is impacting their ability to function daily.

Note: When it is determined that numerous sites of pain exist, document the most severe site of pain. Document additional pain site(s) information in the Notes section.

Question 1: Does the individual report PAIN?

Select the correct response. If No or Unable to Determine, skip to 10.A.1.

Question 2: Location(s) of PAIN site(s):

Select the correct box (boxes) for location of pain. There may be more than one box selected. If not listed, select *Other* and document details in the Notes section.

Question 3: Indicate the level of PAIN the individual reports using a scale from 0-10 (0=no pain, 10=severe pain)

Select the correct box to indicate the level of pain the individual is experiencing. Choose only one response.

Question 4: Indicate the frequency the individual reports the PAIN.

Select the correct box to indicate how frequent the individual has pain and document additional information in the Notes section.

Question 5: Select all the current treatments for PAIN diagnoses:

Select the correct response(s). If Medications is selected, list the medications in 9.D. If treatment is not listed, select *Other* and document details in the Notes section.

Question 6: Does PAIN affect the individual's ability to function?

Answer No or Yes. If Yes, document details in the Notes section.

10. ACTIVITIES OF DAILY LIVING (ADLs)

10.A. ADLs

The assessor must rate the individual's ability to perform their ADLs and to manage them with reasonable safety. There may be instances in which the individual has no opportunity to perform ADL tasks because they may be in a facility, a hospital, or family members are assisting with ADL tasks. In order to accurately assess the individual's ability to perform any ADLs, the assessor is required to review facility charts, in addition to asking the individual and evaluating their abilities.

ADLs include:

- Bathing
- Dressing
- Grooming
- Eating
- Transferring
- Toileting
- Bladder/Bowel Incontinence
- Walking

Walking was added to the ADL section because it is a tool to accurately measure the individual's capability of performing ADLs.

Independent: The ability to completely manage the ADL independently. If an individual can manage the ADL on their own, with the use of an assistive device, they are independent. For example, an individual sits on a shower seat and uses a hand held showerhead to bathe. They do not need any assistance with these devices or with any other aspect of bathing. This individual is independent. The assessor may make a note within the response of "Independent", listing any assistive devices the individual uses in order to be able to complete the ADL independently.

Limited Assistance: Some assistance is required for the individual to complete the ADL. For example, an individual sits on a shower seat and uses a hand held showerhead to bathe. The individual has limited range of motion in their arm because of a shoulder replacement surgery and arthritis. They require assistance with handling and maneuvering the showerhead in order to wash their face, hair and back. This individual requires limited assistance. Select the response(s) in the drop down menu that best describes what assistance is being provided.

Guided Maneuvers: An individual who requires hands-on assistance or requires weight-bearing support while performing ADLs.

Total Assistance: The individual is unable to complete any part of the ADL without assistance.

Utilize the Notes section for documentation of any additional details.

Question 1a: BATHING Ability to prepare a bath and wash oneself, includes turning on the water, regulating temperature, etc.

Select the appropriate response. Check one box only.

Question 1b: If Limited Assistance, indicate ALL types needed for BATHING

Select the appropriate response(s). There may be more than one box selected. If *Other*, document details in the Notes section.

Question 2a: DRESSING Ability to remove clothes from a closet/drawer; application of clothing, including shoes/socks (regular/TEDS); orthotics; prosthesis; removal/storage of items; managing fasteners; and to use any needed assistive devices.

Select the appropriate response. Check one box only.

Question 2b: If Limited Assistance, indicate ALL types needed for DRESSING:

Select the appropriate response(s). There may be more than one box selected.
If *Other*, document details in the Notes section.

Question 3a: GROOMING/PERSONAL HYGIENE Ability to comb/brush hair; brush teeth; care for/inset dentures; shave; apply make-up (if worn); apply deodorant, etc.

Select the appropriate response. Check one box only.

Question 3b: If Limited Assistance, indicate ALL types needed for GROOMING/PERSONAL HYGIENE:

Select the appropriate response(s). There may be more than one box selected.
If *Other*, document details in the Notes section.

Question 4a: EATING Ability to eat, drink, cut, chew, swallow food, and to use any needed assistive devices.

Select the appropriate response. Check one box only. If Does not eat is selected, skip to 10.A.4c.

Question 4b: If Limited Assistance, indicate ALL types needed for EATING:

Select the appropriate response(s). There may be more than one box selected.
If *Other*, document details in the Notes section.

Question 4c: If response to 9A.4a is "4-Does not eat", indicate type of nutritional intake. Check ALL that apply:

Select the appropriate responses. There may be more than one box selected.
If *Other*, document the details in the Notes section.

Question 5a: TRANSFER Ability to move between surfaces, including to/from bed, chair, wheelchair, or to a standing position; onto or off a commode; and to manage/use any needed assistive devices.

Select the appropriate response. Check one box only.

Question 5b: If Limited Assistance, indicate ALL types needed for TRANSFER:

Select the appropriate responses. There may be more than one box selected.
If *Other*, document details in the Notes section.

Question 6a: TOILETING Ability to manage bowel and bladder elimination.

Select the appropriate response. Check one box only.

Question 6b: If Limited Assistance, indicate ALL types needed for TOILETING:

Select the appropriate response(s). There may be more than one box selected.
If *Other*, document details in the Notes section.

Question 6c: BLADDER CONTINENCE Indicate the description that best describes the individual's BLADDER function

Select the appropriate response. Check one box only.

Question 6d: BOWEL CONTINENCE Indicate the description that best describes the individual's BOWEL function

Select the appropriate response. Check one box only.

Question 7a: WALKING Ability to safely walk to/from one area to another; manage/use any needed ambulation devices

Select the appropriate response. Check one box only.

Question 7b: If Limited Assistance, indicate ALL types needed for WALKING:

Select the appropriate response(s). There may be more than one box selected.
If *Other*, document details in the Notes section.

11. MOBILITY
11.A. CONSUMER'S MOBILITY

The assessor is to choose the correct response box (boxes) for each question regarding mobility status that best describes the individual's ability to perform each task.

Bedbound: An individual who is bedridden and never leaves the bed. Even if the individual is able to be transferred from bed to chair with assistance (by an individual or with an assistive device), they are not considered bedbound.

Non-ambulatory: The individual, after rising from the bed/chair (assisted or non-assisted), cannot walk without the assistance of another person.

Guided Maneuvers: An individual who requires hands-on assistance or requires weight-bearing support while performing ADLs.

The assessor can evaluate an individual's mobility through observation and questioning. If the individual is willing, the assessor must ask for a demonstration of walking or wheeling ability across a room and back.

Question 1: BEDBOUND Is the individual bedbound? Indicate in notes any comments or relevant information.

Select the correct response. If Yes, skip to 12.A. Describe additional information in the Notes section.

Question 2a: INDOOR MOBILITY Ability of movement within INTERIOR environment

Select the appropriate response. Check one box only. Describe additional information in the Notes section.

Question 2b: If Limited Assistance, indicate ALL types needed for INDOOR MOBILITY:

Select the appropriate response(s). There may be more than one box selected.
If *Other*, document the details in the Notes section.

Question 3a: OUTDOOR MOBILITY Ability of movement OUTSIDE living arrangement

Select the appropriate response. Check one box only. Describe additional information in the Notes section.

Question 3b: If Limited Assistance, indicate ALL types needed for OUTDOOR MOBILITY:

Select the appropriate response(s). There may be more than one box selected.
If *Other*, document details in the Notes section.

Question 4a: STAIR MOBILITY Movement safely up and down STEPS

Select the appropriate response. Check one box only. Describe additional information in the Notes section.

Question 4b: If Limited Assistance, indicate ALL types needed for STAIR MOBILITY:

Select the appropriate response(s). There may be more than one box selected.
If *Other*, document details in the Notes section.

Question 5: What is the individual's weight bearing status?

Select the correct response.

Note: Putting weight on your legs is called "weight bearing".

Full weight bearing (FWB): You may place your full body weight on your affected leg(s) when you stand or walk. No limitations.

Non-weight bearing (NWB): You do not/cannot place any weight on your affected leg(s). You do not touch the floor with your affected leg(s). If only one leg is affected while you stand or walk, you must hold your affected leg off the floor.

Partial weight bearing (PWB): When you stand or walk, you may place XX percent of your body weight (## pounds) on your affected leg. *Note: These numbers are designated by your physician or therapist.*

Toe-touch weight bearing (TTWB): When you stand or walk, you may touch the floor only for balance. You do not place actual weight on your affected leg.

Select the correct response. If Unable to Determine, describe in the Notes section.

Describe additional information in the notes section.

Question 6: Select all that affect the individual's MOBILITY:

Select the correct response(s). There may be more than one box selected.
If *Other*, document details in the Notes section.

11.B. FALLS

The assessor must document if the individual is at risk of falling.

Factors that may render an individual at risk for falls include, but are not limited to, poor health or declining health, impaired balance, decreased strength and/or flexibility, decreased vision, and medications. This item requires the assessor to make a judgment regarding the individual's risk for falls that is based on observations or information provided by the individual or significant others.

In the Notes section, document what functional deficit related to their diagnoses puts them at risk. Provide as much information as possible.

Document whether or not the individual has fallen recently. Recently is defined as within the last six months.

Prompting questions may include:

- Have you fallen during the past six months?
- How often?
- Where did you fall?
- What were you doing at the time?
- Did you faint or lose consciousness?
- Were you injured in the fall(s)?
- Could you get back up by yourself?
- Did a physician see you or did you go to the emergency room to be evaluated after your fall?
- Do you do anything special to prevent falls?

Question 1: Is the individual at risk of falling?

Select the correct response. Describe additional information in the Notes section.

Question 2: Select the number of times the individual has fallen in the LAST 6 MONTHS:

Select the correct response.

Question 3: Reasons for falls-Document Details in Notes

Select the correct response. If *Other*, document the details in the Notes section. If the individual has fallen, utilize the Notes section to provide details.

12. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)

12.A. IADLs

Deficits in IADLs alone will not meet the criteria for Nursing Facility Clinically Eligible.

IADLs include tasks that are not necessarily done every day, but are important to independent living. These tasks include preparing meals, doing housework, laundry, shopping, using transportation, managing money, using the telephone, and doing home maintenance. The ability to perform IADL tasks can help an assessor determine the impact of physical and mental impairments, since performance of these tasks requires a combination of memory, judgment, and physical ability.

There may be instances in which the individual has no opportunity to perform IADL tasks. For example, some individuals do not prepare meals because a spouse or other relative (who lives with them) routinely does this task. In the same way, individuals who are in an institution at the time of the assessment have no regular opportunity to cook, clean, do laundry, or shop. Therefore, when administering the IADL questions, it is very important for the assessor to stress the ability of the individual to perform the task.

The assessor is to choose one response (box) for each IADL that best describes the individual's ability to perform each task. Record the identity of helpers, if any, in the additional space provided.

Question 1: MEAL PREPARATION Ability to plan/prepare meals, use of kitchen appliances, heat meals. List any needed adaptive equipment/assistive devices in Notes.

Select the appropriate response. Check one box only. Describe additional information in the Notes section.

Question 2: HOUSEWORK Ability to maintain living space; includes tasks such as dishwashing, making the bed, dusting, running the vacuum or sweeping an area. List any needed adaptive equipment/assistive devices in Notes.

Select the appropriate response. Check one box only. Describe additional information in the Notes section.

Question 3: LAUNDRY Ability to gather clothes, place clothes in washing machine, turn on appliance, remove clothes and place in dryer, or hand wash items and hang to dry. List any needed adaptive equipment/assistive devices in Notes.

Select the appropriate response. Check one box only. Describe additional information in the Notes section.

Question 4: SHOPPING Ability to go to the store and purchase needed items, includes groceries and other items. List any needed adaptive equipment/assistive devices in Notes.

Select the appropriate response. Check one box only. Describe additional information in the Notes section.

Question 5: TRANSPORTATION Ability to travel on public transportation or drive a car. List any needed adaptive equipment/assistive devices in the Notes.

Select the appropriate response. Check one box only. Describe additional information in the Notes section.

Question 6: MONEY MANAGEMENT Ability to manage financial matters, writing checks, paying bills, going to the bank. List any needed adaptive equipment/assistive devices in the Notes.

Select the appropriate response. Check one box only. Describe additional information in the Notes section.

Question 7: TELEPHONE Ability to obtain phone numbers, dial the number and communicate with the person on the other end. List any needed adaptive equipment/assistive devices in Notes.

Select the appropriate response. Check one box only. Describe additional information in the Notes section.

Question 8: HOME MANAGEMENT Ability to perform heavier household tasks such as taking out the trash, completing minor repairs around the living space, yard work and/or snow removal. List any needed adaptive equipment/assistive devices in Notes.

Select the appropriate response. Check one box only. Describe additional information in the Notes section.

13. LEVEL OF CARE DETERMINATION (LCD) ASSESSMENT DATA

13.A. ASSESSMENT OUTCOME

This section addresses the level of care outcome based on the information obtained in the LCD. All questions must be completed and follow the order in which they are listed. The assessor must be the first to complete the LOC Determination. If the individual is determined NFCE, the registered nurse must review and enter the correct information in this section. The assessment supervisor is the last to review the assessment.

Question 1: What Level of Care did the physician recommend?

Select the correct response. Check one box only.

Question 2: What is the date the AAA received the individual's MA-51 or Rx Script, signed by a physician?

Using the MM/DD/YYYY format, document the date the AAA received the individual's MA-51 or Rx Script, signed by a physician.

Question 3: Was a Medical Evaluation by a Physician requested but not received?

Select the correct response.

Note: If "yes", and the individual is determined NFCE through the process of the assessment, then assessor should select NFCE as the level of care determination in question 13.A.4. Upon receipt of the MA-51 or Rx Script, a journal note should be entered in the consumer record indicating the date the medical evaluation was received. The LCD itself should not be amended or altered.

Question 4: What is the Level of Care determination for this individual?

Select the correct response.

Question 5: Summarize how the individual's functional limitations and medical conditions support the Level of Care determination. Document a summary of the diagnoses & treatments and how the limitations impede the individual's ability to manage own care needs.

The assessor must provide documentation to support the determination. An example of the adequate documentation would look like the following:

NFCE: Has a medical condition of cerebral palsy diagnosed by a physician that is exhibited by generalized muscular weakness, spasticity in upper extremities, and tremors. She requires monitoring her skin for breakdown, monitoring of medications for side effects, hands-on assistance with a wheelchair/walker mobility and transfer, has bladder and bowel incontinence since she is not able to manage her incontinence and requires total assistance with ADLs.

NFI: Has a medical condition diagnosed by a physician, that includes Asthma, Gastro-esophageal Reflux disease, Osteoarthritis and severe burning of the feet. He is independent with ADLs, other than being slow and needing assistance with getting in and out of shower/bath, walks independently with a cane, can do some IADLs, such as

preparing his meals. He manages his own medications and needs assistance with housework and shopping.

Questions 5: Individual is recommended NFCE:

True or False (Response is model generated)

Question 6: Recommended Tier for NFCE Consumers. If 0, consumer is recommended NFI.

Numeric response is model generated.

Question 7: Are the assessor and the model clinical eligibility results the same? If False, document reasons in NOTES.

True or False (Response is model generated)

If the response is False, review the documentation in the tool. Ensure that you completed the tool as indicated in the LCD instructions.

Note: Medical conditions captured in the Notes section will not be reflected in the model-generated response.

Question 8: Document the reason(s) why assessor disagrees with indicator:

Provide a summary of the individual's condition that supports the level of care determined and indicate how this determination was not captured in the model.

13.B. INDIVIDUAL'S PLACE OF SERVICE PREFERENCE

Question 1: Does the individual want to be served in the community?

Select the correct response.

Question 2: Having been determined NFI, what is the individual's PREFERRED RESIDENTIAL setting?

Select the correct response. Check one box only. If *Other*, document details in the Notes section.

Question 3: Having been determined NFI, what is the individual's PREFERRED COMMUNITY Service Program?

Select the correct response. Check one box only. If *Other*, document details in the Notes section.

13.C. LEVEL OF CARE AUTHENTICATION

Question 1: Name of the assessor completing this assessment:

Document the assessor's first and last name.

Question 2: Date of assessor's signature:

Using the MM/DD/YYYY format, document the date the assessor signed the LCD.

Question 3: Name of Registered Nurse reviewing the assessment for Clinical Eligibility:

Document the name of the registered nurse who reviewed the assessment for clinical eligibility.

Question 4: Date of Registered Nurse review:

Using the MM/DD/YYYY format, indicate the date the registered nurse reviewed the assessment.

Question 5: Name of assessment supervisor who reviewed and approved the Level of Care:

Document the name of the supervisor who reviewed and approved the final Level of Care Determination.

Question 6: Date the assessment Supervisor approved the assessment:

Using the MM/DD/YYYY format, indicate the date the assessment supervisor reviewed and approved the assessment.

Question 7: Date the Level of Care is being issued:

Using the MM/DD/YYYY format, indicate the date the Level of Care is issued. This is the date that the supervisor determines that the LCD is fully completed, and the Level of Care Determination Form is sent to the appropriate entities.

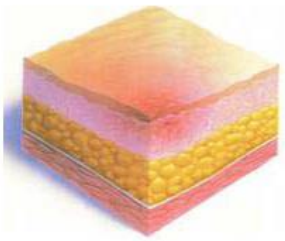
Pressure Ulcer Staging

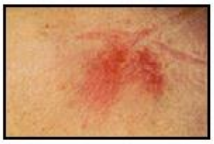
Wound Consultants, Inc

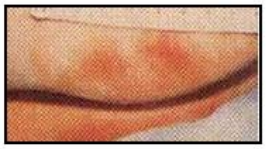
Pressure Ulcer Staging

Stage I:

An observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching). The ulcer appears as a defined area of persistent redness in lightly pigmented skin, whereas in darker skin tones, the ulcer may appear with persistent red, blue, or purple hues.

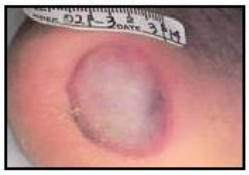


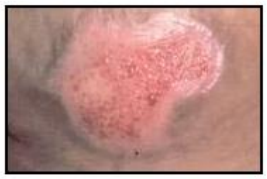


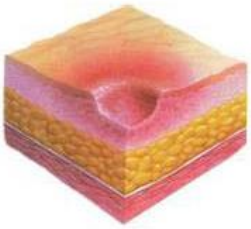


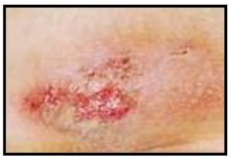
Stage II:

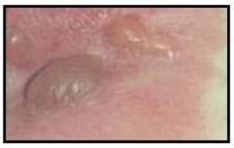
Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister or shallow crater.





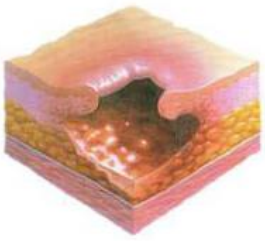


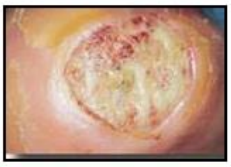


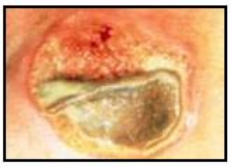


Stage III:

Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.

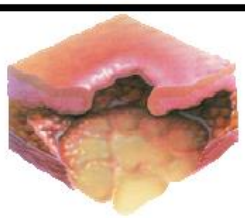






Stage IV:

Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g. tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.



Eschar

Thick dry black necrotic tissue – Unstageable