

DUAL DIAGNOSIS MANAGEMENT

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North Dakota Onsite Nursing
Assessment (05/03)

General Information

Evaluation type Swing Bed Nursing Facility

Resident Name _____
(Last) (First) (MI)

SSN _____ Date of Birth _____ Age _____

Nursing Facility/Swing Bed Name _____

Contact Person _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Legal Representative Information	<input type="checkbox"/> No legal Representative
Legal Representative _____	Phone () _____
Address: _____	City _____ State _____ Zip _____

Race/Ethnic Origin: African American Asian Caucasian Hispanic
 Native American
 Other _____

Gender: Female Male

Source(s) of information:

Chart Family Patient/Resident
 Caregiver Legal Guardian Staff (specify) _____
 Other (specify) _____

Axis III Diagnoses or Significant Medical Problems:

Medical
Information

Name: _____

SSN: _____

Current Medications (prescription, inhalers, over the counter meds e.g., vitamins, herbs). Attach copy of Medication list if needed:

No medications noted or reported at the time of the assessment.

Medication	Frequency	Dosage

Current Treatments/Therapies:

Treatment/Therapy	Frequency

Rank resident's current ability to perform the following day-to-day living activities:

- 1 Total assistance/unable
 2 Performs with assistance of greater than one
 3 Performs with assistance of one
 4 Performs with adaptive equipment
 5 Performs with verbal prompts
 6 Independent

FUNCTIONAL SKILLS:

EATING
 TRANSFERRING
 TOILETING
 LOCOMOTION

Does resident exhibit the following directly related to a Dementia diagnosis and *not* directly related to Mental Retardation or other psychiatric diagnoses (check all that apply): No evidence or diagnosis of dementia

- Impaired ability to learn new information
 Impaired ability to recall previously learned information
 Language disturbance
 Disturbance in executive functioning (planning, organizing, etc).
 Failure to recognize objects in spite of intact sensory functioning
 Impaired ability to carry out motor activities in spite of intact motor function
 Behavioral/Personality changes
 Other (describe) _____
 None

**System
Information**

Name: _____

SSN: _____

NUTRITIONAL STATUS:

Dietary restrictions/Special Diet _____

Appetite: Good Fair Poor **Difficulty:** Gagging Chewing Swallowing Choking

Tube feedings: No Yes, (if yes specify) _____

SKIN: (✓ all that apply) Warm Dry Bruises (specify) _____ Rash (specify) _____

Wounds/Scars (specify) _____ Other (specify) _____

EYES/NOSE:

ORAL:

Visual Aids: Glasses/Contacts Cataracts Glaucoma Dentures Edentulous

Disturbance in smell/taste? (Describe) _____

Other (specify) _____ Other (Specify) _____

HEARING/COMMUNICATION:

Hearing Impaired Hearing Loss Hearing Aids Other (Specify) _____

Does resident understand verbal communication? Yes No **Speech Impairment:** Yes No

What is resident's primary means of communication?

Verbal Signing Writing Gestures

None Other (Specify) _____

RESPIRATORY SYSTEM:

Chronic URI Chronic cough Asthma SOB Wheezing Bronchitis Emphysema

TB Oxygen needs Other (Specify) _____

CARDIOVASCULAR SYSTEM:

Heart disease Palpitations Murmur Anemia Stroke/TIA Edema

High Blood Pressure Blood clots/phlebitis Other (Specify) _____

GASTROINTESTINAL SYSTEM:

Bowel incontinence Ileostomy Colostomy Ulcers Other (Specify) _____

GENITOURINARY SYSTEM:

Urinary incontinence Frequent UTI's Kidney stones Diapers/Depends

Catheter (Specify type) _____ Other (Specify) _____

MUSCULOSKELETAL SYSTEM:

Kyphosis Scoliosis Spastic Flaccid Ataxia Gout

Contractures Paralysis Hemiplegia Paraplegia Quadriplegia Arthritis

Gait: Normal Shuffling Limp Unsteady Assistive Device (specify) _____

Deformities (specify) _____

Limb Loss (specify) _____

Prosthesis (specify) _____

Name: _____

SSN: _____

NORTH DAKOTA LEVEL OF CARE DETERMINATION FORM

IN DETERMINING NURSING FACILITY/SWING BED ELIGIBILITY, THE INDIVIDUAL MUST REQUIRE OR MEET A MINIMUM OF ONE CRITERION IN "SECTION A", TWO CRITERIA INCLUDED IN "SECTION B", ALL CRITERIA IN "SECTION C", OR ALL CRITERIA IN "SECTION D."

CHECK ALL THAT APPLY

SECTION A

- Nursing Facility stay is or is anticipated to be, temporary for receipt of Medicare Part A benefits. Nursing facility stay may be based on this criterion for no more than 14 days beyond termination of Medicare Part A benefits;
- The individual is in a comatose state;
- The individual requires use of a ventilator for at least six (6) hours a day;
- The individual has respiratory problems that require regular treatment, observation, or monitoring that can only be provided by or under the direction of a registered nurse (or in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30 (b), a licensed practical nurse) and the individual is incapable of self care;
- The individual requires constant help at least 60% of the time with at least two of the following Activities of Daily Living (ADL's): **Toileting** (process of using toileting equipment and cleansing self), **Eating** (process of getting food from receptacle into the body), **Transferring** (process of moving to and from bed, chair, toilet), **Locomotion** (process of navigating home environment with or without adaptive devices). Constant help is required if the individual requires a caregiver's continual presence or help, without which the activity would not be completed.
- The individual requires aspiration for maintenance of a clear airway
- The individual has dementia, physician diagnosed or supported with corroborative evidence, for at least six months, and as a result that dementia, the individual's condition has deteriorated to the point that a structured, professionally staffed environment is needed to monitor, evaluate, and accommodate the individual's changing needs.

SECTION B

- The individual requires administration of a prescribed (a) injectable medication; or (b) intravenous medication and solutions on a daily basis; or (c) routine oral medication, eye drops, or ointments on a daily basis.
- The individual has one or more **unstable medical conditions** requiring specific and individual services on a regular and continuing basis that can only be provided by or under the direction of a registered nurse (or in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30 (b), a licensed practical nurse).
- The individual is determined to have restorative potential and can benefit from restorative nursing or therapy treatments (e.g., gait training, bowel and bladder training), which are provided at least **five** days per week.

Level of Care
Continued

Name: _____

SSN: _____

SECTION B (continued)

- The individual requires administration of feedings by nasogastric tube, gastrostomy, jejunostomy, or parenteral route.
- The individual requires care of decubitus ulcers, stasis ulcers, or other widespread skin disorders.
- The individual requires constant help at least 60% of the time with at least one of the following Activities of Daily Living (ADL's): **Toileting** (process of using toileting equipment and cleansing self), **Eating** (process of getting food from receptacle into the body), **Transferring** (process of moving to and from bed, chair, toilet), **Locomotion** (process of navigating home environment with or without adaptive devices). Constant help is required if the individual requires a caregiver's continual presence or help, without which the activity would not be completed.

SECTION C

- If no criteria in Section A or B is met, an individual who applies to or resides in a nursing facility designated as a facility for nongeriatric individuals with physical disabilities may demonstrate that a nursing facility level of care is medically necessary if the individual is determined to have restorative potential. Describe:

SECTION D

- The individual has an acquired brain injury, including anoxia, cerebral vascular accident, brain tumor, infection, or traumatic brain injury; **and**
- As a result of the brain injury, the individual requires direct supervision at least eight hours a day.

Comments:

Evaluator Name and Credentials (printed) _____

Evaluator Signature _____ Date _____

Name: _____

SSN: _____

This section to be completed by DDM physician

Placement Determination:

- Nursing Facility Approved
- Nursing Facility Approved Short Term (indicate days-must be fewer than 180) _____
- Nursing Facility Denied

Rationale for Placement Determination:

- Swing Bed Approved
- Swing Bed Approved Short Term (indicate days-must be fewer than 180) _____
- Swing Bed Denied

Rationale for Placement Determination

Additional Comments (if applicable) :

Physician Name (printed) _____

Physician Signature _____ **Date** _____