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 Division of Quality Assurance Regional Office.

AA.1. Resident Name				AA.5a. Social Security Number
a. First	b. MI	c. Last	d. Jr/Sr	AA.5b. Medicare Number

SECTION AB 10. CONDITIONS RELATED TO MR/DD STATUS	
No MR/DD – Not Applicable	a.
MR/DD with Organic Condition	
Down's Syndrome	b.
Autism	c.
Epilepsy	d.
Other organic condition related to MR/DD	e.
MR/DD with No Organic Condition	f.

SECTION E. MOOD AND BEHAVIOR PATTERNS

Indicators of Depression, Anxiety, Sad Mood

Code for indicators observed in last 30 days, irrespective of 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)

Resident made negative statements *(e.g., "Nothing matters." "Would rather be dead." "What's the use?" Regrets having lived so long; "Let me die.")*	a.
Persistent anger with self or others *(e.g., easily annoyed, anger at placement in nursing home, anger at care received)*	d.
Repetitive health complaints *e.g., persistently seeks medical attention, obsessive concern with body functions)*	h.
Repetitive anxious complaints/concerns (non health related) *(e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues)*	l.
Repetitive physical movements *(e.g., pacing, hand wringing, restlessness, fidgeting, picking)*	n.

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.)

See (A) **Self Performance** codes See (B) **Support Provided** codes	(A) Self Perf.	(B) Support
Bed Mobility	a.	a.
Transfer	b.	b.
Locomotion – on unit	e.	e.
Locomotion – off unit	f.	f.
Dressing	g.	g.
Eating	h.	h.
Toilet Use	l.	l.
Personal Hygiene	j.	j.

SECTION H.2. BOWEL ELIMINATION PATTERN

Constipation	b.
Diarrhea	c.
Fecal Impaction	d.

SECTION I. DISEASE DIAGNOSES

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.

1. DISEASES

Endocrine / Metabolic / Nutritional		Hemiplegia / Hemiparesis	v.
Diabetes mellitus	a.	Multiple Sclerosis	w.
Hyperthyroidism	b.	Paraplegia	x.
Hypothyroidism	c.	Parkinson's disease	y.
Heart / Circulation		Quadriplegia	z.
Arteriosclerotic heart disease (ASHD)	d.	Seizure disorder	aa.
Cardiac dysrhythmias	e.	Transient ischemic attack (TIA)	bb.
Congestive heart failure	f.	Traumatic brain injury	cc.
Deep vein thrombosis	g.	**Psychiatric / Mood**	
Hypertension	h.	Anxiety disorder	dd.
Hypotension	l.	Depression	ee.
Peripheral vascular disease	j.	Manic depression *(bipolar disease)*	ff.
Other cardiovascular disease	k.	Schizophrenia	gg.
Musculoskeletal		**Pulmonary**	
Arthritis	l.	Asthma	hh.
Hip fracture	m.	Emphysema / COPD	ii.
Missing limb *(e.g., amputation)*	n.	**Sensory**	
Osteoporosis	o.	Cataracts	jj.
Pathological bone fracture	p.	Diabetic retinopathy	kk.
Neurological		Glaucoma	ll.
Alzheimer's disease	q.	Macular degeneration	mm.
Aphasia	r.	**Other**	
Cerebral Palsy	s.	Allergies	nn.
Cerebrovascular accident *(stroke)*	t.	Anemia	oo.
Dementia other than Alzheimer's disease	u.	Cancer	pp.
		Renal Failure	qq.

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.

Dizziness / vertigo	f.	Recurrent lung aspiration in the last 90 days	k.
Edema	g.	Shortness of breath	l.
Fever	h.	Syncope *(fainting)*	m.
Hallucinations	I.	Vomiting	o.
Internal bleeding	j.		

SECTION J. - PAIN SYMPTOMS

2. Pain Daily	

SECTION J.3. PAIN SITE

Joint pain *(other than hip)*	g.

SECTION K.5. NUTRITIONAL APPROACHES

Feeding tube	b.

SECTION P. 1a. SPECIAL CARE

Chemotherapy	a..	Suctioning	l.
Dialysis	b.	Tracheostomy care	j.
IV Medications	c.	Transfusions	k.
Oxygen therapy	g.		
Radiation	h.		

SECTION P. 1b THERAPIES

- 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) No. of Days Administered for 15 Min. or More (B) Total No. of Minutes Provided in Last 7 Days	Days (A)	Minutes (B)
a. Speech *(language pathology and audiology services)*		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy *(by any licensed mental health professional)*		

SECTION M. SKIN CONDITION

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.**

		Number at Stage
Stage 1	A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	a.
Stage 2	A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	b.
Stage 3	A full thickness of skin is lost, exposing the subcutaneous tissues; presents as a deep crater with or without undermining adjacent tissue.	c.
Stage 4	A full thickness of skin and subcutaneous tissue is lost exposing muscle or bone.	d.

4. Other Skin Problems or Lesions Present

Check all that apply during last 7 days.

Abrasions, bruises	a.
Burns *(second or third degree)*	b.
Open lesions other than ulcers, rashes, cuts *(e.g., cancer lesions)*	c.
Rashes *(e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster)*	d.
Skin desensitized to pain or pressure	e.
Skin tears or cuts *(other than surgery)*	f.
Surgical wounds	g.
NONE OF THE ABOVE	h.

COMMENTS

PERSON COMPLETING THIS FORM

SIGNATURE – Person Completing this Form	Title	Date Signed