

PREFACE

Each Resident's functional capacity screening is required by KAR 26-41-201, 26-42-201, and 26-43-201 to be:

- On a form specified by the department – the instrument included with this manual, or
- Integrated into a form developed by the facility if all the items on the form specified by the department are included in the facility instrument.

The definitions included in this manual must be used by facility staff in completing the Resident Functional Capacity Screen when using either the form specified by the department included with this manual, or a form developed by the facility.

Resident Functional Capacity Screen Manual

February 1997

(Updated July 11, 2008)

RESIDENT FUNCTIONAL CAPACITY SCREEN

I. Identification Information

A. Resident Name

First: _____ MI: _____

Last: _____

B. Date of Assessment

Month		Day		Year			

C. Primary Reason for Screen:

1. Admission
2. Significant Change
3. Annual

D. Gender:

1. Male 2. Female

E. Birthdate:

Month		Day		Year			

II. Functional Screen

Enter the code in the box to indicate resident's level of self-performance at the time of the functional screen.

0. Independent
1. Supervision needed
2. Physical assistance needed
3. Unable to perform

A. Activities of Daily Living

1. Bathing
2. Dressing
3. Toileting
4. Transfer
5. Walking, Mobility
6. Eating

B. Instrumental Activities of Daily Living

1. Meal Preparation
2. Shopping
3. Money Management
4. Transportation
5. Use of Telephone
6. Laundry, Housekeeping
7. Management of Medications
8. Management of Medical Treatments

C. Bladder Continence (code current performance for resident)

0. Continent
1. Usually Continent
2. Occasionally Incontinent
3. Frequently Incontinent
4. Incontinent

D. Cognition - Memory, Recall (record results from exam in manual)

- A. Short Term Memory
- B. Long Term Memory
- C. Memory/Recall
- D. Decision-Making

Total Score

E. Communication

1. Expresses information content, however able

0. Understandable
1. Usually understandable
2. Sometime understandable
3. Rarely or never understandable

2. Ability to understand others, verbal information, however able

0. Understands
1. Usually Understands
2. Sometimes Understands
3. Rarely or Never Understands

III. Current or Recent Problems and Risks

Check all the current or recent problems and risks the resident has had.

1. Falls, Unsteadiness
2. Impaired Vision
3. Impaired Hearing
4. Wandering
5. Socially Inappropriate Disruptive Behavior
6. Impaired Decision-Making
7. None

IV. Mobility Appliance/Devices

Check all that apply.

- a. Cane, Walker, Crutch
- b. Brace, Prothesis
- c. Wheelchair
- d. Mechanical Lift
- e. None of the Above

RESIDENT FUNCTIONAL CAPACITY SCREEN

INTRODUCTION

The Resident Functional Capacity Screen was developed to assist staff of assisted living facilities, residential health care facilities, homes plus and adult day care centers in identifying the services which a resident may need.

The capacity screen shall be performed by a licensed nurse, licensed social worker, adult care home administrator or an operator. In the event the capacity screen indicates that the resident will need health care services, a licensed nurse must assess the resident and develop a health care plan.

A health care plan will be required for residents who need assistance with the following activities:

- Assistance of one or more persons is needed by the resident to perform an activity of daily living. This includes direct care assistance for bathing, dressing, toileting, transfers, walking and eating. The coding for these would be 2, 3 or 4. Residents coded as independent (0) or requiring supervision (1) do not require a health plan for that activity. There may be instances when supervision of an activity of daily living may require a health plan. This would include residents who have cognitive impairments and are unable to make decisions independently.
- Toileting and management of incontinence.
- Management of medication.

USING THE RESIDENT FUNCTIONAL CAPACITY SCREEN

SOURCES OF INFORMATION

To accurately complete the Resident Functional Capacity Screen you will need to obtain information from a variety of sources. The knowledge and understanding of the resident gained through the information gathering process will assist you in accurately screening the resident's functional status and need for services.

Possible sources of information for accurate completion of the screening process are listed below:

1. The resident should be your primary source of information. Talk with and observe the resident. Use appropriate interview techniques based on any deficits the resident may have such as diminished hearing, eyesight and cognitive function.

2. Interview family members and other individuals who may have information which will assist you in completing the functional screen accurately.
3. There may be instances when the decision to admit or retain a resident is more dependent on the clinical condition of the resident than the functional status. In those instances, contacting the resident's physician or other health care professional will be essential to assure that appropriate services are included in the resident's negotiated service plan.

INTERVIEWING TECHNIQUES

In performing the resident functional capacity screen, you will be assisting individuals and their families in making important decisions related to the services included in the negotiated service agreement. The primary goal is to identify the service needs and preferences of the resident.

When you receive conflicting information from a resident, family or caregivers, clarify the issues before making a screening decision. You will need to weigh all the information and make your best judgment.

The following are some general guidelines to use when interviewing a resident.

- Observe the resident during the interview. This will assist you in answering questions found on the screen.
- Remember, the Resident Functional Capacity Screen is not a questionnaire. It is a common set of items which will assist you in developing a negotiated service agreement.
- Some items will require special sensitivity on your part during the questioning process. This is especially true on the items related to cognition (memory - recall). Please note the instructions for this section.
- Some individuals will be eager to talk, but will not stay on the topic. Gently guide the discussion back to the topic.

You might use one of the following phrases: "What do you mean?" "Tell me what you have in mind." "Tell me more about...," and "Please be more specific," "Give me an example...."

- When you are not sure what has been said, ask the resident or family member to clarify their statement. Be careful not to appear to challenge the individual. Examples would be "I think I hear you saying that..." "Let's see if I understood you correctly, you said..., Is that right?"

Many of the residents you interview will be elderly and in poor health. Older adults may have

vision and hearing impairments and have difficulty concentrating on what you are saying. The following are guidelines which may be useful in assuring a successful interview of an elder.

- Use the individual's last name and title (Mr., Mrs., Miss, Dr., Rev., etc.) when initiating the interview.
- If the resident uses eyeglasses or a hearing aid, be sure that they have them on. Verify that the hearing aid is working.
- Be sure the area where you are conducting the interview is adequately lighted. Ensure that a light is not directly shining into the eyes of the resident.
- Minimize interruptions or distractions during the interview. If a radio and television are on, ask the resident's permission to lower the volume or turn off the set.
- Try to sit so that the resident is across from you. Maintain eye contact. Be sure there is no activity behind you. This could distract the resident.
- Say the resident's name before you ask each question or set of questions. You also may want to ask the resident if they are ready for the next question.
- Provide the resident with ample time to answer a question. As you know, for many older persons it takes a longer time to process information. By waiting quietly for an answer you may be able to obtain more accurate information.
- Repeat a question or item if you think it has been misunderstood or misinterpreted.
- Pause or hesitate to indicate you are listening and need more or better information. This is a good technique to use while you are determining the resident's response pattern.

Coding responses to items on the resident functional capacity screen:

- Each section of the Resident Functional Capacity Screen contains one or more items labeled sequentially. For instance the second item Section II is designated as "II. A."
- Record a check mark in the appropriate boxes when the directions indicate "check all." (See Section III, "Current or Recent Problems or Risks.")
- Record a number in the boxes when the direction indicates "Enter the Code." (See Section II, "Functional Screen.")
- DATES -- Where you are to record month, day, and year, enter two digits for the month, day and year.

- NONE is a response option in several items. Check this item only when none of the other item responses apply. It should not be used to signify lack of information about the item.

ITEM INSTRUCTIONS FOR THE RESIDENT FUNCTIONAL CAPACITY SCREEN

This section contains the operational definitions for each item on the Resident Functional Capacity Screen. It is essential that you complete this document using the operational definitions found in this section. If you have a question concerning the appropriate coding convention, you should contact the Kansas Department on Aging (KDOA) at 785-296-4986 or 800-432-3535 and ask for the Director of Long Term Care or the Director of Mental Health and Residential Health Care Facilities for assistance. To assure accuracy and consistency, it is essential that this form be completed using the definitions found in this section.

SECTION I - IDENTIFICATION INFORMATION

A. Resident Name

Definition: Legal name of resident

Coding: Print in the following order -- first name, middle initial, last name.

B. Date of Screen

Definition: The date the screen was completed.

Coding: Enter the date the screen was completed.

C. Primary Reason for Screen

- Definition:
1. Admission - the functional capacity screen performed prior to or at admission to the facility.
 2. Significant change - the functional capacity screen performed due to a significant change in condition which necessitates amendment of the negotiated service agreement.
 3. Annual - a functional capacity screen performed at least annually. There has been approximately 365 days since the most recent screen was performed.

D. Gender Coding: Enter "1" for "Male" or "2" for "Female."

E. Birth Date Coding: Record the day, month, and year of the resident's birth.

SECTION II - FUNCTIONAL SCREEN

In completing this section of the screen, you will be making determinations concerning the resident's ability to function in their environment. It is essential that you obtain the necessary information from a variety of sources to make an accurate determination of the resident's level of functioning.

Observe the resident during the interview process. Talk with family members. Consult with direct care staff. A resident's ability to function may vary over the day. Ask about resident's abilities over the course of a day. Code for the lowest level of functioning.

If resident uses an assistive device to perform an activity, code the resident's ability with the use of the assistive device. Indicate in the comment section any assistive devices used by the resident to perform an activity of daily living.

Example: Mrs. Greer is recovering from an episode of extreme weakness following an acute illness. While in the hospital she was unable to walk without assistance. She received physical therapy. On the day she was assessed she was able to ambulate 150 feet with a walker. Her balance was improving. Staff were walking with her to remind her to use the walker appropriately. For walking, mobility, the appropriate coding would be "1" as she requires supervision and cuing. Note in comment section that Ms. Greer uses a walker to ambulate.

II. FUNCTIONAL SCREEN	
Enter the code in the box to indicate the resident's level of self performance at the time of the screen.	
<ul style="list-style-type: none"> 0. Independent 1. Supervision needed 2. Assistance of one person required 3. Assistance of two persons required 4. Unable to Perform 	
A. Activities for daily living	
1. Bathing	
2. Dressing	3
3. Toileting	3
4. Transfer	3
5. Walking, mobility	3
6. Eating	1
	1

A. Activities of Daily Living

Definition: **Bathing** - How the resident takes a full body bath or shower, or sponge bath, and transfers in and out of the tub or shower. Does not include washing of back and hair.

Coding: Enter the correct code for the resident's ability to perform the task of bathing.

0. Independent - Able to bathe self without any assistance.
1. Supervision needed - Requires oversight help only. Oversight includes reminding, preparing bath water, handing resident wash cloth. Resident able to transfer into shower or tub and can bathe self with cuing and oversight.
2. Physical assistance needed - Resident requires physical assistance getting into the bathtub and shower and/or requires some assistance with bathing.
3. Unable to perform - Resident unable to perform any part of the task of bathing.

Example: Mrs. Greer indicated and the nurse aide caring for her confirmed that Mrs. Greer performs most of the tasks related to taking a shower, but needs assistance of one person getting in and out of the shower stall. This item would be coded as a "2" Physical assistance by one person needed.

Definition: **Dressing** - How the resident puts on, fastens, and takes off all items of clothing, including donning and removing a prosthesis.

Coding: Enter the correct code to reflect the resident's ability to perform the task of dressing.

0. Independent - Resident is able to select appropriate clothing and dress self without any assistance. Residents who use a prosthesis are able to don and remove the prosthesis independently.
1. Supervision needed - Resident requires oversight, cuing or encouragement to select and/or put on appropriate clothing. Resident requires cuing or oversight to put on a prosthesis.
2. Physical assistance needed - Resident able to perform part of the task of dressing, but requires physical assistance such as guided maneuvering of limbs or other physical assistance.
3. Unable to perform - Resident is totally dependent on another person for all aspects of the task of dressing.

Example: Mr. Ames lives with his wife. He has been diagnosed as having Alzheimer's disease. In the interview, Mrs. Ames states that Mr. Ames can dress himself, but does not always select

clothing appropriate to the season. She selects his clothing and places it on the bed for him. With supervision, Mr. Ames is able to dress himself. Code "1" for supervision required for the task of dressing.

Definition: **Toileting** - How the resident uses the toilet (or commode, bedpan or urinal), transfers on and off the toilet, cleanses, changes pads, manages ostomy or catheter, adjusts clothing.

Coding: Enter the code which indicates the resident's level of functioning when performing the task of toileting.

0. Independent - Resident able to perform the task of toileting without assistance, oversight or cuing.
1. Supervision needed - Oversight, cuing or encouragement required to ensure resident can perform the task of toileting.
2. Physical assistance needed - Resident may be highly involved in the task of toileting, but physical assistance is required to assure that the task is performed safely. Physical assistance may include adjusting clothing, transferring to and from toilet, help using a urinal or bedpan.
3. Unable to perform - Resident requires assistance with **all** tasks related to toileting.

Example: Mr. Smith has had a stroke and has difficulty getting onto and off the toilet. He is unable to adjust his pajamas for toileting. He can assist with hygiene when handed toilet tissue. Code as "2" for physical assistance needed.

Definition: **Transfer** - How the resident moves between surfaces: to and from bed, chair, wheelchair, standing position. Do not include moving to and from bath or toilet.

Coding: Enter the code which indicates the resident's level of functioning for transfers.

0. Independent - Resident able to transfer self without cuing, oversight or physical assistance.
1. Supervision needed - Oversight, cuing, or supervision was required for the resident to transfer safely.
2. Physical assistance needed - Although the resident may be involved in the process of transferring, help was provided such as guided maneuvering of limbs or weight

bearing.

3. Unable to perform - Resident requires **full** assistance of at least one caregiver when transferring.

Example: With the use of a slide board and a trapeze bar Mrs. Winter is able to transfer from her bed to a wheelchair. She is able to transfer from the wheelchair to the toilet without assistance. Code as a "0" independent for transfer.

Definition: **Walking, mobility** - means the ability to move between locations in the environment. If resident uses a wheelchair, code for self-sufficiency of the resident once in the wheelchair.

- Coding:
0. Independent - Resident requires no oversight, cuing or encouragement to ambulate. Residents who use a wheelchair are able to be mobile without assistance from another person.
 1. Supervision - Resident requires cuing, oversight or encouragement to ambulate or to be mobile in a wheelchair.
 2. Physical assistance needed - Resident requires the physical assistance of one or more persons to walk safely. Resident uses a wheelchair and requires another person to move the chair from one place to another.
 3. Unable to perform - Resident unable to perform any of the tasks related to ambulation. Use this code for residents who are bedfast and do not use a wheelchair or other mobility devices.

Example: Mrs. Salisbury has multiple sclerosis. She uses a wheelchair for mobility. She can wheel the chair for short distances in her room on occasion. However, she tires easily and often needs someone to maneuver her wheelchair for her.

Code as a "2" physical assistance needed.

Definition: **Eating** - How the resident eats and drinks (regardless of skill).

- Coding:
0. Independent - Resident able to eat and drink without any cuing, oversight or encouragement.
 1. Supervision - Oversight, cuing or encouragement required to ensure resident eats.
 2. Physical assistance needed - Although resident may be actively involved in the task of eating, assistance is required for some of the tasks. This may include opening individual beverage containers and cutting up food. Use this code for residents who

need some assistance with eating, but are able to partially feed themselves.

3. Unable to perform - Resident must be fed by a caregiver. Use this code for residents who receive their nourishment via intravenous therapy or a feeding tube regardless of their ability to feed themselves.

Example: Mr. Weins is forgetful. His wife states that he likes to watch television while he eats. He will stop eating and she has to remind him several times during a meal to continue eating. Code as a "1" supervision needed.

B. Instrumental Activities of Daily Living

Definition: **Meal preparation** - means the ability to plan, prepare and serve meals.

- Coding:
0. Independent - Resident able to plan, prepare and serve meals.
 1. Supervision needed - Prepares adequate meals if ingredients are provided. Requires cuing or supervision to ensure that adequate meals are prepared.
 2. Heats and serves prepared meals, or prepares meals but does not maintain an adequate diet.
 3. Unable to perform - Resident meals are prepared and served by a caregiver.

Example: Mrs. Jones lives alone. She was admitted to the hospital for treatment of stasis ulcers. On admission her laboratory tests indicated a protein deficiency and anemia. Mrs. Jones stated in the interview that she can prepare her own meals. Code as a "2" as Mrs. Jones does not maintain an adequate diet.

Definition: **Shopping** - Ability to purchase food, clothing and household items.

- Coding:
0. Independent - Able to take care of all shopping needs without assistance.
 1. Supervision needed - Shops independently for small purchases, but needs oversight or supervision for most shopping needs.
 2. Physical assistance needed - Needs to be accompanied on any shopping trip by a caregiver.
 3. Unable to perform - Unable to shop.

Example: Mr. Dunston uses senior transportation to go to the grocery store and to the mall. He really appreciates the mechanical carts available in the grocery store as walking long distances

is tiring for him. Code as a "0".

Definition: **Money Management** - Ability to handle own finances.

Coding: 0. Independent - Manages own finances including budgeting, writing checks, paying bills; does own banking; collects and keeps track of income.

1. Supervision needed - Requires oversight related to financial matters. May need to be reminded to pay bills in a timely manner.
2. Physical assistance needed - Can manage small amounts of money for small purchases but needs assistance in writing checks and balancing checkbook.
3. Unable to perform - Incapable of handling finances.

Example: Mrs. Campbell has developed a severe hand tremor. Her eyesight has also diminished in the past year. Her next door neighbor assists her with paying her bills. Code as a "2".

Definition: **Transportation** - How resident is able to arrange and obtain transportation for shopping, physician appointments and social activities.

Coding: 0. Independent - Travels independently on public transportation or drives own car.

1. Supervision needed - Arranges own travel via taxi or assisted transportation program. Friends or family members provide transportation at the request of the resident. Resident does not require physical assistance in or out of a vehicle.
2. Physical assistance needed - Requires assistance getting into or out of a vehicle. Use this code for residents who use wheelchair accessible vehicles.
3. Unable to perform - Does not travel at all.

Definition: **Use of telephone** - The ability to obtain telephone numbers, dial the phone and answer the phone.

Coding: 0. Independent - Operates a telephone on own initiative. Looks up or obtains and dials numbers. Answers phone without assistance.

1. Supervision needed - Able to dial well-known numbers and answers phone. Needs supervision or cuing to dial infrequently called numbers.
2. Physical assistance needed - Requires physical assistance to answer and/or dial phone.

3. Unable to perform - Unable to use telephone.

Definition: **Laundry, housekeeping** - Ability to do own laundry and perform housekeeping tasks.

- Coding:
0. Independent - Does personal laundry and maintains home alone or with assistance from a homemaker, chore service or other assistance with heavy-work. Assistance is provided no more than one day a week.
 1. Supervision needed - With cuing and oversight, can do laundry and housekeeping tasks.
 2. Physical assistance needed - Can launder small items and perform light housekeeping tasks such as dusting and dishwashing. Other housekeeping and laundry tasks must be performed by someone else.
 3. Unable to perform - Does not perform laundry or housekeeping tasks.

Definition: **Management of medications, treatments** - Ability to self-administer medications and perform treatments as ordered by physician.

- Coding:
0. Independent - Self administers medications in the correct dosage at the ordered times. Performs medical treatments as ordered by physician.
 1. Supervision needed - Able to self administer medications if prepared in advance in separate dosages or with cuing and oversight. Requires cuing and oversight to ensure that ordered treatments are performed.
 2. Physical assistance needed - A caregiver prepares medications for administration and assists the resident to take medications. Requires some assistance from a caregiver when performing ordered treatments.
 3. Unable to perform - A caregiver is needed to administer medications and to perform all tasks related to ordered treatments.

Example: A nurse prefills Mrs. Wales' medication container weekly. Mrs. Wales is able to administer her medications daily. Code as a "2".

C. Bladder Continence

This section deals with the resident's physical ability to control the bladder. The resident's ability to handle the tasks related to toileting included in the activities of daily living section.

For many individuals, incontinence is a sensitive issue. Ask open ended questions which allow the resident to describe their bladder control. Examples would be "Do you have any difficulties controlling your bladder?" or "Do you wear special briefs or pads due to involuntary loss of urine?". Family members and other caregivers may also provide information which will assist you in completing this section.

Definition: **Bladder continence** - Identifies the resident's pattern of bladder continence or control.

- Coding:
0. Continent - Resident has complete control of bladder.
 1. Usually continent - Incontinence episodes occur no more than once weekly.
 2. Occasionally incontinent - Incontinence episodes occur at least twice a week but not daily.
 3. Frequently incontinent - Incontinence episodes tend to occur daily but some control is present.
 4. Incontinent - Lacks control. Multiple episodes of incontinence daily.

Example: Mr. Loomis has an indwelling urinary catheter due to an incompetent urinary sphincter following radiation therapy for prostatic cancer. He uses a leg bag during the day and a drainage bag at night. For the purposes of this screen, Mr. Loomis is considered to be continent with an appliance, the indwelling urinary catheter. Code as "0".

D. Cognition, memory, recall.

Be very cognizant of the resident's feelings when completing this section of the screen. Questions about cognitive function and memory can be sensitive issues. Use a non-judgmental approach. Ask the questions in a private setting.

- Engage the resident in general conversation to help establish rapport.
- Actively listen and observe for clues throughout the screening process.
- Be open, supportive, and reassuring. You may need to ask questions such as "Do you sometimes have trouble remembering things? Tell me what happens....".

A. Short term memory:

- Ask the resident to describe what they had for breakfast.
- Ask the resident to describe their day so far. This could include interactions with family or friends, activities such as watching television or having a bath.

Enter a "0" at A if the resident was able to recall recent events (short term memory). Enter a "1" at A if the resident had difficulty recalling recent events (short term memory).

B. Long term memory: Ask the resident several of the following questions.

- Where did you live before you were admitted to the hospital?
- What is your address?
- Are you married? If yes, ask for the name of their spouse.
- How many children do you have and what are their names?
- When is your birthday? In what year were you born?

Enter a "0" at B if the resident was able to demonstrate long term memory. Enter a "1" at B if the resident had difficulty with long term memory.

C. Memory/recall ability - Through observation during the interview, screen for memory/recall ability.

- Able to identify current season (e.g. correctly refers to weather for time of year, legal holidays, religious celebrations, etc.).
- Able to identify current location (e.g. own home, daughter's home, facility, etc.)
- Able to distinguish between family members, strangers, visitors and health care staff.

Enter a "0" at C if the resident does not appear to have difficulty with memory/recall. Enter a "1" at C if the resident has difficulty with memory/recall.

D. Decision-making ability

- Resident is able to organize daily routine and make consistent, reasonable and organized decisions. (Ask the resident if they have any problems making decisions or do they let spouse, family/friends or staff make decisions for them. Talk with persons who are with client on a daily basis and discuss with them the client's decision-making abilities.)

Enter a "0" at D for decision-making if the resident is able to make consistent, reasonable and organized decisions. Enter a "1" at D if the client has difficulty with decision-making or does not make decisions.

Coding: Enter the total score at D (Memory/recall) on screen.

E. Communication

Definition: **Expresses information content, however able** - determine the resident's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these.

Coding: Enter one number corresponding to the most correct response.

0. Understands--Resident expressed ideas clearly.
1. Usually understood--Resident had difficulty finding the right words or finishing thoughts, resulting in delayed responses; resident required some prompting to make self understood.
2. Sometimes understood --Resident had limited ability to communicate, but was able to express concrete requests regarding basic needs (e.g. food, drink, sleep, toilet).
3. Rarely or never understood - Understanding appeared to be limited. At best, resident used specific sounds or body language to communicate with caregiver(s).

Definition: **Ability to understand others** - Resident's ability to comprehend verbal information. Emphasis is on comprehension rather than hearing.

Coding: Enter one number corresponding to the most appropriate response:

0. Understands - Resident clearly comprehends the speaker's message and demonstrates comprehension by words, actions or behaviors.
1. Usually understands - Resident may miss some part or intent of the message but comprehends most of it. Resident may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions.
2. Sometimes understands - Resident demonstrates frequent difficulties integrating information. Resident responds adequately only to simple and direct questions or directions; rephrasing or simplifying the message(s) and/or using gestures enhances

comprehension.

3. Rarely or never understands -- Resident demonstrates very limited ability to understand communication; or it is difficult to determine whether the resident comprehends messages, based on verbal and nonverbal responses; or the resident can make sounds but does not understand messages.

SECTION III - CURRENT OR RECENT PROBLEMS AND RISKS

Definition: Current or recent problems and risks - To identify problems and risks which, at the time of the screen, affect the resident's functional capacity.

Coding: Check only if the problem or risk has a relationship to the resident's current functional status.

1. Falls, unsteadiness - Resident has fallen within the last 180 days and/or exhibits unsteadiness when attempting to rise from a chair or when walking.
2. Impaired vision - At best, resident can see large print, followed objects with eyes or appeared to only see light, color or shapes. Residents who have glasses should be evaluated with the glasses on.
3. Impaired hearing - Hears only some sounds; often fails to respond even when the speaker lowers voice tone, speaks distinctly, or faces resident. No comprehension of conversational speech, even when the speaker makes maximum adjustments. Residents who use assistive hearing devices should be evaluated with the devices.
4. Wandering - Movement with no identified rational purpose; resident appears oblivious to needs or safety. This behavior must be differentiated from purposeful movement (e.g., a hungry person moving about an area in search of food; pacing).
5. Socially inappropriate, disruptive behavior -Includes verbal abuse (others were threatened, screamed at, cursed at); physical abuse (others were hit, shoved, scratched, sexually abused); made disrupting sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared or threw food or feces, hoarding, rummaged through other's belongings.
6. Impaired decision-making. Resident has difficulty making decisions and/or makes decisions which are harmful or potentially harmful to resident.
7. None - None of the above problems or risks were identified.

SECTION IV - MOBILITY APPLIANCE/DEVICES

Definition: Identify the devices needed by the resident to perform activities of daily living.

Coding: Check all that apply.

SECTION V - ADL/IADL

Definition: Identify the potential for improved functioning in activities of daily living and instrumental activities of daily living. Ask the resident whether he or she believes they could be more self-sufficient if given more time, direction or a different kind of assistance. Listen to and record what the resident believes.

Coding: Check all that apply.

SECTION VI - MEDICATIONS

Definition: All medications which the resident is taking at the time of the screen. Include PRN medications and over the counter medications. You may want to review the medication by asking to see the medication containers. Indicate the dosage route and frequency of all prescription drugs and over the counter drugs.

SECTION VII - ORDERED THERAPIES AND TREATMENT

Definition: All therapies and treatments which the resident is receiving under a physician's order.

SECTION VIII - PRIMARY PERSON FOR LEGAL AND FINANCIAL MATTERS

Definition: Identify the individual(s) responsible for making decisions related to the resident's finances.

Coding: A. Check all that apply.

- Guardian - an individual appointed by a court of law to be the legal representative of another individual.
- Durable power of attorney for health care - an individual named by the resident as his/her agent in a durable power of attorney to make decisions related to health care.
- Durable power of attorney/power of attorney - an individual named by the resident as his/her agent to make financial decisions.

- Other legal oversight - Check this item if a conservator has been appointed by a court of law to manage the resident's financial affairs.

B. Primary person who manages care/financial matters, if other than resident. Record the name, address and phone number of the resident's legal representative in this item. If there are other individuals who participate in the management of the resident's care/financial matters, document their names, addresses and phone numbers in the Comment Section.

Definition: Individual, other than resident, who is responsible for making decisions related to care and services.

Coding: Print name, address and phone number in the space provided.

NOTE: The facility should maintain a copy of current advance directives in the resident's administrative file or the resident's clinical record.

SECTION IX – COMMENTS

Enter any pertinent information which you believe will be useful in making appropriate referrals for services in this section. Record pertinent medical or resident-specific information which would assist the referral process. If you have contacted the attending physician, other health care providers, or family and friends who could assist the resident in obtaining appropriate long term care services, list their name(s) and phone numbers in this section.

SECTION X - PARTICIPATION IN THE SCREEN

Definition: Indicate whether the resident, family and other individuals participated in the screening process. Others could be caregivers other than family members, case managers, and health care professionals with knowledge of the resident.

SECTION XI - SIGNATURES OF THOSE COMPLETING SCREEN

Definition: Identification of the specific individual(s) who conducted the functional capacity screen.

Coding: The administrator, licensed nurse, licensed social worker and/or operator must indicate their participation in the screening process by signing and dating the form.

**ADDRESS WHERE RESIDENT CAN BE CONTACTED
FOR FURTHER INFORMATION AND REFERRAL SERVICES**

If the resident's location for services will be different from the address recorded in Section I, enter the new address. In order to ensure that appropriate referral services can be made, it is essential that the location of the resident be identified.