

CLIENT FACE SHEET

The Client Face Sheet contains fundamental information about the client. Information from sections in the face sheet that are designated by an asterisk (*) next to the section number are automatically entered into the assessment.

A. NAME AND ID NUMBERS

*1. Name of Client	Blue	James	Test
	a. (Last/Family Name)	b. (First Name)	c. (Middle Name)
*2. Case Record No.			
*3. Government Pension And Health Insurance Numbers	a. Social Security Number: 0 0 0 - 3 3 - 3 3 3 3 b. Medicaid Number c. Primary Private Insurance Number d. Veterans Administration Number e. Medicare number (or comparable railroad insurance number): f. Medicaid Card Control Number (CCN)		

B. ASSIGN ORGANIZATIONAL LEVELS RESPONSIBLE FOR CLIENT

1. First Level	Program Name/Service	2
	0. Unassigned 1. ADHC 2. EDA 3. PCA 4. RFSR 5. LT-PCS 6. PAS 7. PACE 8. ARCP 9. NF	
2. Second Level	Region Number	2
3. Third Level	Case Management/Program Agency	00000
4. Fourth Level	MDS-HC Assessor	LK
5. Fifth Level	Where Conducted	1
	1. Home 2. Nursing Home 3. Hospital 4. ICF/DD 5. PACE 6. ADHC 7. ARCP 8. Telephone	

C. PERSONAL INFORMATION

*1. Gender	1. Male	2. Female	
*2. Birthdate	0 4	1 8	1 9 7 7
	Month	Day	Year
*3. Race / Ethnicity	0. No 1. Yes (Answer All)		
	Race: a. American Indian/ Alaskan Native b. Asian c. Black / African Amer	d. Native Hawaiian or other Pacific Islander e. White f. Hispanic or Latino	0 0 0
*4. Marital Status	1. Never married	3. Widowed	5. Divorced
	2. Married	4. Separated	6. Other
*5. Language	Primary Language		0
	0. English	1. Spanish	2. French 3. Other
*6. Education (Highest Level Completed)	1. No Schooling 2. 8th grade or less 3. 9 - 11 grades 4. High school		5. Technical or trade school 6. Some college 7. Bachelor's degree 8. Graduate degree
*7. Responsibility / Advanced Directives	(Code for responsibility/advanced directives)		
	0. No 1. Yes		
	a. Client has a legal guardian		0
	b. Client has advanced medical directives in place. (for example, a do not hospitalize order)		0

D. GOALS / REFERRAL ITEMS (Completed at Intake Only)

*1. Date Case Opened/ Reopened	1 2	0 9	2 0 0 9
	Month	Day	Year

*2. Reason For Referral	1. Post hospital care 2. Community chronic care 3. Home placement screen	4. Eligibility for home care 5. Day Care 6. Other	4
*3. Goals Of Care	(Code for client/family understanding of goals of care)		
	0. No 1. Yes (Answer All)		
	a. Skilled nursing treatments	0	d. Client/family education
	b. Monitoring to avoid complications	1	e. Family respite
	c. Rehabilitation	0	f. Palliative care
*4. Time since Last Hospital Stay	Time since discharge from last in-patient setting (Code for most recent instance in LAST 180 DAYS)		0
	0. No hospitalization within 180 days 1. Within last week 2. Within 8 to 14 days 3. Within 15 to 30 days 4. More than 30 days ago		
*5. Where Lived At Time Of Referral	1. Private home/apt. with no home care services 2. Private home/apt. with home care services 3. Board and care / assisted living / ICF/DD 4. Nursing home 5. Other		1
*6. Who Lived With At Referral	1. Lived alone 2. Lived with spouse only 3. Lived with spouse and other(s) 4. Lived with child (not spouse) 5. Lived with other(s) (Not spouse or children) 6. Lived in group setting with non-relative(s)		1
7. Prior NH Placement	Resided in a nursing home at anytime d/ 5 YEARt prior to case opening		0
	0. No 1. Yes		
*8. Residential History	Moved to current residence within last two years		0
	0. No 1. Yes		
9. Denial Date	Month Day Year		
10. Denial Reason	Reasons for denial:		
	1. Level of Care not met 2. Imminent Risk criteria not met 3. Timely and complete packet not submitted by Nursing Facility		

E. CONTACT INFORMATION

1. Client Contact Info	a. Address 1: 555 Home Care Lane b. Address 2: c. City: Baton Rouge d. State: LA e. Zip: 70817 f. Home Tel: 777-7777 g. Work Tel: h. Cell Tel: i. Fax Tel: j. E-Mail: k. Directions: l. Facility m. Parish n. Mailing Address Name: o. Address 1: p. Address 2: q. City: r. State: s. Zip:		
2. Emergency Contact Info	a. Name: Betty Test b. Address 1: 656 Lane Drive c. Address 2: d. City: Baton Rouge e. State: LA f. Zip: 70817 g. Home Tel: 666-7878 h. Work Tel: j. Cell Tel: k. Fax Tel: l. E-mail:		

3.	Primary Physician Contact Info	a. Name	Dr. Frequent Flyer				
		b. Address 1:	8888 Tidy Ave.				
		c. Address 2:					
		d. City:	Baton Rouge	e. State:	LA	f. Zip:	70817
		g. Home Tel:		h. Work Tel:	999-8787		
		i. Pager Tel:		j. Fax Tel:			
		k. E-mail					
		4.	Other Contact Info	Type of Other Contact			
				1. Personal Representative			
				2. Tutor			
3. Curator							
4. Power of Attorney							
5. Other							
Specify:	Mother						
a. Name	Sally Fields						
b. Address 1:	656 Nursery Lane						
c. Address 2:							
d. City:	Baton Rouge	e. State:	LA	f. Zip:	70817		
g. Home Tel:	444-3333	h. Work Tel:					
i. Cell Tel:		j. Fax Tel:					
k. E-mail							

NOTEBOOK - General Notes on Client

12/9/2009 11:26:52 PM - Loida Kellgren
 Sally Fields, Mr. Blue's mother, was present at the time of the assessment and provided information, along with Mr. Blue.

MINIMUM DATA SET - HOME CARE (MDS-HC)
 Unless otherwise noted, score for last 3 days
 Examples of exceptions include IADLs / Continence / Services / Treatments
 where status scored over last 7 days

RUG SCORES

Impaired Cognition 4 5.12 (IA_2)
 RUG Category ADL RUG III Scoring

SECTION AA. NAME AND IDENTIFICATION NUMBERS

1. Name of Client	Blue James T
	a. (Last/Family Name) b. (First Name) c. (Middle Name)
2. Case Record No.	
3. Government Pension And Health Insurance Numbers	a. Pension (Social Security) Number 0 0 0 - 3 3 - 3 3 3 3 b. Health insurance number (of other comparable insurance number)

SECTION BB. PERSONAL ITEMS (Complete at Intake Only)

1. Gender	1. Male 2. Female	
2. Birthdate	0 4 - 1 8 - 1 9 7 7 Month Day Year	
3. Race / Ethnicity	0. No 1. Yes (Answer All) Race: a. American Indian/Alaskan Native 0 b. Asian 0 c. Black / African Amer 1 d. Native Hawaiian or other Pacific Islander 0 e. White 0 f. Hispanic or Latino 0 Ethnicity:	
4. Marital Status	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced 6. Other	1
5. Language	Primary Language 0. English 1. Spanish 2. French 3. Other	0
6. Education (Highest Level Completed)	1. No Schooling 2. 8th grade or less 3. 9 - 11 grades 4. High school 5. Technical or trade school 6. Some college 7. Bachelor's degree 8. Graduate degree	4
7. Responsibility / Advanced Directives	(Code for responsibility/advanced directives) 0. No 1. Yes a. Client has a legal guardian 0 b. Client has advanced medical directives in place. (for example, a do not hospitalize order) 0	

SECTION CC. REFERRAL ITEMS (Complete at Intake Only)

1. Date Case Opened/Reopened	1 2 - 0 9 - 2 0 0 9 Month Day Year	
2. Reason For Referral	1. Post hospital care 2. Community chronic care 3. Home placement screen 4. Eligibility for home care 5. Day Care 6. Other	4
3. Goals Of Care	(Code for client/family understanding of goals of care) 0. No 1. Yes (Answer All) a. Skilled nursing treatments 0 b. Monitoring to avoid complications 1 c. Rehabilitation 0 d. Client/family education 0 e. Family respite 0 f. Palliative care 0	
4. Time since Last Hospital Stay	Time since discharge from last in-patient setting (Code for most recent instance in LAST 180 DAYS) 0. No hospitalization within 180 days 1. Within last week 2. Within 8 to 14 days 3. Within 15 to 30 days 4. More than 30 days ago	0
5. Where Lived At Time Of Referral	1. Private home/apt. with no home care services 2. Private home/apt. with home care services 3. Board and care/assisted living/group home 4. Nursing home 5. Other	1
6. Who Lived With At Referral	1. Lived alone 2. Lived with spouse only 3. Lived with spouse and other(s) 4. Lived with child (not spouse) 5. Lived with other(s) (Not spouse or children) 6. Lived in group setting with non-relative(s)	1

7. Prior NH Placement	Resided in a nursing home at anytime d. 5 YEAR: prior to case opening 0. No 1. Yes	0
8. Residential History	Moved to current residence within last two years 0. No 1. Yes	0

SECTION A. ASSESSMENT INFORMATION

1. Assessment Reference Date	Date of assessment 0 7 - 1 5 - 2 0 1 0 Month Day Year	
2. Reasons For Assessment	Type of assessment 1. Initial Assessment 2. Follow-up assessment 3. Routine assessment at fixed intervals 4. Review within 30-day period prior to discharge from program 5. Review at return from hospital 6. Change in status 7. Other	1
3. Time To Next Assessment	Number of days or months until next assessment is due 0. Follow up assessment not required 1. 30 days 5. 5 months 2. 60 days 6. 6 months 3. 90 days 7. 9 months 4. 4 months 8. 1 year	8

SECTION B. COGNITIVE PATTERNS

1. Memory Recall Ability	(Code for recall of what was learned or known) 0. Memory OK 1. Memory problem a. Short-term memory OK -- seems/appears to recall after 5 min. b. Procedural memory OK -- Can perform all or almost all steps in a multitask sequence without cues for initiation	1
2. Cognitive Skills For Daily Decision Making	a. How well client made decisions about organizing the day (e.g., when to get up or have meals, which clothes to wear or activities to do) 0. INDEPENDENT -- Decisions consistent/reasonable/safe 1. MODIFIED INDEPENDENT -- Some difficulty in new situations only 2. MINIMALLY IMPAIRED -- In specific situations, decisions are poor / unsafe and cues/supervision needed at those times 3. MODERATELY IMPAIRED -- Decision consistently poor or unsafe, cues/supervision required at all times 4. SEVERELY IMPAIRED -- Never/rarely made decisions b. Worsening of decision making as compared to 90s DAYS AGO (or since last assessment if less than 90 days) 0. No 1. Yes	2
3. Indicators Of Delirium	a. Sudden or new change in mental function LAST 7 DAYS (including ability to pay attention, awareness of surroundings, being coherent, unpredictable variation over course of day) 0. No 1. Yes b. LAST 90 DAY (or since last assessment if less than 90 days), client has become agitated or disoriented such that their safety is endangered or they require protection by others 0. No 1. Yes	0

SECTION C. COMMUNICATION/HEARING PATTERNS

1. Hearing	(With hearing appliance if used) 0. HEARS ADEQUATE -- Normal talk, TV, phone, doorbell 1. MINIMAL DIFFICULT -- When not in quiet setting 2. HEARS IN SPECIAL SITUATIONS ONLY -- Speaker has to adjust tonal quality and speak distinctly 3. HIGHLY IMPAIRED -- Absence of useful hearing	0
2. Making Self Understood (Expression)	(Expressing information content -- however able) 0. UNDERSTOOD -- Expresses ideas without difficulty 1. USUALLY UNDERSTOOD -- Difficulty finding words or finishing thoughts, BUT, if given time, little or no prompting required 2. OFTEN UNDERSTOOD -- Difficulty finding words or finishing thoughts, prompting usually required 3. SOMETIMES UNDERSTOOD -- Ability is limited to making concrete requests 4. RARELY / NEVER UNDERSTOOD	0
3. Ability To Understand Others (Comprehension)	(Understands verbal information -- however able) 0. UNDERSTAND -- Clear comprehension 1. USUALLY UNDERSTAND -- Misses part/intent of message, BUT, comprehends most conversation with little/no prompting 2. OFTEN UNDERSTAND -- Misses some part/intent of message; with prompting can often comprehend conversation 3. SOMETIMES UNDERSTAND -- Responds adequately to simple, direct communication 4. RARELY / NEVER UNDERSTANDS	0
4. Communication Decline	Worsening in communication (making self understood or understanding others) as compared to 90 DAYS AGO (or since last assessment if less than 90 days) 0. No 1. Yes	0

SECTION D. VISION PATTERNS

1. Vision	(Ability to see in adequate light and with glasses if used) 0. ADEQUATE -- Sees fine detail, including regular print in newspapers / books 1. IMPAIRED -- Sees large print, but not regular print in newspapers / books 2. MODERATELY IMPAIRED -- Limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY IMPAIRED -- Object identification in question, but eyes appear to follow objects 4. SEVERELY IMPAIRED -- No vision or sees only light, colors, or shapes; eyes do not appear to follow objects	0
2. Visual Limitation/Difficulties	Saw halos or rings around lights, curtains over eyes, or flashes of lights 0. No 1. Yes	0
3. Vision Decline	Worsening of vision as compared to status: 90 DAYS AGO (or since last assessment if less than 90 days) 0. No 1. Yes	0

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. Indicators Of Depression, Anxiety, Sad Mood	(Code for observed indicators irrespective of assumed cause) 0. Indicator not exhibited in last 3 days 1. Exhibited 1-2 of last 3 days 2. Exhibited on each of last 3 days a. A Feeling Of Sadness Or Being Depressed life is not worth living, nothing matters, that he or she is of no use to anyone or would rather be dead. 1 b. Persistent Anger With Self Or Others -- e.g., easily annoyed, anger at care received 0 c. Expressions of What Appear To Be Unrealistic Fears -- e.g., fear of being abandoned, left alone, being with others 0 d. Repetitive Health Complaints -- e.g., persistently seeks medical attention, obsessive concern with body functions 0 e. Repetitive Anxious Complaints, Concern -- e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues 0 f. Sad, Pained, Worried Facial Expressions-- e.g., Furrowed brows 1 g. Recurrent Crying, Tearfulness 0 h. Withdrawal From Activities Of Interest-- e.g., no interest in long standing activities or being with family / friends 0 i. Reduced Social Interaction 0	0
2. Mood Decline	Mood indicators have become worse as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days) 0. No 1. Yes	0
3. Behavioral Symptoms	Instances when client exhibited behavioral symptoms. If Exhibited, ease of altering the symptom when it occurred 0. Did not occur in last 3 days 1. Occurred, easily altered 2. Occurred, not easily altered a. WANDERIN: -- Moved without rational purpose, seemingly oblivious to needs or safety 0 b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS-- Threatened screamed at, cursed at others 0 c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS-- Hit, shoved, scratched, sexually abused others 0 d. SOCIALLY INAPPROPRIATE / DISRUPTIVE BEHAVIORAL SYMPTOMS -- Disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smears/throws food/feces, rummaging, repetitive behavior, rises early and causes disruption 0 e. RESISTS CAR -- Resisted taking medications / injections, ADL assistance, eating, or changes in position 0	0
4. Changes In Behavior Symptoms	Behavioral symptoms have become worse or are less well tolerated by family as compared 90 DAYS AG (or since last assessment if less than 90 days) 0. No, or no change 1. Yes	0

SECTION F. SOCIAL FUNCTIONING

1. Involvement	a. At ease interacting with others (e.g., enjoys time with others) 0. At ease 1. Not at ease b. Openly expresses conflict or anger with family / friends 0. No 1. Yes	0
2. Change In Social Activities	As compared to 90 DAYS AG (or since last assessment if less than 90 days ago), decline in the client's level of participation in social, religious, occupational or other preferred activities. IF THERE WAS A DECLINE, client distressed by this fact 0. No decline 1. Decline, not distressed 2. Decline, distressed	0
3. Isolation	a. Length of time client is alone during day (morning, afternoon) 0. Never or hardly ever 1. About one hour 2. Long periods of time -- e.g., all morning 3. All of the time b. Client says or indicates that he / she feels lonely 0. No 1. Yes	3

SECTION G. INFORMAL SUPPORT SERVICES

1. Two Key Informal Helpers	NAME OF PRIMARY AND SECONDARY HELPERS Fields Sally a. (Last / Family Name) b. (First) Test Betty c. (Last / Family Name) d. (First) (A) (B) Prim Secn 0 0 e. Lives with client 0. Yes 1. No 2. No such helper [skip other items in the appropriate column] f. Relationship to client 0. Child or child-in-law 2. Other Relative 4. None 1. Spouse 3. Friend / neighbor 0. Yes 1. No g. Advice or emotional support 0 0 h. IADL care 0 0 i. ADL care 0 1 If needed, willingness (with ability) to increase help: 0. More than 2 hours 1. 1-2 hours per day 2. No j. Advice or emotional support 1 2 k. IADL care 1 2 l. ADL care 1 2 m. Disabled 1 0 0. No 1. Yes n. Date of Birth (A) 0 2 / 2 1 / 1 9 4 0 Month Day Year (B) 0 8 / 0 1 / 1 9 8 6 Month Day Year
2. Caregiver Status	0. No 1. Yes a. A caregiver is unable to continue in caring activities--e.g., decline in the health of the caregiver makes it difficult to continue 1 b. Primary caregiver is not satisfied with support received from family and friends (e.g., other children of client) 0 c. Primary caregiver expresses distress, anger or depression 0
3. Extent Of Informal Help (Hours Of Care, Rounded)	For instrumental and personal activities of daily living received over the LAST 7 DAYS indicate extent of help from family, friends, and neighbors HOURS a. Sum of time across five weekdays 1 5 b. Sum of time across two weekend days 8

SECTION H. PHYSICAL FUNCTIONING
IADL PERFORMANCE IN 7 DAYS
ADL PERFORMANCE IN 3 DAYS

1.	IADL Self Performance	Code for functioning in routine activities around the home or in the community during LAST 7 DAYS		
		(A) IADL SELF PERFORMANCE CODE (Code for client's performance during LAST 7 DAYS)		
		0. INDEPENDEN - did on own		
		1. SOME HELP - help some of the time		
		2. FULL HELP - performed with help all of the time		
		3. BY OTHERS - performed by others		
		8. ACTIVITY DID NOT OCCUR		
		(B) IADL DIFFICULTY CODE (How difficult it is, or would it be, for client to do activity on own)		
		0. NO DIFFICULTY		
		1. SOME DIFFICULT - e.g., needs some help, is very slow, or fatigued		
2. GREAT DIFFICULT - e.g., little or no involvement in the activity is possible				
	(A)	(B)		
a. MEAL PREPARATIOI - How meals are prepared (e.g., planning meals cooking, assembling ingredients, setting out food, utensils)	3	2		
b. ORDINARY HOUSE WOF - How ordinary work around the the house is performed (e.g., doing dishes, dusting, making bed, tidying up, laundry)	1	1		
c. MANAGING FINANC - How bills are paid, checkbook is balanced household expenses are balanced	3	1		
d. MANAGING MEDICATIC - How medications are managed (e.g., remembering to take medicines, opening bottles taking correct drug dosages, giving injections, applying ointments)	3	1		
e. PHONE USI - How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification)	0	0		
f. SHOPPING - How shopping is performed for food and household items (e.g., selecting items, managing money)	3	1		
g. TRANSPORTATIC - How client travels by vehicle (e.g., gets to places beyond walking distance)	3	1		
2.	ADL Self Performance	The following address the client's physical functioning in routine personal activities of daily life, for example, dressing, eating, etc. during the LAST 3 DAYS considering all episodes of these activities. For clients who performed an activity independently, be sure to determine and record whether others encouraged the activity or were present to supervise or oversee the activity. (NOTE - For bathing, code for most dependent single episode in LAST 7 DAYS)		
		0. INDEPENDEN -- No help, setup, or oversight -- OR -- Help, setup, oversight provided only 1 or 2 times (with any task or subtask)		
		1. SETUP HELP ONL -- Article or device provided within reach of client 3 or more times		
		2. SUPERVISIOI -- Oversight, encouragement or cueing provided 3 or more times during last 3 days -OR- Supervision (1 or more times) plus physical assistance provided only 1 or 2 times (for a total of 3 or more episodes of help or supervision)		
		3. LIMITED ASSISTANC -- Client highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times -OR- Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help)		
		4. EXTENSIVE ASSISTANC -- Client performed part of activity on own (50% or more of subtasks), but help of following type(s) were provided 3 or more times: -- Weight-bearing support -- OR -- -- Full performance by another during part (but not all) of last 3 days		
		5. MAXIMAL ASSISTANC -- Client involved and completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times		
		6. TOTAL DEPENDENC -- Full performance of activity by another		
		8. ACTIVITY DID NOT OCCI (regardless of ability)		

	a. MOBILITY IN BE -- Including moving to and from lying position, turning side to side, and positioning body while in bed	0
	b. TRANSFER -- Including moving to and between surfaces - to / from bed, chair, wheelchair, standing position [Note--Excludes to / from bath / toilet]	0
	c. LOCOMOTION IN HOME [Note--If in wheelchair, self-sufficiency once in chair]	0
	d. LOCOMOTION OUTSIDE OF HOME [Note--If in wheelchair, self-sufficiency once in chair]	0
	e. DRESSING UPPER BOI -- How client dresses / undresses (street clothes, underwear above waist, includes prostheses, orthotics, fasteners, pullovers, etc.	2
	f. DRESSING LOWER BOD -- How client dresses / undresses (street clothes, underwear from the waist down, includes prostheses, orthotics, belts, pants, skirts, shoes, and fasteners	2
	g. EATING -- Including taking in food by any method, including tube feedings	1
	h. TOILET USI -- Including using the toilet or commode, bedpan urinal, transferring on / off toilet, cleaning self after toilet use or incontinent episode, changing pad, managing special devices required (ostomy or catheter), and adjusting clothes.	0
	i. PERSONAL HYGIEN -- Including combing hair, brushing teeth, shaving applying makeup, washing / drying face and hands (exclude baths and showers)	2
	j. BATHING -- How client takes full-body bath / shower or sponge bath. (EXCLUDI washing of back and hair). Includes how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area. Code for most dependent episode in LAST 7 DAYS	2
3.	ADL Decline ADL status has become worse (i.e., now more impaired in self performance) as compared to st: 90 DAYS AG (or since last assessment if less than 90 days) 0. No 1. Yes	0
4.	Primary Modes Of Locomotion 0. No assistive device 3. Scooter (e.g., Amigo) 1. Cane 4. Wheelchair 2. Walker / Crutch 8. ACTIVITY DID NOT OCCUR	
	a. Indoors	0
	b. Outdoors	0
5.	Stair Climbing In the LAST 3 DAYS how client went up and down stairs (e.g., single or multiple steps, using handrail as needed) 0. Up and down stairs without help 1. Up and down stairs with help 2. Not go up and down stairs	1
6.	Stamina a. In a typical week, during t LAST 30 DAYS (or since last assessment) code the number of days client usually went out of the house or building in which client lives. (no matter how short a time period) 0. Every day 2. 1 day a week 1. 2-6 days a week 3. No days	2
	b. Hours of physical activities in LAST 3 DAYS (e.g., walking, cleaning house, exercise) 0. Two or more hours 1. Less than two hours	1
7.	Functional Potential 0. No 1. Yes (Answer all)	
	a. Client believes he / she capable of increased functional independence (ADL, IADL, mobility)	0
	b. Caregivers believe client is capable of increased functional independence (ADL, IADL, mobility)	0
	c. Good prospects of recovery from current disease or conditions, improved health status expected	0

SECTION I. CONTINENCE IN LAST 7 DAYS

1.	Bladder Continece	a. In LAST 7 DAY control of urinary bladder function (with appliances such as catheters or incontinence program employed) [Note-if dribbles, volume insufficient to soak thru underpants] 0. CONTINENI -- Complete control; DOES NOT USE any type of catheter or other urinary collection device that 1. CONTINENT WITH CATHETE -- Complete control with use of any type of catheter or urinary collection device does not leak urine 2. USUALLY CONTINEA -- Incontinent episodes once a week or less 3. OCCASIONALLY INCONTINEA -- Incontinent episodes 2 or more times a week but not daily 4. FREQUENTLY INCONTINEA -- Tends to be incontinent daily, but some control present 5. INCONTINEN -- Inadequate control, multiple daily episodes 8. DID NOT OCCUR -- No urine output from bladder	2
		b. Worsening of bladder incontinence as compared to status 90 DAYS AG (or since last assessment if less than 90 days) 0. No 1. Yes	0
2.	Bladder Devices	0. No 1. Yes (During Last 7 Days)	
		a. Used pads or briefs to protect against wetness	0
	b. Used an indwelling urinary catheter	0	

3.	Bowel Continence	In LAST 7 DAY control of bowel movement (with appliance or bowel continence program if employed)	0
		0. CONTINENT -- Complete control; DOES NOT USE ostomy device	
		1. CONTINENT WITH OSTOMY -- Complete control with use of ostomy device that does not leak stool	
		2. USUALLY CONTINENT -- Bowel incontinent episodes less than weekly	
		3. OCCASIONALLY INCONTINENT -- Bowel incontinent episodes once a week	
		4. FREQUENTLY INCONTINENT -- Bowel incontinent episodes 2 - 3 times a week	
		5. INCONTINENT -- Bowel incontinent all (or almost all) of time	
		8. DID NOT OCCUR -- No bowel movement during entire 7 day assessment period	

4.	Pain	a. Frequency that client complains or shows evidence of pain	3
		0. No pain (score b-e as 0)	
		1. Less than daily	
		2. Daily - one period	
		3. Daily - multiple periods (e.g., morning and evening)	
		b. Intensity of pain	2
		0. No pain	
		1. Mild	
		2. Moderate	
		3. Severe	
		4. Times when pain is horrible or excruciating	
		c. From client's viewpoint, pain intensity disrupts usual activities	0
		0. No	
		1. Yes	
		d. Character of pain	2
		0. No pain	
		1. Localized - single site	
		2. Multiple sites	
		e. From client's viewpoint, medications adequately control pain	2
		0. Yes or no pain	
		1. Medications do not adequately control pain	
		2. Pain present, medication not taken	

SECTION J. DISEASE DIAGNOSES

Disease / infection that doctor has indicated is present and affects client's status, requires treatment, or symptom management. Also include if disease is monitored by a home care professional or is the reason for a hospitalization LAST 90 DAYS (or since last assessment if less than 90 days)

- 0. Not present
- 1. Present -- not subject to focused treatment or monitoring by home care professional
- 2. Present -- monitored or treated by home care professional

1.	Diseases	Heart / Circulation		p. Osteoporosis	0
		a. Cerebrovascular accident (stroke)	0	Senses	
		b. Congestive heart failure	0	q. Cataract	0
		c. Coronary artery disease	0	r. Glaucoma	0
		d. Hypertension	0	Psychiatric / Mood	
		e. Irregularly irregular pulse	0	s. Any psychiatric diagnosis	0
		f. Periph. vascular disease	0	Infections	
		Neurological		t. HIV infection	1
		g. Alzheimer's	0	u. Pneumonia	0
		h. Dementia other than Alzheimer's disease	0	v. Tuberculosis	0
		i. Head trauma	0	w. Urinary tract infection (in LAST 30 DAYS)	0
		j. Hemiplegia / hemiparesis	0	Other Diseases	
		k. Multiple sclerosis	0	x. Cancer--(in past 5 years) (not including skin cancer)	0
		l. Parkinsonism	0	y. Diabetes	0
		Musculo / Skeletal		z. Emphysema/COPD/asthma	0
		m. Arthritis	0	aa. Renal failure	0
		n. Hip fracture	0	ab. Thyroid disease (Hyper or hypo)	0
		o. Other fractures (e.g., wrist, vertebral)	0		
2.	Other Current Or More Detailed Diagnosis and ICD-9 Codes	a.			
		b.			
		c.			
		d.			

5.	Falls Frequency	Number of times fell LAST 90 DAYS (or since last assessment if less than 90 days) If none, code "0"; if more than 9, code "9"	0
6.	Danger Of Fall	0. No 1. Yes	
		a. Unsteady gait	1
		b. Client limits going outdoors due to fear of falling (e.g., stopped using bus, goes out only with others)	0
7.	Life Style (Drinking / Smoking)	0. No 1. Yes	
		a. In the LAST 90 DAY (or since last assessment if less than 90 days), client felt the need or was told by others to cut down on drinking, or other were concerned with client's drinking	0
		b. In the LAST 90 DAY (or since last assessment if less than 90 days), client had to have a drink in the morning to steady nerves (i.e., "eye opener") or been in trouble due to drinking	0
		c. Smoked or chewed tobacco daily	1
8.	Health Status Indicators	0. No 1. Yes (Answer all)	
		a. Client feels he / she has poor health (when asked)	1
		b. Has conditions or diseases that make cognition, ADL, mood, or behavior patterns unstable (fluctuations, precarious, deteriorating)	0
		c. Experiencing a flare-up of a recurrent or chronic problem	0
		d. Treatments changed LAST 30 DAY: (or since last assessment if less than 30 days) because of new acute episode or condition	0
		e. Prognosis of less than six months to live--e.g., physician has told client or client's family that client has end-stage disease	0
9.	Other Status Indicators	0. No 1. Yes (Answer all)	
		a. Fearful of a family member or caregiver	1
		b. Unusually poor hygiene	0
		c. Unexplained injuries, broken bones, or burns	0
		d. Neglected, abused, or mistreated	0
		e. Physically restrained (e.g., limbs restrained, used bed rails, constrained to chair when sitting)	0

SECTION K. HEALTH CONDITIONS/PREVENTIVE HEALTH MEASURES

1.	Preventive Health (Past Two Years)	0. No 1. Yes (During past 2 years) (Answer all)	
		a. Blood pressure measured	1
		b. Received influenza vaccination	1
		c. Test for blood in stool or screening endoscopy	1
		d. IF FEMALE: Received breast examination or mammography	0
2.	Problem Conditions Present On 2 Or More Days	0. No 1. Yes (During 2 of last 3 days) (Answer all)	
		a. Diarrhea	0
		b. Difficulty urinating or urinating 3 or more times a night.	0
		c. Fever	0
		d. Loss of appetite	0
		e. Vomiting	0
3.	Problem Conditions	0. No 1. Yes (Any time during last 3 days) (Answer all)	
		Physical Health	
		a. Chest pain / pressure at rest or on exertion	0
		b. No bowel movement in 3 days	0
		c. Dizziness or lightheadedness	1
		d. Edema	0
		e. Shortness of breath	1
		Mental Health	
		f. Delusions	0
		g. Hallucinations	0

SECTION L. NUTRITION/HYDRATION STATUS			
1.	Weight	0. No 1. Yes	
		a. Unintended weight loss of 5% or more in LAST 30 DAYS [or 10% or more in the LAST 180 DAY:]	0
		b. Severe malnutrition (Cachexia)	0
		c. Morbid Obesity	0
2.	Consumption	0. No 1. Yes	
		a. In at least 2 of the last 3 day ate one or fewer meals a day	0
		b. In last 3 days noticeable decrease in the amount of food client usually eats or fluids usually consumes	0
		c. Insufficient fluid--did not consume all / almost all fluids during last 3 days	0
		d. Enteral tube feeding	0
3.	Swallowing	0. NORMAL -- Safe and efficient swallowing of all diet consistencies	0
		1. REQUIRES DIET CHANGE TO SWALLOW SOLID FOODS (mechanical diet or able to ingest specific foods only)	
		2. REQUIRES MODIFICATION TO SWALLOW SOLID FOODS AND LIQUIDS (puree, thickened liquids)	
		3. COMBINED ORAL AND TUBE FEEDING	
		4. NO ORAL INTAKE (NPO)	

SECTION M. DENTAL STATUS (ORAL HEALTH)

1.	Oral Status	0. No 1. Yes	
		a. Problem chewing (e.g., poor mastication, immobile jaw, surgical resection, decreased sensation/motor control, pain while eating)	0
		b. Mouth is "dry" when eating a meal	0
		c. Problem brushing teeth or dentures	0

SECTION N. SKIN CONDITION

1.	Skin Problems	Any troubling skin conditions or changes in skin condition (e.g., burns, bruises, rashes, itchiness, body lice, scabies)	0
		0. No 1. Yes	

2.	Ulcers (Pressure/Stasis)	Presence of an ulcer anywhere on the body. Ulcers include: 0. No Ulcer 1. Any area of persistent skin redness 2. Partial loss of skin layers 3. Deep craters in the skin 4. Breaks in skin exposing muscle or bone		
	a. Pressure ulcer -- any lesion caused by pressure, shear forces, resulting in damage of underlying tissues		0	
	b. Stasis ulcer -- open lesion caused by poor circulation in the lower extremities		0	
3.	Other Skin Problems Requiring Treatment	0. No 1. Yes (Answer All)		
	a. Burns (Second/third degree)	0		
	b. Open lesions other than ulcers, rashes, cuts (e.g., cancer)	0		
	c. Skin tears or cuts		0	
	d. Surgical wound		0	
	e. Corns, calluses, structural problems, infections, fungi		0	
4.	History Of Resolved Pressure Ulcers	Client previously had (at any time) or has an ulcer anywhere on the body 0. No 1. Yes		0
5.	Wound/Ulcer Care	Have the following treatments been completed in the last 7 days? 0. No 1. Yes (Answer All)		
	a. Antibiotics, systemic or topical		0	
	b. Dressings		0	
	c. Surgical wound care		0	
	d. Other wound / ulcer care (e.g., pressure relieving device, nutrition, turning, debridement)		0	

SECTION O. ENVIRONMENTAL ASSESSMENT

1.	Home Environment	0. No 1. Yes (Answer all)		
	a. Lighting in evening (including inadequate or no lighting in living room, sleeping room, kitchen, toilet, corridors)		0	
	b. Flooring and carpeting (e.g., holes in floor, electric wires where client walks, scatter rugs)		0	
	c. Bathroom and toiletroom (e.g., non-operating toilet, leaking pipes, no rails though needed, slippery bathtub, outside toilet)		1	
	d. Kitchen (e.g., dangerous stove, operative refrigerator, infestation by rats or bugs)		0	
	e. Heating and cooling (e.g., too hot in summer, too cold in winter, wood stove in a home with an asthmatic)		0	
	f. Personal safety (e.g., fear of violence, safety problem in going to mailbox or visiting neighbors, heavy traffic in street)		0	
	g. Access to home (e.g., difficulty entering / leaving home)		0	
	h. Access to rooms in house (e.g., unable to climb stairs)		0	
2.	Living Arrangement	a. As compared to 90 DAYS AGO (or since last assessment), client now lives with other person -- e.g., moved in with another person, other person moved in with client. 0. No 1. Yes b. Client or primary caregiver feels that client would be better off in another living environment 0. No 1. Caregiver only 2. Client and caregiver		0

SECTION P. SERVICE UTILIZATION (IN LAST 7 DAYS)

1.	Formal Care (Minutes rounded to even 10 minutes)	Extent of care or care management LAST 7 DAYS (or since last assessment if less than 7 days) involving	(A) # of Days	(B) Hours	(C) Mins
	a. Home health aides		0		
	b. Visiting nurses		0		
	c. Homemaking services		0		
	d. Meals		0		
	e. Volunteer services		0		
	f. Physical therapy		0		
	g. Occupational therapy		0		
	h. Speech therapy		0		
	i. Day care or day hospital		0		
	j. Social worker in home		0		

2.	Special Treatments Therapies, Programs	Special treatments, therapies, programs received or scheduled during LAST 7 DAY: (or since last assessment if less than 7 days) and adherence to the required schedule. Includes services received in the home or on an outpatient basis. 0. Not Applicable 1. Scheduled, full adherence as prescribed 2. Scheduled, partial adherence 3. Scheduled, not received		
	Respiratory Treatments			
	a. Oxygen		0	
	b. Respirator for assistive breathing		0	
	c. All other respiratory treatments		0	
	Other Treatments			
	d. Alcohol / drug treatment program		0	
	e. Blood transfusion(s)		0	
	f. Chemotherapy		0	
	g. Dialysis		0	
	h. IV infusion - central		0	
	i. IV infusion - peripheral		0	
	j. Medication by injection		0	
	k. Ostomy care		0	
	l. Radiation		0	
	m. Tracheostomy care		0	
	Therapies			
	n. Exercise therapy			0
	o. Occupational therapy			0
	p. Physical therapy			0
	Programs			
	q. Day center			0
	r. Day hospital			0
	s. Hospice care			0
	t. Physician or clinic visit			1
	u. Respite care			0
	Special Procedures Done In Home			
	v. Daily nurse monitoring (e.g., EKG, urinary output)			0
	w. Nurse monitoring less than daily			0
	x. Medical alert bracelet or electronic security alert			0
	y. Skin treatment			0
	z. Special diet			0
3.	Management Of Equipment (in Last 3 Days)	Management Codes: 0. Not used 1. Managed on own 2. Managed on own if laid out or with verbal reminders 3. Partially performed by others 4. Fully performed by others		
	a. Oxygen		0	
	b. IV		0	
	c. Catheter			0
	d. Ostomy			0
4.	Visits In Last 90 Days Or Since Last Assessment	Enter 0 if none, if more than 9, code "9" a. Number of times ADMITTED TO HOSPITAL with overnight stay b. Number of times VISITED EMERGENCY ROOM without overnight stay c. EMERGENCY CARE -- Including unscheduled nursing, physician, or therapeutic visits to office or home		
	a.			0
	b.			0
	c.			0
5.	Treatment Goals	Any treatment goals that have been met in LAST 90 DAYS (or since last assessment if less than 90 days) 0. No 1. Yes		0
6.	Overall Change In Care Needs	Overall self sufficiency changed significantly compared to status of 90 DAYS AGO (or since last assessment if less than 90 days) 0. No change 1. Improved-- receives fewer supports 2. Deteriorated-- receives more support		0
7.	Trade Offs	Due to limited funds, during last month, client made trade-offs in purchasing any of the following: prescribed medications, sufficient home heat, physician care, adequate food, home care 0. No 1. Yes		0

SECTION Q. MEDICATIONS

1.	Number of Medications	Record the number of different medicines (prescriptions and over the counter), including eye drops, taken regularly or on an occasional basis in the LAST 7 DAYS (or since last assessment) [If none, code "0", if more than 9, code "9"]		5
2.	Receipt of Psychotropic Medication	Psychotropic medications taken LAST 7 DAY! (or since last assessment) [Note-Review client's medications with list that applies to the following categories] 0. No 1. Yes		
	a. Antipsychotic / neuroleptic		0	
	b. Anxiolytic		0	
	c. Antidepressant			1
	d. Hypnotic			0
3.	Medical Oversight	Physician reviewed client's medications as a whole in LAST 180 DAY (or since last assessment) 0. Discussed with at least one phys. (or no medication taken) 1. No single physician reviewed all medications		1
4.	Compliance / Adherence With Medications	Compliant all or most of time w medication: prescribed by a physician (during and between therapy visit) LAST 7 DAYS 0. Always compliant 1. Compliant 80% of the time or more 2. Compliant less than 80% of the time, including failure to purchase prescribed medications 3. NO MEDICATIONS PRESCRIBED		0

5. List Of All Medications

List prescribed and nonprescribed medications taken in the LAST 7 DAY: (or since last assessment)

- a. Name and Dose -- Record name of the medication and dose ordered
- b. Form Code the route of administration using the following list:

1. By Mouth (PO)	6. Rectal (R)
2. Sublingual (SL)	7. Topical
3. Intramuscular (IM)	8. Inhalation
4. Intravenous (IV)	9. Enteral tube
5. Subcutaneous (SQ)	10. Other
- c. Number Taken -- Record the number of units (pills, cc, tsp, etc) taken each time the medication is administered.
- d. Freq -- Code the number of times per day, week, or month the medication is administered using the following list:

PRN As necessary	QW Once each week
QH Every hour	2W 2 times every week
Q2H Every 2 hours	3W 3 times every week
Q3H Every 3 hours	4W 4 times each week
Q4H Every 4 hours	5W 5 times each week
Q6H Every 6 hours	6W 6 times each week
Q8H Every 8 hours	1M Once every month
QD Once daily	2M Twice every month
BID 2 times daily (includes every 12 hours)	C Continuous
TID 3 times daily	O Other
QID 4 times daily	
5D 5 times daily	
QOD Every other day	

	a. Name and Dose	b. Form	c. Number Taken	d. Freq
a.	Combivir 150 MG	1	1	BID
b.	Sulfamethoxazole/TMP DST - PM	1	1	QD
c.	Lexapro 10 MG - PM	1	1	QD
d.	Azithromycin 600 MG	1	2	QW
e.	Sustiva 600 MG	1	1	QD
f.				
g.				
h.				
i.				
j.				
k.				
l.				
m.				
n.				
o.				
p.				
q.				
r.				
s.				
t.				
u.				
v.				
w.				
x.				

SECTION R. ASSESSOR INFORMATION

1. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:

a. Signature of Assessment coordinator
Loida Kellgren

b. Title of Assessment Coordinator
OAAS Medical Certification Program Manager

c. Date Assessment Coordinator signed as complete
 0 7 / 1 5 / 2 0 1 0
 Month Day Year

Other Signatures	Title	Section	Date
d.			
e.			
f.			
g.			
h.			
i.			

7/15/2010 2:54:49 PM - Loida Kellgren - Section E. Mood and Behavior Patterns - E_1_a - Indicators of Depression / Anxiety - Feeling of sadness

Mr. Blue reports that he is currently being treated for depression and anxiety. He takes Lexapro 10 MG, one time per day, usually at bed time. Mr. Blue's next doctor's appointment to follow up on his depression is in 2 weeks.

7/15/2010 2:58:40 PM - Loida Kellgren - Section AA. Name and Identification Numbers - AA_1_a - Last name of client
Mr. Blue lives with his mother, Sally Fields. Ms. Fields and Mr. Blue were present for this assessment. Mr. Blue was able to respond for himself during most of MDS-HC assessment and demonstrated ability to understand questions being asked. Mrs. Fields also responded to some of the assessment questions.

7/15/2010 3:03:52 PM - Loida Kellgren - Section H. Physical Functioning - H_2_a - ADL Self Performance - Mobility in bed

Mr. Blue stated that he has no difficulty with Bed Mobility ADL. He is able to turn from side to side, and go from lying to sitting position while in bed without assistance.

7/15/2010 3:06:16 PM - Loida Kellgren - Section H. Physical Functioning - H_2_b - ADL Self Performance - Transfer

Mr. Blue reported that he has no difficulty with transferring ADL. Mr. Blue is able to transfer without assistance of any type.

7/15/2010 3:10:05 PM - Loida Kellgren - Section H. Physical Functioning - H_2_c - ADL Self Performance - Locomotion inhome

Mr. Blue reported that he is able to walk in the home by himself without difficulty. Mr. Blue greeted this assessor at the door and walked without difficulty during the 2 1/2 hour duration of this assessment.

7/15/2010 3:15:21 PM - Loida Kellgren - Section H. Physical Functioning - H_2_d - ADL Self Performance - Locomotion outside of home

Mr. Blue reported that he has no difficulty with walking outside of the home, and that he does not require any type of assistance in performing this ADL. Mr. Blue reported that he often walks to the neighborhood store, or to visit neighborhood friends "just to get out of the house for a while".

7/15/2010 3:20:21 PM - Loida Kellgren - Section H. Physical Functioning - H_2_h - ADL Self Performance - Toilet use

Mr. Blue reported that he has "a lot of difficulty" with toileting ADL because he has started to experience "wetting accidents" that require him to change out of wet clothing during the day. Mrs. Fields reported that her son has refused her assistance with this task because "he is embarrassed for his mother to see him in that condition". Mr. Blue stated that he would like some help with this ADL, and prefers another man to assist him if at all possible.

7/15/2010 3:28:34 PM - Loida Kellgren - Section H. Physical Functioning - H_1_a_A - IADL Self Performance - Performance code - Meal preparation

Mrs. Fields reported that her son "cannot cook for himself", and that a few months ago he "left a pot on the stove and almost burned the house down". Mr. Blue stated that he would like someone to cook for him. Mrs. Fields stated that she has other children and responsibilities that require her attention, and that she "cannot continue helping to the degree she has been" with Mr. Blue's care needs.

7/15/2010 3:32:50 PM - Loida Kellgren - Section H. Physical Functioning - H_1_d_A - IADL Self Performance - Performance code - Managing medications

Mrs. Fields reports that her son's medications are critical to his well being, but that he often has to be reminded to take his medications. Mrs. Fields has been trying to help her son by reminding him to take his medications, but she can no longer continue due to other family responsibilities. Mr. Blue reports that he tried having his friend remind him, but that plan "didn't work out".

7/15/2010 3:37:15 PM - Loida Kellgren - Section H. Physical Functioning - H_1_g_A - IADL Self Performance - Performance code - Transportation

Mrs. Fields stated that she had been taking her son to his monthly doctor's visits, but that she cannot continue due to a conflict with her other family responsibilities. Mr. Blue does not drive, and is requesting some assistance with scheduling his medical appointments and would like someone to go with him to those appointments if possible. Printed: 7/21/2010 6:37:01 PM

7/15/2010 3:40:31 PM - Loida Kellgren - Section H. Physical Functioning - H_2_j - ADL Self Performance - Bathing

Mrs. Fields reports that her son requires "supervision" to ensue he takes a bath and that he changes his clothes on a regular basis, especially now that he is "having wetting episodes".

CAP - ADHERENCE

CAP - ALCOHOL ABUSE

OBJECTIVE
To review conditions which determine adherence to treatments and therapies. Numerous studies suggest that persons who adhere to treatment have better health outcomes. Adherence activates nonspecific or concomitant features of the treatment or, at least, reveals the client's attitude and willingness to be cured. Thus, nonadherence is a risk factor.

TRIGGERS
Adherence problem suggested if individual not compliant all or most of the time with one or more of the following:

Did not trigger	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> One or more of the selected list of treatments or therapies scheduled during the last 7 days				
Oxygen	P2a	0	0-3	2,3
Respirator for assistive breathing	P2b	0	0-3	2,3
All other respiratory treatments	P2c	0	0-3	2,3
Alcohol/drug treatment program	P2d	0	0-3	2,3
Blood transfusion(s)	P2e	0	0-3	2,3
Chemotherapy	P2f	0	0-3	2,3
Dialysis	P2g	0	0-3	2,3
IV infusion - central	P2h	0	0-3	2,3
IV infusion - peripheral	P2i	0	0-3	2,3
Medication by injection	P2j	0	0-3	2,3
Ostomy care	P2k	0	0-3	2,3
Radiation	P2l	0	0-3	2,3
Tracheostomy care	P2m	0	0-3	2,3
Exercise therapy	P2n	0	0-3	2,3
Occupational therapy	P2o	0	0-3	2,3
Physical therapy	P2p	0	0-3	2,3
Physician or clinic visit	P2t	1	0-3	2,3
Respite care	P2u	0	0-3	2,3
Daily nurse monitoring (e.g. EKG ...)	P2v	0	0-3	2,3
Nurse monitoring less than daily	P2w	0	0-3	2,3
Medical alert bracelet ...	P2x	0	0-3	2,3
Skin treatment	P2y	0	0-3	2,3
Special diet	P2z	0	0-3	2,3
<input type="checkbox"/> Compliant less than 80% of the time with medications prescribed by the physician				
Compliant with medications in last 7 days ...	Q4	0	0-3	2

OBJECTIVE
To identify alcohol abuse or dependence. Also reviewed is hazardous, non-excessive drinking that places the elder at risk of adverse consequences due to the decreased metabolism of alcohol with aging, to related health complications, or to drug interactions.

TRIGGERS
An alcohol abuse or dependency problem is suggested if either of the following is present:

Did not trigger	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Fell need or been told by others to cut down on drinking, or others concerned with elder's drinking. Told to decrease drinking in last 90 days ...	K7a	0	0,1	1
<input type="checkbox"/> Client has to have drink first thing in the morning to steady nerves (i.e., an "eye opener") or been in any sort of trouble because of drinking. Had to have a drink in last 90 days ...	K7b	0	0,1	1

CAP - ADL

CAP - BEHAVIOR

OBJECTIVE
To identify individuals who have the potential for either greater independence in self-care or prolonged periods in which the risk of decline is lessened. Guidance is provided to help recognize reversible causes of disability and instituting programs of rehabilitation for elders who are motivated or where decline is of a recent origin. The primary focus is on programs that can be carried out by the individual and his or her family.

TRIGGERS
ADL improvement suggest if all three (3) of the following conditions are met:

Did not trigger	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> (1) ADL deficits are present:				
<input type="checkbox"/> Individual gets suprvsn/physical help from others, or totally dependent on others in two or more areas.				
Mobility in Bed - Move from lying position ...	H2a	0	0-6, 8	1-6, 8
Transfer - Moving between surfaces ...	H2b	0	0-6, 8	1-6, 8
Locomotion in Home	H2c	0	0-6, 8	1-6, 8
Locomotion Outside of Home	H2d	0	0-6, 8	1-6, 8
Dressing Upper Body - Dressing above waist ...	H2e	2	0-6, 8	1-6, 8
Dressing Lower Body - Dressing below waist ...	H2f	2	0-6, 8	1-6, 8
Eating - Taking food by any method ...	H2g	1	0-6, 8	1-6, 8
Toilet Use - Toileting by any method ...	H2h	0	0-6, 8	1-6, 8
Personal Hygiene - Hair, teeth, shaving ...	H2i	2	0-6, 8	1-6, 8
Bathing - How client takes full body bath ...	H2j	2	0-6, 8	2-6, 8
<input type="checkbox"/> (2) AND has good ability to understand others				
Ability to Understand Others - Verbally ...	C3	0	0-4	0-2
<input type="checkbox"/> (3) AND one or more of the following are present:				
<input type="checkbox"/> Individual has declined in functional status				
Change in Care Needs - In last 90 days ago ...	P6	0	0,1,2	2
ADL Decline - ADL status worse ...	H3	0	0,1	1
<input type="checkbox"/> Unstable, flare up, or new acute condition				
Has condition making ADL unstable ...	K8b	0	0,1	1
Experiencing a flare-up ...	K8c	0	0,1	1
Treatment changed in last 30 days ...	K8d	0	0,1	1
<input type="checkbox"/> Client, caregiver, or assessor believes that functional improvement is possible				
Has condition making ADL unstable ...	H7a	0	0,1	1
Experiencing a flare-up ...	H7b	0	0,1	1
Treatment changed in last 30 days ...	H7c	0	0,1	1

OBJECTIVE
To identify elders with behavioral symptoms distressing to themselves or to others and to suggest approaches to care.

TRIGGERS
Review of behavior status suggested if sum of the following items equals one (1) or higher (where each item has a possible score range of 0,1,2):

Did not trigger	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Wandering Moves with no rational purpose ...	E3a	0	0,1,2	1,2
<input type="checkbox"/> Verbally abusive Threatened, screamed at, cursed at others ...	E3b	0	0,1,2	1,2
<input type="checkbox"/> Physically abusive Hit, shoved, scratched, abused others ...	E3c	0	0,1,2	1,2
<input type="checkbox"/> Social inappropriate/disruptive Disruptive sounds, throws feces, disrobing ...	E3d	0	0,1,2	1,2
<input type="checkbox"/> Resists care Resists taking medications, eating ...	E3e	0	0,1,2	1,2

CAP - BOWEL MANAGEMENT

OBJECTIVE
To evaluate the problems and draw attention to bowel functioning and disorders of the gastrointestinal system.

TRIGGERS
Review for bowel problem when one or more of the following present:

Did not trigger	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Bowel incontinence Control of bowels in the last 7 days ...	J3	0	0-5, 8	2-5
<input type="checkbox"/> Diarrhea Diarrhea	K2a	0	0,1	1
<input type="checkbox"/> Constipation No bowel movement in 3 days	K3b	0	0,1	1

CAP - BRITTLE SUPPORTS

OBJECTIVE
To identify families who are expected to have difficulty in responding to the unfolding needs of impaired elders. Identified families provide limited/minor care at baseline and are expected to change little over the ensuing months. These family systems are considered to be brittle. In the extreme case, there are also a small number of actively involved families for whom new demands for caregiving help can strain their response and not be able to address the needs of the client.

TRIGGERS
Review for probable brittle informal support system when BOTH of the following conditions are present:

Did not trigger	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> (1) Client has some level of IADL dependency				
<input type="checkbox"/> IADL dependency indicated if any of the following are NOT performed independently (0 is independent)				
Meal preparation	H1aA	3	0-3, 8	1-3, 8
Ordinary housework	H1bA	1	0-3, 8	1-3, 8
Managing finances	H1cA	3	0-3, 8	1-3, 8
Managing medications	H1dA	3	0-3, 8	1-3, 8
Phone use	H1eA	0	0-3, 8	1-3, 8
Shopping	H1fA	3	0-3, 8	1-3, 8
Transportation	H1gA	3	0-3, 8	1-3, 8
<input type="checkbox"/> (2) Caregiver does NOT provide care on a regular basis if either of the following conditions exist:				
<input type="checkbox"/> Absence of primary caregiver				
Caregiver lives with client	G1eA	0	0,1,2	2
<input type="checkbox"/> Insufficient care if two or more of the following conditions are met:				
Alone all of the time during day ...	F3a	3	0-3	3
No IADL care from primary caregiver ...	G1hA	0	0,1	1
No ADL care from primary caregiver ...	G1iA	0	0,1	1

CAP - CARDIO / RESPIRATORY

OBJECTIVE
To alert the home care professional to problems of the cardiovascular or respiratory systems that require medical management. Many elders with cardio-respiratory difficulties will already be under the care of a physician. However, other may attribute symptoms to aging and therefore may not be receiving appropriate care.

TRIGGERS
Review for cardio-respiratory problem when one or more of the following present:

TRIGGERED	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Chest pains				
Chest pain or pressure in last 3 days ...	K3a	0	0,1	1
<input type="checkbox"/> Shortness of breath				
Shortness of breath.	K3e	1	0,1	1
<input type="checkbox"/> Irregular pulse				
Irregularly irregular pulse.	J1e	0	0,1,2	1,2

CAP - COGNITION

OBJECTIVE
To determine whether problems of cognition exist, whether they are acute or chronic, and, if chronic, whether measure may be necessary to compensate for the deficits.

TRIGGERS
A cognition problem suggested if one or more of the following are present:

TRIGGERED	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Short-term memory appears to be a problem				
Memory OK - Recalls after 5 minutes ...	B1a	1	0,1	1
<input type="checkbox"/> Minimally, moderately or severely impaired in making decisions organizing the day.				
How well client organizes day ...	B2a	2	0-4	2-4
<input type="checkbox"/> Sudden or new onset or change in mental function				
Change in mental function in last 7 days ...	B3a	0	0,1	1
<input type="checkbox"/> In the last 90 days, client has become agitated or disoriented such that his or her safety is endangered or client requires protection by others.				
Became agitated in last 90 days ...	B3b	0	0,1	1

CAP - COMMUNICATION DISORDERS

OBJECTIVE
To identify the communication problems of community-based elders, to suggest when referrals are needed for complete hearing and communication assessments and remedy, and to provide specific strategies to help facilitate effective communication between elders, their families and other caregivers.

TRIGGERS
Communication problem suggested if one or more of following present:

Did not trigger	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Hearing difficulty				
Hearing - With hearing appliance if used ...	C1	0	0-3	1-3
<input type="checkbox"/> Problem making self understood				
Making self understood - Expressing info ...	C2	0	0-4	1-4
<input type="checkbox"/> Problem understanding others				
Ability to understand others - Verbally	C3	0	0-4	1-4

CAP - DEHYDRATION

OBJECTIVE
To alert the home care professional to the existence of dehydration or risk factors that may predispose the client to dehydration, and to provide care planning recommendations for resolving the problem or minimizing the likelihood of its occurrence.

TRIGGERS
Dehydration suggested if one or more of the following present:

Did not trigger	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Fever on at least 2 or more of the last 3 days				
Fever.	K2c	0	0,1	1
<input type="checkbox"/> Decrease in food eaten				
In last 3 days, noticeable decrease in food eaten ...	L2b	0	0,1	1
<input type="checkbox"/> Insufficient fluid				
Did not consume all fluids during last 3 days ...	L2c	0	0,1	1

CAP - DEPRESSION AND ANXIETY

OBJECTIVE
To help identify community-dwelling elders who suffer from the symptoms of anxiety or depression and identify possible treatment options. Symptoms of depression and anxiety are common among community dwelling elders, although the full-blown syndrome of major depression appears to become less common with increasing age in community settings.

TRIGGERS
A mood problem requiring intervention is suggested if the sum of the following items equals TWO OR MORE (where each item is scored as 0, 1, 2):

TRIGGERED	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> A feeling of sadness or depression				
Feels life is not worth living, nothing matters ...	E1a	1	0,1,2	1
<input type="checkbox"/> Persistent anger with self or others				
Easily annoyed, anger at care received ...	E1b	0	0,1,2	1
<input type="checkbox"/> Expression of unrealistic fears				
Fear of being abandoned ...	E1c	0	0,1,2	1
<input type="checkbox"/> Repetitive health complaints				
Persistently seeks medical attention ...	E1d	0	0,1,2	1
<input type="checkbox"/> Repetitive anxious complaints, concerns				
Persistently seeks reassurance ...	E1e	0	0,1,2	1
<input type="checkbox"/> Sad, pained, worried facial expressions				
Furrowed brow ...	E1f	1	0,1,2	1
<input type="checkbox"/> Recurrent crying, tearfulness				
Recurrent crying and tearfulness ...	E1g	0	0,1,2	1

CAP - ELDER ABUSE

CAP - HEALTH PROMOTION

OBJECTIVE To help identify clients who are in situations of abuse or neglect or at significant risk of abuse and to help determine whether these situations require immediate action. In some countries and communities reporting of such cases to a designated agency is required.				
TRIGGERS Review is suggested if one or more of the following is present:				
TRIGGERED	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Fearful of a family member or caregiver <i>Fearful of a family member or caregiver.</i>	K9a	1	0,1	1
<input type="checkbox"/> Unexplained injuries, broken bones, burns <i>Unexplained injuries, broken bones, or burns.</i>	K9c	0	0,1	1
<input type="checkbox"/> Neglected, abused, or mistreated <i>Neglected, abused, or mistreated.</i>	K9d	0	0,1	1
<input type="checkbox"/> Physically restrained <i>Physically restrained (e.g. bed rails ...)</i>	K9e	0	0,1	1

OBJECTIVE To promote well-being and independence through increased stamina and smoking cessation.				
TRIGGERS A life style or stamina problem suggested when either of the two following sub-triggers are present:				
Did not trigger	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> (1) STAMINA problem is considered to be potentially remedial when both of the following are present:				
<input type="checkbox"/> Some independence in decision making <i>How well client made organizing decisions ...</i>	B2a	2	0-4	0,1
<input type="checkbox"/> One or more stamina problems below present: <i>Number of days client out of house ...</i> <i>Hours of physical activity in last 3 days ...</i> <i>How client went up and down stairs ...</i>	H6a H6b H5	2 1 1	0,1,2,3 0,1 0,1,2	2,3 1 1,2
<input type="checkbox"/> (2) SMOKING is triggered when both of the following are present:				
<input type="checkbox"/> Some Independence in decision making <i>How well client made organizing decisions ...</i>	B2a	2	0-4	0,1
<input type="checkbox"/> Smoked or chewed tobacco daily <i>Lifestyle - Smoked or chewed daily ...</i>	K7c	1	0,1	1

CAP - ENVIRONMENTAL ASSESSMENT				
OBJECTIVE To identify environmental conditions that are hazardous, especially when there is a functional status problem that places the client at risk (i.e., relevant CAPs are triggered in these areas).				
TRIGGERS Review for potential role of environmental factors in impeding function when one or more of the following factors are present that make the home environment uninhabitable or hazardous.				
TRIGGERED	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Lighting <i>Lighting in evening ...</i>	O1a	0	0,1	1
<input type="checkbox"/> Flooring and carpeting <i>Holes in floor, electric wires ...</i>	O1b	0	0,1	1
<input type="checkbox"/> Bathroom environment <i>Non-operating toilet, leaking pipes ...</i>	O1c	1	0,1	1
<input type="checkbox"/> Kitchen environment <i>Dangerous stove, inoperative refrigerator ...</i>	O1d	0	0,1	1
<input type="checkbox"/> Heating and cooling <i>Too hot in summer, too cold in winter ...</i>	O1e	0	0,1	1
<input type="checkbox"/> Personal safety <i>Fear of violence, safety problem going out ...</i>	O1f	0	0,1	1

CAP - IADL				
OBJECTIVE To identify interventions for restoring or replacing the individual's impaired function.				
TRIGGERS The IADL trigger has two overlapping components. Clients can trigger on one or both components of this trigger				
TRIGGERED	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> (1) An increased probability for IADL improvement is present when ALL THREE of the following are met:				
<input type="checkbox"/> (a) Client understands or usually understands others <i>Ability to Understand Others - Verbal</i>	C3	0	0-4	0,1,2
<input type="checkbox"/> (b) Client, caregiver or assessor believe that functional improvement is possible <i>Client believes he/she is capable ...</i> <i>Caregivers believe client is capable ...</i> <i>Good prospects of recovery ...</i>	H7a H7b H7c	0 0 0	0,1 0,1 0,1	1 1 1
<input type="checkbox"/> (c) AND one or more of the following situations are present: <i>NOT independent in meal preparation ...</i> <i>AND client involvement is possible ...</i> <i>NOT independent in managing finances ...</i> <i>AND client involvement is possible ...</i> <i>NOT independent in managing medications ...</i> <i>AND client involvement is possible ...</i>	H1aA H1aB H1cA H1cB H1dA H1dB	3 2 3 1 3 1	0-3, 8 0,1,2 0-3, 8 0,1,2 0-3, 8 0,1,2	1,2,3 0,1 1,2,3 0,1 1,2,3 0,1
<input type="checkbox"/> (2) A markedly higher prospect of requiring a significant increase in formal IADL care is indicated when THREE OR MORE of the following are met:				
<input type="checkbox"/> Some/great difficulty in meal preparation <i>Meal Preparation - How prepared ...</i>	H1aB	2	0,1,2	1,2
<input type="checkbox"/> Some/great difficulty in managing medication <i>Managing Medications - Remembering, taking ...</i>	H1dB	1	0,1,2	1,2
<input type="checkbox"/> Some/great difficulty in shopping <i>Shopping - How shopping is performed ...</i>	H1fB	1	0,1,2	1,2
<input type="checkbox"/> Some/great difficulty in transportation <i>Transportation - How client travels by vehicle ...</i>	H1gB	1	0,1,2	1,2

CAP - FALLS				
OBJECTIVE To ascertain if falls have occurred recently and if the client is at risk of falling, and to provide care planning guidance for minimizing the risk of falls and limiting the extent of possible injury.				
TRIGGERS Potential for additional falls or risk of initial fall suggested if one or more of the following is present:				
TRIGGERED	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Falls in the last 90 days <i>Number of times fell in last 90 days ...</i>	K5	0	0-9	1-9
<input type="checkbox"/> Sudden change of mental functioning <i>Sudden change in mental function in last 7 days ...</i>	B3a	0	0,1	1
<input type="checkbox"/> Being treated for dementia <i>Alzheimer's</i>	J1g	0	0,1,2	2
<input type="checkbox"/> Being treated for Parkinsonism <i>Parkinsonism</i>	J1i	0	0,1,2	2
<input type="checkbox"/> Unsteady gait AND does not limit going out <i>Unsteady gait</i> <i>Client limits going out due to fear of falling ...</i>	K6a K6b	1 0	0,1 0,1	1 0

CAP - INSTITUTIONAL RISK

CAP - NUTRITION

OBJECTIVE				
To identify persons with impaired functioning who are at high-risk of institutionalization in the coming months, and suggests support strategies to help these individuals remain in the community.				
TRIGGERS				
The following sets of conditions suggest that the client is at a relatively high risk of nursing home placement in the ensuing 3-month period if four or more of the following are present:				
Did not trigger	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Prior nursing home placement <i>Resided in NH during last 5 years ...</i>	CC7	0	0,1	1
<input type="checkbox"/> Goes out one or fewer days a week <i>Number of days out of the house ...</i>	H6a	2	0,1,2,3	2,3
<input type="checkbox"/> Incontinent of urine at least occasionally <i>Control of urinary bladder in last 7 days ...</i>	I1a	2	0-5, 8	3,4,5
<input type="checkbox"/> Neurological diagnosis <i>Alzheimer's ...</i> <i>Dementia other than Alzheimer's ...</i> <i>Head trauma ...</i> <i>Multiple sclerosis ...</i>	J1g J1h J1i J1k	0 0 0 0	0,1,2 0,1,2 0,1,2 0,1,2	1,2 1,2 1,2 1,2
<input type="checkbox"/> If either present, functional decline in past 90 days <i>Self sufficiency changed in last 90 days ...</i> <i>ADL status worse in last 90 days ...</i>	P6 H3	0 0	0,1,2 0,1	2 1
<input type="checkbox"/> One or more early-loss ADL deficits (dressing, personal hygiene, bathing) <i>How client dresses upper body ...</i> <i>How client dresses lower body ...</i> <i>Personal hygiene - combing hair, brushing teeth ...</i> <i>How client takes full body baths ...</i>	H2e H2f H2i H2j	2 2 2 2	0-6, 8 0-6, 8 0-6, 8 0-6, 8	2-6 2-6 2-6 2-6
<input type="checkbox"/> Sudden or new onset/change in mental functioning <i>Sudden change in mental in last 7 days ...</i>	B3a	0	0,1	1
<input type="checkbox"/> Meal preparation and shopping both did not occur in the prior 7-day period. <i>How meals are prepared ...</i> <i>How shopping for food is performed ...</i>	H1aA H1fA	3 3	0-3, 8 0-3, 8	8 8

OBJECTIVE				
To detect persons with malnutrition and those at increased risk for development of nutritional problems.				
TRIGGERS				
A nutrition problem is suggested if one or more of the following is present:				
Did not trigger	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Unintended weight loss of 5% or more in the last 30 days or 10% or more in the last 180 days <i>Unintended weight loss in last 30 days ...</i>	L1a	0	0,1	1
<input type="checkbox"/> Decrease in food eaten <i>In last 3 days, noticeable decrease in food eaten ...</i>	L2b	0	0,1	1
<input type="checkbox"/> Insufficient Fluid <i>Did not consume all fluids in last 3 days ...</i>	L2c	0	0,1	1
<input type="checkbox"/> Cancer <i>Cancer in past 5 years (not skin cancer)</i>	J1x	0	0,1,2	1
<input type="checkbox"/> Severe malnutrition <i>Sever malnutrition (cachexia)</i>	L1b	0	0,1	1

CAP - ORAL HEALTH

OBJECTIVE				
To detect oral health problems that cause pain, inability to eat or speak, malnutrition, and problems of self-esteem or enjoyment of food.				
TRIGGERS				
Oral health problem suggested if one or more of the following are present:				
Did not trigger	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Problem in chewing (e.g., pain while eating) <i>Poor mastication, immobile jaw ...</i>	M1a	0	0,1	1
<input type="checkbox"/> Problem in swallowing <i>Normal, or diet modification, tube feeding ...</i>	L3	0	0-4	1-4
<input type="checkbox"/> Mouth is "dry" when eating a meal <i>Mouth is "dry" when eating a meal</i>	M1b	0	0,1	1
<input type="checkbox"/> Problem brushing teeth or dentures <i>Problem brushing teeth or dentures</i>	M1c	0	0,1	1

CAP - MEDICATION MANAGEMENT

OBJECTIVE				
To compile a comprehensive list of all medications being taken and to have the client understand the need to have their medications continually evaluated so as to maximize efficacy and minimize hazards.				
TRIGGERS				
Trigger if either of the following are true:				
TRIGGERED	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> (1) Medication problems indicated if BOTH of the following conditions are met: <input type="checkbox"/> Taking medication without physician review <i>Number of meds taken in last 7 days ...</i> <i>Physician did NOT review meds in last 7 days ...</i>	Q1 Q3	5 1	0-9 0,1	1-9 1
<input type="checkbox"/> (2) Medication problems indicated if BOTH of the following conditions are met: <input type="checkbox"/> Taking 5 or more medications <i>Number of meds taken in last 7 days ...</i> <input type="checkbox"/> Possible inappropriate drug therapy suggested if one or more of the following are present: <i>Renal failure</i> <i>Extrapyramidal syndromes (e.g., Parkinsonism)</i> <i>Diarrrhea</i> <i>Dry mouth</i> <i>Constipation (no movement in 3 days)</i> <i>Dizziness or lightheadedness</i> <i>Rashes, itching, bruising</i>	Q1 J1aa J1f K2a M1b K3b K3c N1	5 0 0 0 0 0 1 0	0-9 0,1,2 0,1,2 0,1 0,1 0,1 0,1 0,1	5-9 1,2 1,2 1 1 1 1 1

CAP - PAIN

OBJECTIVE				
Identify elders in whom pain limits their ability to function. This may be a direct effect of pain or fear of pain or it may be that the pain is impairing the client's interpersonal relationships or the analgesics are having deleterious effects... Although individuals with chronic pain also require diagnostic evaluation, many have undergone such an evaluation and for these persons control of the pain with a minimum of side effects is a high priority.				
TRIGGERS				
A pain problem is suggested if the following present:				
TRIGGERED	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Complains or shows evidence of pain <i>Frequency with which client complains of pain ...</i>	K4a	3	0-3	1-3

CAP - PALLIATIVE CARE

OBJECTIVE				
To evaluate the need for comprehensive care to clients who wish to receive a palliative approach at home.				
TRIGGERS				
Review for whether Palliative Care approach may be appropriate when one or both of the following are present:				
Did not trigger	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> End stage disease, with six or fewer months to live <i>Doctor has told client of end-stage disease ...</i>	K8e	0	0,1	1
<input type="checkbox"/> Hospice care <i>Hospice care</i>	P2s	0	0-3	1,2,3

CAP - PRESSURE ULCERS

CAP - PSYCHOTROPIC DRUGS

OBJECTIVE				
To assist home health care providers in identifying clients who are at risk for developing skin breakdown, (or require treatment for pressure ulcers that are present) and to provide care planning interventions for the prevention and treatment of pressure ulcers. Prevention of pressure ulcers is of vital importance in home health care. Once manifest, these lesions can cause great discomfort and lead to serious medical complications including increased mortality.				
TRIGGERS				
Review if one or more of the following are present:				
Did not trigger	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Bed mobility problem <i>Including moving to and from lying position ...</i>	H2a	0	0-6, 8	3-6, 8
<input type="checkbox"/> Fecal incontinence <i>In last 7 days, control of bowel movement ...</i>	I3	0	0-5, 8	3-5
<input type="checkbox"/> Pressure ulcer present <i>Any lesion caused by pressure, shear forces ...</i>	N2a	0	0-4	1-4
<input type="checkbox"/> History of a previous pressure ulcer <i>Previously had or has an ulcer ...</i>	N4	0	0,1	1

OBJECTIVE				
To identify persons taking psychotropic drugs who need a medical review of their medication regimen, or who might benefit from more or different medical monitoring of psychotropic drug effects.				
TRIGGERS				
Further assessment is indicated when both of the conditions below are met:				
TRIGGERED	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> (1) Client is taking a psychotropic drug				
<input type="checkbox"/> Psychotropic medications taken in the last 7 days				
Antipsychotic/neuroleptic	Q2a	0	0,1	1
Anxiolytic	Q2b	0	0,1	1
Antidepressant	Q2c	1	0,1	1
<input type="checkbox"/> (2) AND one or more of following conditions are Met:				
<input type="checkbox"/> Indications of delirium when either of the following conditions are met:				
Sudden change in mental function in last 90 ...	B3a	0	0,1	1
Client has become agitated in last 90 days ...	B3b	0	0,1	1
<input type="checkbox"/> Indicators of cognitive or communication decline when either of the following conditions are met:				
Worsening of decision making in last 90 days ...	B2b	0	0,1	1
Worsening in communication in last 90 days ...	C4	0	0,1	1
<input type="checkbox"/> Indications of depression, anxiety if one or more of the following items are selected:				
Feelings of sadness or depression	E1a	1	0,1,2	2
Persistent anger with self or others ...	E1b	0	0,1,2	2
Expressions of unrealistic fear ...	E1c	0	0,1,2	2
Repetitive health complaints ...	E1d	0	0,1,2	2
Persistently seeks attention, reassurance ...	E1e	0	0,1,2	2
Sad, pained facial expressions ...	E1f	1	0,1,2	2
Recurrent crying, tearfulness	E1g	0	0,1,2	2
<input type="checkbox"/> Indication with a behavior problem if one or more of the following items are selected:				
Wandering with no rational reason ...	E3a	0	0,1,2	2
Verbally abusive to others ...	E3b	0	0,1,2	2
Physically, sexually abusive to others ...	E3c	0	0,1,2	2
Disruptive sounds, noises, screaming ...	E3d	0	0,1,2	2
Resisted taking medication/injections ...	E3e	0	0,1,2	2
<input type="checkbox"/> Worsening behavior symptoms				
Behavior became worse in last 90 days	E4	0	0,1	1
<input type="checkbox"/> Locomotion difficulties exist if either of the following conditions are met:				
Locomotion at home not independent ...	H2c	0	0-6, 8	2-6, 8
Locomotion outside of home not independent ...	H2d	0	0-6, 8	2-6, 8
<input type="checkbox"/> An incontinence problem exists if either of the following conditions are met:				
Bladder control problems in last 7 days ...	I1a	2	0-5, 8	3,4,5
Bowel control problems in last 7 days ...	I3	0	0-5, 8	3,4,5
<input type="checkbox"/> Parkinson				
Parkinsonism	J1l	0	0,1,2	1,2
<input type="checkbox"/> Delusion or hallucination problem exists if either of the following conditions are met:				
Delusions	K3f	0	0,1	1
Hallucinations	K3g	0	0,1	1
<input type="checkbox"/> Falling in the past 90 days				
Number of times fell in last 90 days ...	K5	0	0-9	1-9
<input type="checkbox"/> Unsteady gait				
Unsteady gait	K6a	1	0,1	1

OBJECTIVE				
To alert home health care workers of need to determine if client has unmet preventive health needs (e.g., blood pressure screening, immunizations) and meet as many of them in the home as possible. It is preferable to prevent illness and disability rather than to be required to address them once they have occurred. It has been suggested to incorporate some screening activities often, but not always, within the context of routine, episodic patient encounters.				
TRIGGERS				
A preventative health follow-up is required when one or more of the following are present:				
INCOMPLETE	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Failure to have blood pressure measurement <i>Blood pressure measured</i>	K1a	1	0,1	0
<input type="checkbox"/> Failure to receive influenza vaccine <i>Received influenza vaccination</i>	K1b	1	0,1	0
<input type="checkbox"/> Failure to have a breast examination (if female) <i>Client is female</i>	BB1	2	1,2	2
<i>Received breast examination or mamo ...</i>	K1d	0	0,1	0
<input type="checkbox"/> No test for blood in stool or screening in the last 2 years <i>Tested for blood in stool ...</i>	K1c	1	0,1	0

CAP - REDUCTION OF FORMAL SERVICES

OBJECTIVE				
To evaluate the formal services currently being delivered with the goal of service reduction. The concept of service reduction is not linked to benefit limits (the number of allowable visits) or to client eligibility requirements, rather it is based on an assessment of whether the treatment is warranted or the assistance is still needed.				
TRIGGERS				
Review for potential to reduce services when both of the following conditions are present				
Did not trigger	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> (1) No indication that further improvement is possible				
<input type="checkbox"/> Functional potential improbable if all below are answered negatively.				
Client believes capable of incr. Independence ...	H7a	0	0,1	0
Caregivers believe capable of incr. indep ...	H7b	0	0,1	0
Good prospects of recovery ...	H7c	0	0,1	0
<input type="checkbox"/> (2) AND one or more of the following occur:				
<input type="checkbox"/> An improvement in status-receives few supports <i>Overall self sufficiency improved in last 90 ...</i>	P6	0	0,1,2	1
<input type="checkbox"/> One or more treatment goals met in past 90 days <i>Have any goals been met in last 90 days</i>	P5	0	0,1	1

CAP - SKIN AND FOOT CONDITIONS

OBJECTIVE
To identify elders who have skin or foot problems or are at risk of developing them, and to provide care planning suggestions for the prevention and treatment of these conditions.

TRIGGERS
Review if one or more of the following are present:

Did not trigger	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Any troubling skin conditions or changes <i>Troubling skin or changes (e.g., burns, bruises ...)</i>	N1	0	0,1	1
<input type="checkbox"/> Coms/calluses, structural problems, infections, fungi <i>Coms/calluses, structural problems ...</i>	N3e	0	0,1	1
<input type="checkbox"/> Open Lesions <i>Other than ulcers, rashes, cuts (e.g., cancer)</i>	N3b	0	0,1	1

CAP - SOCIAL FUNCTION

OBJECTIVE
To help client maintain or restore satisfactory life roles, social relation or pleasurable activities or develop new ones. Social dysfunction can originate in health, mental, spiritual, functional, environmental domains and problematic social exchanges with people. This results in unhappiness, anxiety and loneliness. To minimize discontent and dysfunction and maximize socialization, it is necessary to identify and modify the problems and compensate for the immutability.

TRIGGERS
A social functioning problem is suggested if one or more of the following are present:

TRIGGERED	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Distressed due to decline in last 90 days of participation in social, religious, occupational, preferred activities <i>Decline in participation in last 90 days ...</i>	F2	0	0,1,2	2
<input type="checkbox"/> Feels lonely <i>Client says or indicates loneliness ...</i>	F3b	1	0,1	1

CAP - URINARY INCONTINENCE

OBJECTIVE
To analyze potentially reversible causes of incontinence and to review possible treatment methods.

TRIGGERS
A problem with urinary continence is suggested if:

Did not trigger	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Occasional, frequent or frank urinary incontinence <i>In last 7 days control of urinary bladder function ...</i>	I1	2	0-5, 8	3,4,5
<input type="checkbox"/> Use of pads <i>Use of pads to protect against wetness ...</i>	I2a	0	0,1	1
<input type="checkbox"/> Use of indwelling catheter <i>Use of an indwelling urinary catheter</i>	I2b	0	0,1	1

CAP - VISUAL FUNCTION

OBJECTIVE
To guide evaluation of clients having one or more of the following:
1) New vision loss
2) Long standing, irreversible vision loss
3) Neglect by client in managing ocular regimens

TRIGGERS
Review is suggested if one or more of the following is present:

Did not trigger	Question Number	Client's Response	Possible Responses	Triggering Responses
<input type="checkbox"/> Visual impairment <i>Ability to see in adequate light w/o glasses ...</i>	D1	0	0-3	1-3
<input type="checkbox"/> Any visual limitation/difficulty <i>Saw halos or rings around lights ...</i>	D2	0	0-4	1
<input type="checkbox"/> Worsening of vision <i>Worsening of vision in last 90 days ...</i>	D3	0	0-4	1

LOCET - PATHWAY 1. Activities of Daily Living

Did not trigger	Question Number	Resident's Response	Possible Responses
<input type="checkbox"/> Locomotion	H2c	0	0 - 6, 8
<input type="checkbox"/> Eating	H2g	1	0 - 6, 8
<input type="checkbox"/> Transfer	H2b	0	0 - 6, 8
<input type="checkbox"/> Bed Mobility	H2a	0	0 - 6, 8
<input type="checkbox"/> Toilet Use	H2h	0	0 - 6, 8
<input type="checkbox"/> Dressing	H2e	2	0 - 6, 8
<input type="checkbox"/> Personal Hygiene	H2i	2	0 - 6, 8
<input type="checkbox"/> Bathing	H2j	2	0 - 6, 8
<input type="checkbox"/> Bladder Continence	I1a	2	0 - 5, 8
<input type="checkbox"/> Medication Management	H1d	3	0 - 3, 8
<input type="checkbox"/> Meal Preparation	H1a	3	0 - 3, 8
<input type="checkbox"/> Shopping	H1f	3	0 - 3, 8
<input type="checkbox"/> Days out of house within a week	H6a	2	0 - 3
<input type="checkbox"/> ADL status change in last 90 days	H3	0	0 - 1

LOCET - PATHWAY 2. Cognitive Performance

Did not trigger	Question Number	Resident's Response	Possible Responses
<input type="checkbox"/> Daily decision making capability	N/A		
<input type="checkbox"/> Short term memory	B1a	1	0 - 1
<input type="checkbox"/> Memory exercise questions	N/A		
<input type="checkbox"/> Cognitive skills for daily decision making	B2a	2	0 - 4
<input type="checkbox"/> Making self understood	C2	0	0 - 4
<input type="checkbox"/> Change in mental functioning in last 7 days	N/A		

LOCET - PATHWAY 6. Behavior

Did not trigger	Question Number	Resident's Response	Possible Responses
<input type="checkbox"/> Applicant displays challenging behavior	N/A		
<input type="checkbox"/> Wandering	E3a	0	0 - 2
<input type="checkbox"/> Verbally abusive behavior	E3b	0	0 - 2
<input type="checkbox"/> Physically abusive behavior	E3c	0	0 - 2
<input type="checkbox"/> Socially inappropriate / disruptive behavior	E3d	0	0 - 2
<input type="checkbox"/> Delusions	K3f	0	0 - 1
<input type="checkbox"/> Hallucinations	K3g	0	0 - 1

MDS-HC Assessment List

ID	Last Name	First Name	Date	Type	Locked	Images	Category	ADL	RUG III	Coordinato	PW1	PW2	PW6
40052117	Blue	James			No	No	Impaired C	4	5.11 (IA_1)		Inc	Met	Inc
40050147	Blue	James	12/9/2009	Initial	No	No	Impaired C	4	5.12 (IA_2)	Loida Kell	NotMet	NotMet	NotMet
40063577	Blue	James	7/15/2010	Initial	No	No	Impaired C	4	5.12 (IA_2)	Loida Kell	NotMet	NotMet	NotMet