

CARE LEVEL DETERMINATION WORKSHEET (FOR NURSING FACILITIES)

Completion of this form is voluntary. Personally identifiable information will be used to determine the level of care for Medicaid reimbursement and will be used for no other purpose. Refer to the Long Term Care Resident Assessment Instrument User's Manual, for assistance when completing this form. Complete and submit this form to your Office of Quality Assurance Regional Office.

AA.1. Resident Name			AA.5a. Social Security Number					
a. (First) b. (Middle Initial) c. (Last) d. (Jr./Sr.)			AA.5b. Medicare Number					
SECTION AB 10. CONDITIONS RELATED TO MR/DD STATUS			SECTION H.2. BOWEL ELIMINATION PATTERN					
Not applicable - no MR/DD		a.	Constipation	b.				
MR/DD with Organic Condition			Diarrhea	c.				
Down's Syndrome		b.	Fecal Impaction	d.				
Autism		c.	SECTION I. DISEASE DIAGNOSES					
Epilepsy		d.	Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses.)					
Other organic condition related to MR/DD		e.						
MR/DD with no organic condition		f.	1.DISEASES					
SECTION E. MOOD AND BEHAVIOR PATTERNS			ENDOCRINE/METABOLIC/ NUTRITIONAL					
Indicators of Depression, Anxiety, Sad Mood	(Code for indicators observed in last 30 days, irrespective of the assumed cause) 0 = Indicator not exhibited in last 30 days 1 = Indicator of this type exhibited up to five days a week 2 = Indicator of this type exhibited daily or almost daily (6, 7 days a week)		Diabetes mellitus	a.	Multiple Sclerosis	w.		
			Hyperthyroidism	b.	Paraplegia	x.		
			Hypothyroidism	c.	Parkinson's disease	y.		
			HEART/CIRCULATION		Arteriosclerotic heart disease (ASHD)	d.	Quadruplegia	z.
			a. Resident made negative statements, e.g., "Nothing matters; Would rather be dead; What's the use; regrets having lived so long; Let me die"		Cardiac dysrhythmias	e.	Seizure disorder	aa.
					Congestive heart failure	f.	Transient ischemic attack (TIA)	bb.
			d. Persistent anger with self or others, e.g., easily annoyed, anger at placement in nursing home; anger at care received.		Deep vein thrombosis	g.	Traumatic brain injury	cc.
					Hypertension	h.	PSYCHIATRIC/MOOD	
			h. Repetitive health complaints, e.g., persistently seeks medical attention, obsessive concern with body functions		Hypotension	i.	Anxiety disorder	dd.
					Peripheral vascular disease	j.	Depression	ee.
i. Repetitive anxious complaints/concerns (non health related), e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues		Other cardiovascular disease	k.	Manic depression (bipolar disease)	ff.			
		MUSCULOSKELETAL		Schizophrenia	gg.			
n. Repetitive physical movements, e.g., pacing, hand wringing, restlessness, fidgeting, picking		Arthritis	l.	PULMONARY				
		Hip fracture	m.	Asthma	hh.			
G.B. ADL SUPPORT PROVIDED (Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification.)			Missing limb (e.g. amputation)	n.	Emphysema/COPD	ii.		
			Osteoporosis	o.	SENSORY			
See (A) SELF PERFORMANCE codes See (B) SUPPORT PROVIDED codes		(A) self perf.	(B) support	Pathological bone fracture	p.	Cataracts	jj.	
				NEUROLOGICAL		Diabetic retinopathy	kk.	
a. Bed Mobility				Alzheimer's disease	q.	Glaucoma	ll.	
				OTHER		Macular degeneration	mm.	
b. Transfer				Aphasia	r.	Allergies	nn.	
				Cerebral Palsy	s.	Anemia	oo.	
e. Locomotion – on unit				Cerebrovascular accident (stroke)	t.	Cancer	pp.	
				Dementia other than Alzheimer's disease	u.	Renal Failure	qq.	
f. Locomotion – off unit				Hemiplegia/Hemiparesis	v.			
g. Dressing								
h. Eating								
i. Toilet Use								
j. Personal Hygiene								

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SECTION I.3. - OTHER CURRENT DIAGNOSES										
a.										
b.										
c.										
d.										
e.										
SECTION J.1. - PROBLEM CONDITIONS (Check all problems present in last 7 days unless another time frame is indicated.)					SECTION M. SKIN CONDITION					
Dizziness/vertigo	f.	Recurrent lung aspiration in the last 90 days	k.	1.	ULCERS (Due to any cause)	(Record the number of ulcers at each ulcer stage - regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days . Code 9 = 9 or more.) [Requires full body exam.]	# at Stage			
Edema	g.	Shortness of breath	l.					a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.		
Fever	h.	Syncope (fainting)	m.					b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister or shallow crater.		
Hallucinations	i.	Vomiting	o.					c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.		
Internal bleeding	j.							d. Stage 4. A full thickness of skin and subcutaneous tissue is lost exposing muscle or bone.		
SECTION J. - PAIN SYMPTOMS					4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT	Check all that apply during last 7 days			
2. PAIN DAILY							Abrasions, bruises	a.		
SECTION J.3. - PAIN SITE							Burns (second or third degree)	b.		
Joint pain (other than hip)				g.			Open lesions other than ulcers, rashes, cuts, e.g., cancer lesions.	c.		
SECTION K.5. - NUTRITIONAL APPROACHES							Rashes, e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster.	d.		
Feeding tube				b.	Skin desensitized to pain or pressure	e.				
SECTION P. 1a. - SPECIAL CARE					OTHER SKIN PROBLEMS OR LESIONS PRESENT	Skin tears or cuts (other than surgery)	f.			
Chemotherapy	a.	Suctioning	l.	Record the number of days and total minutes each of the following therapies was administered (for at least 15 min./day) in the last 7 calendar days. (Enter 0 if none or less than 15 minutes daily.) NOTE - count only post admission therapies. (A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in last 7 days						
Dialysis	b.	Tracheostomy care	j.							
IV Medications	c.	Transfusions	k.							
Oxygen therapy	g.									
Radiation	h.									
SECTION P. 1b - THERAPIES										
				DAYS (A)	MIN. (B)					
a. Speech - language pathology & audiology services										
b. Occupational therapy										
c. Physical therapy										
d. Respiratory therapy										
e. Psychological therapy (by any licensed mental health professional)										
COMMENTS										
PERSON COMPLETING THIS FORM										
SIGNATURE					Title			Date Signed		