BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

	.00	~. ID L I 1	10711011	11 OI IIII.	111011	
1.	RESIDENT NAME®					
		a. (First)	b. (Middle	nitial)	c. (Last)	d. (Jr/Sr)
2.	GENDER®	1. Male	2. Fema	ale		
3.	BIRTHDATE®	Mont	h Day	— Yea	ar	
4.	RACE/⊕	1 American	n Indian/Alaskan Nati	VO	4. Hispanic	
	ETHNICITY	2. Asian/Pa	cific Islander t of Hispanic origin	ve	5. White, not of Hispanic of	
5.	SOCIAL	a. Social Se	ecurity Number			
	SECURITY®		\vdash			
	AND		-			
	MEDICARE NUMBERS⊕	b. Medicare	number (or compara	able railroad in	surance numb	er)
	IC in 1st box if					
	non med. no.]					
6.	FACILITY	a. State No.				
	PROVIDER NO.®					
				+ + +	- 	
		b. Federal N	lo.			
7.	MEDICAID					
	NO. ["+" if pending, "N"					
	if not a					
	Medicaid					
	recipient]®					
8.		[Note—Oth	er codes do not apply	to this form]		
	FOR ASSESS-		reason for assessment (re		14)	
	MENT	2 Annu	al assessment `	, , ,	,	
			icant change in statu			
			icant correction of pri terly review assessm		ment	
		10 Signif	icant correction of pri	eni or quarterly as	ssessment	
		0. <i>NON</i>	E OF ABOVE	or quartorry as		
		b. Codes fo	or assessments req	uired for Med	dicare PPS or	the State
			care 5 day assessme			
			care 30 đay assessm care 60 day assessm			
			care 60 day assessin care 90 day assessin			
		5. Medio	care readmission/retu	ırn assessme	nt	
			state required asses			
			care 14 day assessm Medicare required a			
		o. Other	ivieulcare required a	3362211611		

 Signatures of Persons who Completed a Portion of the Accompanying Assessment of Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		
i.		
j.		
k.		
I.		

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1.	DATE OF	Date the stay began. Note — Does not include readmission if record wa	
	ENTRY	closed at time of temporary discharge to hospital, etc. In such cases, us admission date	e prior
		Month Day Year	
2.	ADMITTED	Private home/apt. with no home health services	
	FROM (AT ENTRY)	Private home/apt. with home health services Board and care/assisted living/group home	
	,	4. Nursing home 5. Acute care hospital	
		6. Psychiatric hospital, MR/DD facility	
		7. Rehabilitation hospital 8. Other	
3.	LIVED ALONE	0. No	
	(PRIOR TO	1. Yes	
1	ENTRY) ZIP CODE OF	2. In other facility	
4.	PRIOR		
	PRIMARY RESIDENCE		
5.	RESIDEN- TIAL	(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above)	
	HISTORY 5 YEARS	Prior stay at this nursing home	
	PRIOR TO	Stay in other nursing home	a.
	ENTRY	Other residential facility—board and care home, assisted living, group	b.
		home	c.
		MH/psychiatric setting	d.
		MR/DD setting	e.
		NONE OF ABOVE	f.
6.	LIFETIME OCCUPA-		
	TION(S) [Put "/"		
	between two		
7.	occupations] EDUCATION	1. No schooling 5. Technical or trade school	
' '	(Highest	2. 8th grade/less 6. Some college	
	Level Completed)	3.9-11 grades 7. Bachelor's degree 4. High school 8. Graduate degree	
8.	LANGUAGE	(Code for correct response)	
		a. Primary Language	
		0. English 1. Spanish 2. French 3. Other	
		b. If other, specify	
9.	MENTAL HEALTH	Does resident's RECORD indicate any history of mental retardation,	
	HISTORY	mental illness, or developmental disability problem? 0. No 1. Yes	
10.	CONDITIONS RELATED TO	(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely)	
	MR/DD STATUS	Not applicable—no MR/DD (Skip to AB11)	a.
	SIAIOS	MR/DD with organic condition	a.
		Down's syndrome	b.
		Autism	c.
		Epilepsy	d.
		Other organic condition related to MR/DD	e.
		MR/DD with no organic condition	f.
11.	DATE		
	BACK- GROUND		
	INFORMA- TION	Month Day Year	
	COMPLETED		

SECTION AC CUSTOMARY ROUTINE

	(Check all that apply. If all information UNKNOWN, check last box only	/.)
	CYCLE OF DAILY EVENTS	
(In year prior to DATE OF ENTRY	Stays up late at night (e.g., after 9 pm)	a.
to this nursing	Naps regularly during day (at least 1 hour)	b.
home, or year last in	Goes out 1+ days a week	c.
community if now being	Stays busy with hobbies, reading, or fixed daily routine	d.
admitted from another	Spends most of time alone or watching TV	е.
nursing home)	Moves independently indoors (with appliances, if used)	f.
	Use of tobacco products at least daily	g.
	NONE OF ABOVE	h.
	EATING PATTERNS	
	Distinct food preferences	i.
	Eats between meals all or most days	j.
	Use of alcoholic beverage(s) at least weekly	k.
	NONE OF ABOVE	I.
	ADL PATTERNS	
	In bedclothes much of day	m.
	Wakens to toilet all or most nights	n.
	Has irregular bowel movement pattern	о.
	Showers for bathing	p.
	Bathing in PM	q.
	NONE OF ABOVE	r.
	INVOLVEMENT PATTERNS	
	Daily contact with relatives/close friends	s.
	Usually attends church, temple, synagogue (etc.)	t.
	Finds strength in faith	u.
	Daily animal companion/presence	v.
	Involved in group activities	w.
	NONE OF ABOVE	x.
	UNKNOWN—Resident/family unable to provide information	у.

	Daily animal companion/presence		V.
	Involved in group activities		w.
	NONE OF ABOVE		x.
	UNKNOWN—Resident/family unabl	e to provide information	у.
	TION AD. FACE SHEET SIGNAT		
0.0			
a. Signa	ture of RN Assessment Coordinator		Date
informati dates sp applicab basis for from fed pation in ness of t substant certify th	that the accompanying information accurately on for this resident and that I collected or coord ecified. To the best of my knowledge, this infor le Medicare and Medicaid requirements. I und ensuring that residents receive appropriate and eral funds. I further understand that payment of the government-funded health care programs is his information, and that I may be personally suital criminal, civil, and/or administrative penaltic at I am authorized to submit this information by	inated collection of this information was collected in accorda erstand that this information is used quality care, and as a basis for such federal funds and continue s conditioned on the accuracy and bject to or may subject my organios for submitting false information this facility on its behalf.	on on the ence with sed as a payment d particid truthfulization to on. I also
Signa	ture and Title	Sections	Date
b.			
C.			
d.			
e.			
f.			
g.			
es		MDS 2.0 Septemb	per, 2000

Resident Numeric Identifier_

MINIMUM DATA SET (MDS) - VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING **FULL ASSESSMENT FORM**

(Status in last 7 days, unless other time frame indicated)

1. R	ESIDENT	DENTIFICATION AND BACKGROUND INFORMA	ATION 3	MEMORY/ RECALL	(Check all that resident last 7 days)	was norma	lly able to recall during
- 1	NAME			ABILITY	Го	a. The	ot ho/oho io in a nursina ham-
		a. (First) b. (Middle Initial) c. (Last) d.	(Jr/Sr)		Location of own room	b.	at he/she is in a nursing home
2.	ROOM				i		ONE OF ABOVE are recalled
	NUMBER		4	COGNITIVE SKILLS FOR	(Made decisions regard	•	• ,
	MENT	a. Last day of MDS observation period		DAILY DECISION-			sistent/reasonable some difficulty in new situations
RE	FERENCE DATE	Marth Pour Year		MAKING		<i>IRED</i> —dec	sions poor; cues/supervision
		Month Day Year			required 3. SEVERELY IMPAIRE	D—never/ra	arely made decisions
	DATE OF	b. Original (0) or corrected copy of form (enter number of correction)		INDICATORS			s.) [Note: Accurate assessment and family who have direct kno
	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospit last 90 days (or since last assessment or admission if less than 9		OF DELIRIUM— PERIODIC DISOR-	of resident's behavior 0. Behavior not present	over this tii	ne].
		Month Day Year		DERED THINKING/ AWARENESS	Behavior present, not Behavior present, over functioning (e.g., new)	er last 7 days	appears different from resident's
!	STATUS	1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated			sidetracked)		fficulty paying attention; gets
F	MEDICAL RECORD NO.				SURROUNDINGS-	(e.g., move	EPTION OR AWARENESS OF s lips or talks to someone not where else; confuses night and
S	CURRENT PAYMENT OURCES FOR N.H. STAY	(Billing Office to indicate; check all that apply in last 30 days) Medicaid per diem Medicare per diem Self or family pays for full per diem	f.		c. EPISODES OF DISC	cal, irrelevar	O SPEECH—(e.g., speech is t, or rambling from subject to
	JIAI	Medicare ancillary part A Medicaid resident liability or Medicare co-payment	h.			frequent po	5—(e.g., fidgeting or picking at skir sition changes; repetitive physical
		Medicare ancillary part B CHAMPUS per diem d. Private insurance per diem (including co-payment) Other per diem	<u>i.</u>		difficult to arouse; little	body move	,
		a. Primary reason for assessment Admission assessment (required by day 14) Annual assessment	J.		DAY—(e.g., sometime sometimes present, s	es better, so ometimes r	,
	MENT ote—If this	Significant change in status assessment Significant correction of prior full assessment Quarterly review assessment	6	CHANGE IN COGNITIVE STATUS	compared to status of 90 than 90 days)) days ago	abilities have changed as (or since last assessment if less
is a	a discharge	6 Discharged—return not anticipated			0. No change	1. Improve	d 2. Deteriorated
	or reentry sessment,	7. Discharged—return anticipated 8. Discharged prior to completing initial assessment	SE	CTION C	COMMUNICATION	N/HFAR	ING PATTERNS
on	ly a limited	9. Reentry		HEARING	(With hearing appliance		
M	Subset of IDS items need be	10. Significant correction of prior quarterly assessment 0. NONE OF ABOVE b. Codes for assessments required for Medicare PPS or the State		, ILAIIIIO	0. HEARS ADEQUATED 1. MINIMAL DIFFICULT	LY—normal Ywhen not	in quiet setting
C	ompleted]	Medicare 5 day assessment Medicare 30 day assessment			tonal quality and spea 3. HIGHLY IMPAIRED/a	ak distinctly	IS ONLY—speaker has to adjust
		3. Medicare 60 day assessment 4. Medicare 90 day assessment	2	COMMUNI-	(Check all that apply d		<u>~</u>
		Medicare readmission/return assessment		CATION DEVICES/	Hearing aid, present and	•	• /
		Other state required assessment Medicare 14 day assessment		TECH-	Hearing aid, present and	d not used re	egularly
		8. Other Medicare required assessment		NIQUES	Other receptive comm. to	echniques u	sed (e.g., lip reading)
		(Check all that apply) Durable power attorney/financial	d.		NONE OF ABOVE		
	BILITY/ LEGAL	Legal guardian a. Family member responsible	3	MODES OF EXPRESSION	(Check all used by resid		e needs known)
			e.				2' / /
	UARDIAN	Other legal oversight b. Patient responsible for self		LXI IILOOIOI	Speech	1 1	Signs/gestures/sounds
	UARDIAN	Durable power of Patient responsible for self	f.	EXI TIEGGION	Writing messages to	a. (Signs/gestures/sounds Communication board
G	UARDIAN	Durable power of attorney/health care c. Patient responsible for self	f. g.	EXI NEOGION	Writing messages to express or clarify needs	a. b.	
GI AI	DVANCED	Durable power of attorney/health care c. Patient responsible for self NONE OF ABOVE (For those items with supporting documentation in the medical record, check all that apply)	f. g.	EXITEGORY.	Writing messages to	b.	Communication board Other
G A[DVANCED	Durable power of attorney/health care (For those items with supporting documentation in the medical record, check all that apply) Living will Patient responsible for self NONE OF ABOVE **RONE OF ABOVE** **RONE OF ABOV	f. g.	MAKING	Writing messages to express or clarify needs American sign language	b. c.	Communication board Other NONE OF ABOVE
]]	DVANCED	Durable power of attorney/health care c. Patient responsible for self NONE OF ABOVE (For those items with supporting documentation in the medical record, check all that apply) Living will a. Peeding restrictions Do not resuscitate b. Medication restrictions			Writing messages to express or clarify needs American sign language or Braille (Expressing information 0. UNDERSTOOD	a. b. c. content—h	Communication board Other NONE OF ABOVE owever able)
GI AI	DVANCED	Durable power of attorney/health care (For those items with supporting documentation in the medical record, check all that apply) Living will Do not resuscitate Do not hospitalize Other treatment restrictions Patient responsible for self NONE OF ABOVE ROWNE OF ABOVE NONE OF ABOVE Other treatment restrictions Other treatment restrictions	f. 4	. MAKING SELF	Writing messages to express or clarify needs American sign language or Braille (Expressing information 0. UNDERSTOOD	a. b. c. content—h	Communication board Other NONE OF ABOVE
GI AI	DVANCED	Durable power of attorney/health care (For those items with supporting documentation in the medical record, check all that apply) Living will Do not resuscitate Do not hospitalize Organ donation Description Patient responsible for self NONE OF ABOVE ROWNE OF ABOVE ACCUMENTATION NONE OF ABOVE Octumentation in the medical record, check all that apply) Living will Do not resuscitate Do not hospitalize Other treatment restrictions	f. 4	MAKING SELF UNDER-	Writing messages to express or clarify needs American sign language or Braille (Expressing information 0. UNDERSTOOD 1. USUALLY UNDERSTOUGHT) thoughts 2. SOMETIMES UNDER	a. b. c. content—h	Communication board Other NONE OF ABOVE owever able)
G A[DVANCED	Durable power of attorney/health care (For those items with supporting documentation in the medical record, check all that apply) Living will Do not resuscitate Do not hospitalize Other treatment restrictions Patient responsible for self NONE OF ABOVE ROWNE OF ABOVE NONE OF ABOVE Other treatment restrictions Other treatment restrictions	f. 4	MAKING SELF UNDER-	Writing messages to express or clarify needs American sign language or Braille (Expressing information 0. UNDERSTODD 1. USUALLY UNDERST thoughts 2. SOMETIMES UNDER requests 3. RARELLY/NEVER UN	a. b. c. content—h TOOD—diffi	Communication board Other NONE OF ABOVE owever able) culty finding words or finishing ability is limited to making concrete
AIDIII	DVANCED RECTIVES	Durable power of attorney/health care c. Patient responsible for self NONE OF ABOVE (For those items with supporting documentation in the medical record, check all that apply) Living will a. Feeding restrictions Do not resuscitate b. Medication restrictions Do not hospitalize c. Other treatment restrictions Autopsy request e. NONE OF ABOVE	f. 4	MAKING SELF UNDER- STOOD	Writing messages to express or clarify needs American sign language or Braille (Expressing information 0. UNDERSTOOD 1. USUALLY UNDERST thoughts 2. SOMETIMES UNDER requests 3. RARELY/NEVER UN (Code for speech in the	a. b. c. content—h	Communication board Other NONE OF ABOVE owever able) culty finding words or finishing ability is limited to making concrete D
AIDII	DVANCED RECTIVES	Durable power of attorney/health care (For those items with supporting documentation in the medical record, check all that apply) Living will Do not resuscitate Do not hospitalize Organ donation Autopsy request D. Patient responsible for self NONE OF ABOVE Patient responsible for self NONE OF ABOVE	f. 4 g. h.	MAKING SELF UNDER- STOOD	Writing messages to express or clarify needs American sign language or Braille (Expressing information 0. UNDERSTOOD 1. USUALLY UNDERST thoughts 2. SOMETIMES UNDER requests 3. RARELY/NEVER UN (Code for speech in the 0. CLEAR SPEECH—d 1. UNCLEAR SPEECH	a. b. c. content—h FOOD—diffile RSTOOD— DERSTOO JOERSTOO JOER	Communication board Other NONE OF ABOVE owever able) culty finding words or finishing ability is limited to making concrete D igible words numbled words
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AI DII	DVANCED RECTIVES	Durable power of attorney/health care c. Patient responsible for self NONE OF ABOVE (For those items with supporting documentation in the medical record, check all that apply) Living will a. Do not resuscitate b. Medication restrictions Do not hospitalize c. Organ donation d. Autopsy request e. Other treatment restrictions NONE OF ABOVE COGNITIVE PATTERNS (Persistent vegetative state/no discernible consciousness)	f. 4 g. h.	MAKING SELF UNDER- STOOD SPEECH CLARITY ABILITYTO UNDER-	Writing messages to express or clarify needs American sign language or Braille (Expressing information 0. UNDERSTOOD 1. USUALLY UNDERST thoughts 2. SOMETIMES UNDER requests 3. RARELY/NEVER UN (Code for speech in the 0. CLEAR SPEECH—d 1. UNCLEAR SPEECH—d 2. NO SPEECH—abset (Understanding verbaling)	a. b. c.content—h	Communication board Other NONE OF ABOVE owever able) culty finding words or finishing ability is limited to making concrete D igible words numbled words en words
AIDIII	DVANCED RECTIVES TON B. OMATOSE MEMORY	Durable power of attorney/health care c. Patient responsible for self NONE OF ABOVE (For those items with supporting documentation in the medical record, check all that apply) Living will a. Do not resuscitate b. Medication restrictions Do not hospitalize c. Other treatment restrictions Autopsy request e. NONE OF ABOVE COGNITIVE PATTERNS (Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (If yes, skip to Section G) (Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes	f. 4 g. h. i.	MAKING SELF UNDER- STOOD SPEECH CLARITY	Writing messages to express or clarify needs American sign language or Braille (Expressing information 0. UNDERSTOOD 1. USUALLY UNDERSTOOD 1. USUALLY UNDERSTOOD 1. USUALLY UNDERSTOOD 1. USUALLY UNDERSTOOD 1. UNCLEAR SPEECH—d 1. UNCLEAR SPEECH—d 1. UNCLEAR SPEECH—d 2. NO SPEECH—abser (Understanding verbalin 0. UNDERSTANDS 1. USUALLY UNDERSTONDS	a. b. c. content—h FOOD—diffi RSTOOD— IDERSTOO last 7 days istinct, intell —slurred, m nce of spoke	Communication board Other NONE OF ABOVE owever able) culty finding words or finishing ability is limited to making concrete D igible words numbled words en words
T	DVANCED RECTIVES TION B. OMATOSE MEMORY	Durable power of attorney/health care c. NONE OF ABOVE (For those items with supporting documentation in the medical record, check all that apply) Living will a. Do not resuscitate b. Medication restrictions Do not hospitalize c. Other treatment restrictions Autopsy request e. NONE OF ABOVE COGNITIVE PATTERNS (Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (If yes, skip to Section G) (Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem	f. 4 g. h. i.	MAKING SELF UNDER- STOOD SPEECH CLARITY ABILITY TO UNDER- STAND	Writing messages to express or clarify needs American sign language or Braille (Expressing information 0. UNDERSTODD 1. USUALLY UNDERSTODD 1. USUALLY UNDERSTODD 1. USUALLY UNDERSTODD 1. UNCLEAR SPEECH—d 5. UNDERSTANDS 1. USUALLY UNDERSTODD 1. UNDERSTANDS 1. USUALLY UNDERSTODD 1. UNDERSTANDS 2. SOMETIMES UNDE	a. b. c. content—h TOOD—diffinant Todays istinct, intell —slurred, m nce of spoke formation of	Communication board Other NONE OF ABOVE owever able) culty finding words or finishing ability is limited to making concrete D igible words numbled words an words content—however able)
T C	DVANCED RECTIVES TION B. OMATOSE MEMORY	Durable power of attorney/health care c. Patient responsible for self NONE OF ABOVE (For those items with supporting documentation in the medical record, check all that apply) Living will a. Do not resuscitate b. Medication restrictions Do not hospitalize c. Other treatment restrictions Autopsy request e. NONE OF ABOVE COGNITIVE PATTERNS (Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (If yes, skip to Section G) (Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes	f. 4 g. h. i.	MAKING SELF UNDER- STOOD SPEECH CLARITY ABILITY TO UNDER- STAND	Writing messages to express or clarify needs American sign language or Braille (Expressing information 0. UNDERSTOOD 1. USUALLY UNDERST thoughts 2. SOMETIMES UNDER requests 3. RARELY/NEVER UN (Code for speech in the 0. CLEAR SPEECH—d 1. UNCLEAR SPEECH—d 2. NO SPEECH—abser (Understanding verbali in 0. UNDERSTANDS 1. USUALLY UNDERST message 2. SOMETIMES UNDE direct communication 3. RARELY/NEVER UN	a. b. c. content—h TOOD—diffile RSTOOD— JDERSTOO Jast 7 days istinct, intell —slurred, rn nce of spoke formation of TANDS—ma RSTANDS—MA RSTA	Communication board Other NONE OF ABOVE owever able) culty finding words or finishing ability is limited to making concrete D igible words numbled words en words content—however able) ay miss some part/intent of responds adequately to simple, DS
GI ALIII	DVANCED RECTIVES TION B. OMATOSE MEMORY	Durable power of attorney/health care (For those items with supporting documentation in the medical record, check all that apply) Living will Do not resuscitate Do not hospitalize Organ donation Autopsy request COGNITIVE PATTERNS (Persistent vegetative state/no discernible consciousness) O. No 1. Yes (If yes, skip to Section G) (Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes D. Long-term memory OK—seems/appears to recall long past	f. 4 g. h. i.	MAKING SELF UNDER- STOOD SPEECH CLARITY ABILITY TO UNDER- STAND	Writing messages to express or clarify needs American sign language or Braille (Expressing information 0. UNDERSTOOD 1. USUALLY UNDERST thoughts 2. SOMETIMES UNDER requests 3. RARELY/NEVER UN (Code for speech in the 0. CLEAR SPEECH—d 1. UNCLEAR SPEECH—d 2. NO SPEECH—abset (Understanding verbal in 0. UNDERSTANDS 1. USUALLY UNDERST message 2. SOMETIMES UNDERST message 2. SOMETIMES UNDERST message 2. SOMETIMES UNDERST message 3. RARELY/NEVER UN Resident's ability to expr	a. b. c. content—h COOD—diffi RSTOOD— IDERSTOO last 7 days istinct, intell —slurred, rnce of spoke information of TANDS—ma RSTANDS— IDERSTAN RSTANDS—ss, unders	Communication board Other NONE OF ABOVE owever able) culty finding words or finishing ability is limited to making concrete D igible words numbled words an words ontent—however able) ay miss some part/intent of -responds adequately to simple,

during last 7 days

SECTION D. VISION PATTERNS

		7.0.0.1.7.1.1.2.11.10	
1.	VISION	(Ability to see in adequate light and with glasses if used)	
		O. ADEQUATE—sees fine detail, including regular print in newspapers/books I. 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	
2.	LIMITATIONS/	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes NONE OF ABOVE	а. b. с.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

		tiasnes of light; sees "curtains" over	eyes	b.
		NONE OF ABOVE		c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying 0. No 1. Yes	glass	
SE	CTION E. M	OOD AND BEHAVIOR PAT	TERNS	
1.	INDICATORS OF DEPRES- SION,	(Code for indicators observed in assumed cause) 0. Indicator not exhibited in last 30 d 1. Indicator of this type exhibited up	last 30 days, irrespective of the ays to five days a week	
	ANXIETY, SAD MOOD	Indicator of this type exhibited dai VERBAL EXPRESSIONS	h. Repetitive health	<u>(</u> ()
		a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die!"	complaints—e.g., persistently seeks medical attention, obsessive concern with body functions i. Repetitive anxious complaints/concerns (non- health related) e.g.,	
		b. Repetitive questions—e.g., "Where do I go; What do I do?"	persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues	
		c. Repetitive verbalizations— e.g., calling out for help, ("God help me")	SLEEP-CYCLE ISSUES j. Unpleasant mood in morning	3
		d. Persistent anger with self or others—e.g., easily	k. Insomnia/change in usual sleep pattern	
		annoyed, anger at placement in nursing home; anger at care received	SAD, APATHETIC, ANXIOUS APPEARANCE I. Sad, pained, worried facial	
		e. Self deprecation—e.g.,"/ am nothing; I am of no use to anyone"	expressions—e.g., furrowed brows	
		f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others	m. Crying, tearfulness n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking	,
		g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack	Withdrawal from activities of interest —e.g., no interest in long standing activities or being with family/friends P. Reduced social interaction	
2.	MOOD PERSIS- TENCE	One or more indicators of depress not easily altered by attempts to "the resident over last 7 days 0. No mood 1. Indicators presindicators easily altered	ed, sad or anxious mood were cheer up", console, or reassure	
3.	CHANGE IN MOOD	Resident's mood status has changed days ago (or since last assessment 0. No change 1. Improved	d as compared to status of 90 if less than 90 days)	
4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequence 0. Behavior not exhibited in last 7 1. Behavior of this type occurred 2. Behavior of this type occurred 3. Behavior of this type occurred 6	y in last 7 days days I to 3 days in last 7 days 4 to 6 days, but less than daily	
		(B) Behavioral symptom alterabilit 0. Behavior not present OR behav 1. Behavior was not easily altered	vior was easily altered	a) (B)
		 a. WANDERING (moved with no rat oblivious to needs or safety) 	ional purpose, seemingly	
		b. VERBALLY ABUSIVE BEHAVIOR were threatened, screamed at, cu	irsed at)	
		c. PHYSICALLY ABUSIVE BEHAVI were hit, shoved, scratched, sexual	ally abused)	
		 SOCIALLY INAPPROPRIATE/DISYMPTOMS (made disruptive so self-abusive acts, sexual behavior smeared/threw food/feces, hoardi belongings) 	unds, noisiness, screaming, or disrobing in public, ng, rummaged through others'	
		e. RESISTS CARE (resisted taking assistance, or eating)	medications/ injections, ADL	

5. CHANGE IN Resident's behavior status has changed as compared to status of 90
BEHAVIORAL days ago (or since last assessment if less than 90 days)
SYMPTOMS 0. No change 1. Improved 2. Deteriorated

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF	At ease interacting with others	I_
1.	INITIATIVE/	_	a.
	INVOLVE-	At ease doing planned or structured activities	b.
	MENT	At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED	Covert/open conflict with or repeated criticism of staff	a.
	RELATION-	Unhappy with roommate	b.
	SHIPS	Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family/friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	b.
		, ,	С.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS 1. (A) ADL SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)

0. INDEPENDENT—No help or oversight —OR— Help/oversight provided only 1 or 2 times

	uuiiiig iasi	1 days		
	last7 days	SION—Oversight, encouragement or cueing provided 3 or more time: —OR— Supervision (3 or more times) plus physical assistance provi s during last 7 days	ded c	ng only
	guided ma	ASSISTANCE—Resident highly involved in activity; received physical ineuvering of limbs or other nonweight bearing assistance 3 or more ti help provided only 1 or 2 times during last 7 days	help i mes	n —
	period, hel — Weight-	VE ASSISTANCE—While resident performed part of activity, over last p of following type(s) provided 3 or more times: bearing support ff performance during part (but not all) of last 7 days	7-da	у
	4. TOTAL DE	EPENDENCE—Full staff performance of activity during entire 7 days		
	8. ACTIVITY	DID NOT OCCUR during entire 7 days		
	(B) ADL SUPF	PORT PROVIDED—(Code for MOST SUPPORT PROVIDED L SHIFTS during last 7 days; code regardless of resident's self-	(A)	(B)
		ce classification)	ш	
	1. Setup help		SELF-PERF	SUPPORT
	3. Two+ perso	n physical assist 8. ADL activity itself did not occur during entire 7 days	SEL	SUF
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
C.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMO- TION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMO- TION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing , including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

2.	BATHING	How resident takes full-body ba		
		transfers in/out of tub/shower (I Code for most dependent in a	EXCLUDE washing of back and hair.)	
		(A) BATHING SELF-PERFOR	RMANCE codes appear below (A) (B)
		Independent—No help pro		
		Supervision—Oversight he		
		 Physical help limited to train 	•	
		 Physical help in part of bat Total dependence 	ning activity	
		Activity itself did not occur	during entire 7 days	
		(Bathing support codes are as	defined in Item 1, code B above)	
3.	TEST FOR	(Code for ability during test in t	• /	
	BALANCE	Maintained position as requi Unsteady but able to rebala	ired in test nce self without physical support	
	(see training manual)	Partial physical support duri	ng test;	
	Indiridally	or stands (sits) but does not 3. Not able to attempt test with		
		a. Balance while standing		
		b. Balance while sitting—positi		
4.	FUNCTIONAL LIMITATION	(Code for limitations during las placed resident at risk of injury)	t 7 days that interfered with daily function	ns or
	IN RANGE OF	(A) RANGE OF MOTION	(B) VOLUNTARY MOVEMENT	r
	MOTION	No limitation Limitation on one side	No loss Partial loss	
	(see training manual)	Limitation on both sides		A) (B)
	manuaij	a. Neck	olbou	
		b. Arm—Including shoulder orc. Hand—Including wrist or fine	<u> </u>	+
		d. Leg—Including hip or knee		
		e. Foot—Including ankle or toe	s	
		f. Other limitation or loss		
5.	MODES OF LOCOMO-	(Check all that apply during la	ast 7 days)	
	TION	Cane/walker/crutch	a. Wheelchair primary mode of locomotion	d.
		Wheeled self	<u>b.</u>	
-	MODES OF	Other person wheeled (Check all that apply during la	c. NONE OF ABOVE	e.
6.	TRANSFER	Bedfast all or most of time	Lifted mechanically	
			a.	d.
		Bed rails used for bed mobility or transfer	Transfer aid (e.g., slide board, trapeze, cane, walker, brace)	e.
		Lifted manually	c. NONE OF ABOVE	f.
7.	TASK		ere broken into subtasks during last 7	
7.	TASK SEGMENTA- TION	Some or all of ADL activities w days so that resident could pe 0. No 1. Yes	rform them	
8.	SEGMENTA- TION ADL	days so that resident could pe 0. No 1. Yes Resident believes he/she is ca	rform them	
8.	SEGMENTA- TION ADL FUNCTIONAL REHABILITA-	days so that resident could pe 0. No 1. Yes Resident believes he/she is cal least some ADLs	rform them pable of increased independence in at	а.
8.	SEGMENTA- TION ADL FUNCTIONAL	days so that resident could pe 0. No 1. Yes Resident believes he/she is cal least some ADLs	rform them	
8.	SEGMENTA- TION ADL FUNCTIONAL REHABILITA- TION	days so that resident could pe 0. No 1. Yes Resident believes he/she is cal least some ADLs Direct care staff believe resider	rform them pable of increased independence in at nt is capable of increased independence	
8.	SEGMENTA- TION ADL FUNCTIONAL REHABILITA- TION	days so that resident could pe 0. No 1. Yes Resident believes he/she is cal least some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks Difference in ADL Self-Perform	rform them pable of increased independence in at nt is capable of increased independence	b. c.
8.	SEGMENTA- TION ADL FUNCTIONAL REHABILITA- TION	days so that resident could pe 0. No 1. Yes Resident believes he/she is cal least some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks Difference in ADL Self-Perform mornings to evenings	rform them pable of increased independence in at nt is capable of increased independence //activity but is very slow	b. c. d.
8.	SEGMENTA- TION ADL FUNCTIONAL REHABILITA- TION POTENTIAL	days so that resident could pe 0. No 1. Yes Resident believes he/she is calleast some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks Difference in ADL Self-Perform mornings to evenings NONE OF ABOVE	rform them pable of increased independence in at it is capable of increased independence /activity but is very slow nance or ADL Support, comparing	b. c.
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9.	SEGMENTA- TION ADL FUNCTIONAL REHABILITA- TION POTENTIAL CHANGE IN ADL FUNCTION	days so that resident could pe 0. No 1. Yes Resident believes he/she is cal least some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks Difference in ADL Self-Perform mornings to evenings NONE OF ABOVE Resident's ADL self-performar to status of 90 days ago (or sid days) 0. No change 1. Imp	prom them pable of increased independence in at it is capable of increased independence ractivity but is very slow nance or ADL Support, comparing nee status has changed as compared nee last assessment if less than 90 proved 2. Deteriorated	b. c. d.
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9. SE(SEGMENTATION ADL FUNCTIONAL REHABILITATION POTENTIAL CHANGE IN ADL FUNCTION CTION H. CO CONTINENCE (Code for resi 0. CONTINENCE (BOWEL, les 2. OCCASION BOWEL, on 3. FREQUENT control presi 4. INCONTINE BOWEL, all BOWEL CONTI- NENCE BLADDER	days so that resident could pe 0. No 1. Yes Resident believes he/she is cal least some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks Difference in ADL Self-Perform mornings to evenings NONE OF ABOVE Resident's ADL self-performar to status of 90 days ago (or sir days) 0. No change 1. Imp DNTINENCE IN LAST 1 ESELF-CONTROL CATEGOR dent's PERFORMANCE OVE. T—Complete control [includes loes not leak urine or stool] CONTINENT—BLADDER, incomes than weekly VALLY INCONTINENT—BLADDE ent (e.g., on day shift); BOWEL, ENT—Had inadequate control E (or almost all) of the time Control of bowel movement, w programs, if employed Control of urinary bladder func	rform them spable of increased independence in at int is capable of increased independence int is capable of increased independence int is capable of increased independence in at increased in at incr	b. c. d. e.
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9. SEC 1.	SEGMENTATION ADL FUNCTIONAL REHABILITATION POTENTIAL CHANGE IN ADL FUNCTION CTION H. CC CONTINENCE (Code for resi 0. CONTINENCE BOWEL, les 2. OCCASION BOWEL, on 3. FREQUENT control press 4. INCONTINE BOWEL, all BOWEL CONTI- NENCE BLADDER CONTI- NENCE BOWEL BOWEL	days so that resident could pe 0. No 1. Yes Resident believes he/she is cal least some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks Difference in ADL Self-Perform mornings to evenings NONE OF ABOVE Resident's ADL self-performar to status of 90 days ago (or sir days) 0. No change 1. Imp DNTINENCE IN LAST 1 SELF-CONTROL CATEGOR dent's PERFORMANCE OVE T—Complete control [includes does not leak urine or stool] ONTINENT—BLADDER, income status week TLY INCONTINENT—BLADDE ent (e.g., on day shift); BOWEL, ENT—Had inadequate control E (or almost all) of the time Control of bowel movement, w programs, if employed Bowel elimination pattern	rform them pable of increased independence in at a tris capable of increased independence in a tris capable of increased independence or ADL Support, comparing increased as compared and a capable of increased increa	b. c. d. e.
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	Numeric Identi	fier					
3.	APPLIANCES AND	Any scheduled toileting plan	a.	Did not use toilet room/	f.		
	PROGRAMS	Bladder retraining program	b.	Pads/briefs used	g.		
		External (condom) catheter	c.	Enemas/irrigation	h.		
		Indwelling catheter	d.	Ostomy present	i.		
		Intermittent catheter	e.	NONE OF ABOVE	j.		
4.	CHANGE IN URINARY	Resident's urinary continence 90 days ago (or since last ass		anged as compared to status of nt if less than 90 days)			
	CONTI- NENCE	0. No change 1. Im	proved	2. Deteriorated			
SECTION I. DISEASE DIAGNOSES							
Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)							

	tive diagnoses)				
1.	DISEASES	(If none apply, CHECK the N	ONE O	, '	
		ENDOCRINE/METABOLIC/		Hemiplegia/Hemiparesis	V.
		NUTRITIONAL		Multiple sclerosis	w.
		Diabetes mellitus	a.	Paraplegia	x.
		Hyperthyroidism	b.	Parkinson's disease	у.
		Hypothyroidism	c.	Quadriplegia	z.
		HEART/CIRCULATION		Seizure disorder	aa.
		Arteriosclerotic heart disease (ASHD)	d.	Transient ischemic attack (TIA) Traumatic brain injury	bb. cc.
		Cardiac dysrhythmias	е.	PSYCHIATRIC/MOOD	CC.
		Congestive heart failure	f.	Anxiety disorder	
		Deep vein thrombosis	g.	Depression	dd.
		Hypertension	h.	·	ee.
		Hypotension	i.	Manic depression (bipolar disease)	ff.
		Peripheral vascular disease	i.	Schizophrenia	gg.
		Other cardiovascular disease	k.	PULMONARY	33.
		MUSCULOSKELETAL		Asthma	hh.
		Arthritis	I.	Emphysema/COPD	ii.
		Hip fracture	m.	SENSORY	
		Missing limb (e.g., amputation)		Cataracts	jj.
		Osteoporosis	0.	Diabetic retinopathy	kk.
		Pathological bone fracture	p.	Glaucoma	II.
		NEUROLOGICAL		Macular degeneration	mm.
		Alzheimer's disease	q.	OTHER	
		Aphasia	r.	Allergies	nn.
		Cerebral palsy	s.	Anemia	00.
		Cerebrovascular accident		Cancer	pp.
		(stroke)	t.	Renal failure	qq.
		Dementia other than		NONE OF ABOVE	
		Alzheimer's disease	u.	NONE OF ABOVE	rr.
2.	INFECTIONS	Alzheimer's disease (If none apply, CHECK the N			rr.
2.	INFECTIONS	(If none apply, CHECK the No			
2.	INFECTIONS	(If none apply, CHECK the No Antibiotic resistant infection (e.g., Methicillin resistant		F ABOVE box)	g.
2.	INFECTIONS	(If none apply, CHECK the No Antibiotic resistant infection (e.g., Methicillin resistant staph)	ONE O	F ABOVE box) Septicemia	g.
2.	INFECTIONS	(If none apply, CHECK the No Antibiotic resistant infection (e.g., Methicillin resistant staph) Clostridium difficile (c.diff.)	a. b.	FABOVE box) Septicemia Sexually transmitted diseases Tuberculosis Urinary tract infection in last 30	g.
2.	INFECTIONS	(If none apply, CHECK the Not Antibiotic resistant infection (e.g., Methicillin resistant staph) Clostridium difficile (c.diff.) Conjunctivitis	a. b.	FABOVE box) Septicemia Sexually transmitted diseases Tuberculosis Urinary tract infection in last 30 days	g. h. i.
2.	INFECTIONS	(If none apply, CHECK the Not Antibiotic resistant infection (e.g., Methicillin resistant staph) Clostridium difficile (c.diff.) Conjunctivitis HIV infection	a. b. c.	FABOVE box) Septicemia Sexually transmitted diseases Tuberculosis Urinary tract infection in last 30 days Viral hepatitis	g. h. i. j.
2.	INFECTIONS	(If none apply, CHECK the Not Antibiotic resistant infection (e.g., Methicillin resistant staph) Clostridium difficile (c.diff.) Conjunctivitis HIV infection Pneumonia	a. b. c. d.	FABOVE box) Septicemia Sexually transmitted diseases Tuberculosis Urinary tract infection in last 30 days Viral hepatitis Wound infection	g. h. i. j. k.
		(If none apply, CHECK the Not Antibiotic resistant infection (e.g., Methicillin resistant staph) Clostridium difficile (c.diff.) Conjunctivitis HIV infection	a. b. c.	FABOVE box) Septicemia Sexually transmitted diseases Tuberculosis Urinary tract infection in last 30 days Viral hepatitis	g. h. i. j.
3.	OTHER	(If none apply, CHECK the Not Antibiotic resistant infection (e.g., Methicillin resistant staph) Clostridium difficile (c.diff.) Conjunctivitis HIV infection Pneumonia	a. b. c. d.	FABOVE box) Septicemia Sexually transmitted diseases Tuberculosis Urinary tract infection in last 30 days Viral hepatitis Wound infection	g. h. i. j. k.
		(If none apply, CHECK the Note Antibiotic resistant infection (e.g., Methicillin resistant staph) Clostridium difficile (c. diff.) Conjunctivitis HIV infection Pneumonia Respiratory infection a.	a. b. c. d.	FABOVE box) Septicemia Sexually transmitted diseases Tuberculosis Urinary tract infection in last 30 days Viral hepatitis Wound infection NONE OF ABOVE	g. h. i. j. k.
	OTHER CURRENT OR MORE DETAILED	(If none apply, CHECK the Note Antibiotic resistant infection (e.g., Methicillin resistant staph) Clostridium difficile (c. diff.) Conjunctivitis HIV infection Pneumonia Respiratory infection a. b.	a. b. c. d.	FABOVE box) Septicemia Sexually transmitted diseases Tuberculosis Urinary tract infection in last 30 days Viral hepatitis Wound infection NONE OF ABOVE	g. h. i. j. k.
	OTHER CURRENT OR MORE	(If none apply, CHECK the Ni Antibiotic resistant infection (e.g., Methicillin resistant staph) Clostridium difficile (c. diff.) Conjunctivitis HIV infection Pneumonia Respiratory infection a. b. c.	a. b. c. d.	FABOVE box) Septicemia Sexually transmitted diseases Tuberculosis Urinary tract infection in last 30 days Viral hepatitis Wound infection NONE OF ABOVE	g. h. i. j. k.
	OTHER CURRENT OR MORE DETAILED DIAGNOSES	(If none apply, CHECK the Note Antibiotic resistant infection (e.g., Methicillin resistant staph) Clostridium difficile (c. diff.) Conjunctivitis HIV infection Pneumonia Respiratory infection a. b.	a. b. c. d.	FABOVE box) Septicemia Sexually transmitted diseases Tuberculosis Urinary tract infection in last 30 days Viral hepatitis Wound infection NONE OF ABOVE	g. h. i. j. k.

SECTION J. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS		(Check all problems present in last 7 days unless other time frame is indicated)				
		INDICATORS OF FLUID		Dizziness/Vertigo	f.		
		STATUS		Edema	g.		
		Weight gain or loss of 3 or		Fever	h.		
		more pounds within a 7 day	_	Hallucinations	i.		
		period	a.	Internal bleeding			
		Inability to lie flat due to shortness of breath	b.	Recurrent lung aspirations in last 90 days	<u>у.</u> k.		
		Dehydrated; output exceeds		Shortness of breath	l.		
		input	C.	Syncope (fainting)	m.		
		Insufficient fluid; did NOT consume all/almost all liquids		Unsteady gait	n.		
		provided during last 3 days	d.	Vomiting	0.		
		OTHER		NONE OF ABOVE	p.		
		Delusions	e.				

2.	PAIN	(Code the highest level of pa	in prese	ent in the last 7 days)	
	SYMPTOMS	a. FREQUENCY with which		b. INTENSITY of pain	
		resident complains or shows evidence of pain		1. Mild pain	
		0. No pain (<i>skip to J4</i>)		2. Moderate pain	
		1. Pain less than daily		 Times when pain is horrible or excruciating 	
		2. Pain daily		nonible of orteradiating	
3.	PAIN SITE	(If pain present, check all sites that apply in last 7 days)			
		Back pain	a.	Incisional pain	f.
		Bone pain	b.	Joint pain (other than hip)	g.
		Chest pain while doing usual activities	c.	Soft tissue pain (e.g., lesion, muscle)	h.
		Headache	d.	Stomach pain	i.
		Hip pain	e.	Other	j.
4.	ACCIDENTS	(Check all that apply)			
		Fell in past 30 days	a.	Hip fracture in last 180 days	c.
		Fell in past 31-180 days	b.	Other fracture in last 180 days	d.
				NONE OF ABOVE	e.
5.	STABILITY OF	patterns unstable—(fluctuating	ident's c g, precar	ognitive, ADL, mood or behavior ious, or deteriorating)	a.
	CONDITIONS	Resident experiencing an acut chronic problem	e episo	de or a flare-up of a recurrent or	b.
		End-stage disease, 6 or fewer	months	to live	c.
		NONE OF ABOVE			d.

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL	Chewing problem	Chewing problem						
	PROBLEMS	Swallowing problem					b.		
		Mouth pain					C.		
		NONE OF ABOVE					d.		
2.	HEIGHT AND WEIGHT	Record (a.) height in inches a recent measure in last 30 day standard facility practice—e.g. off, and in nightclothes	s ;meás	ure we	eight co	onsistently in accord	d with		
		, ,	a. HT (in.) b. WT (lb.)						
3.	WEIGHT CHANGE	a. Weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes							
		b.Weight gain —5 % or more 180 days 0. No 1. Yes		0 day	s; or 10	% or more in last			
4.	NUTRI-	Complains about the taste of	·	Leav	ac 25%	6 or more of food			
4.	TIONAL	many foods	a.			nost meals	c.		
	PROBLEMS	Regular or repetitive complaints of hunger	b.	NON	IE OF A	ABOVE	d.		
5.	NUTRI-	(Check all that apply in las	t 7 days	5)					
	TIONAL APPROACH-	Parenteral/IV	a.	Dietary supplement betwee		plement between			
	ES	Feeding tube	b.	meals			f.		
		Mechanically altered diet	c.		guard sil, etc.	, stabilized built-up	g.		
		Syringe (oral feeding)	d.	On a	planne	ed weight change			
		Therapeutic diet	e.	progr	am		h.		
						ABOVE	i.		
	PARENTERAL OR ENTERAL INTAKE	ENTERAL a Code the proportion of total calories the resident received through							
		b. Code the average fluid inta 0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day	· 3	3. 1001 I. 1501	to 150 to 200	ube in last 7 days 00 cc/day 00 cc/day re cc/day			

SECTION L. ORAL/DENTAL STATUS

1.		Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
	DISEASE PREVENTION	Has dentures or removable bridge	b.
		Some/all natural teeth lost—does not have or does not use dentures (or partial plates)	C.
		Broken, loose, or carious teeth	d.
		Inflamed gums (gingiva);swollen or bleeding gums;oral abcesses; ulcers or rashes	e.
		Daily cleaning of teeth/dentures or daily mouth care—by resident or staff	f.
		NONE OF ABOVE	a

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SE	CHON M. S	KIN CONDITION	
1.	ULCERS (Due to any	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.]	Number at Stage
	cause)	A. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	at
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	
2.	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)	
		a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue	
		Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
3.	HISTORY OF	Resident had an ulcer that was resolved or cured in LAST 90 DAYS	
	RESOLVED ULCERS	0. No 1. Yes	
4.	OTHER SKIN	(Check all that apply during last 7 days)	
	PROBLEMS	Abrasions, bruises	a.
	OR LESIONS PRESENT	Burns (second or third degree)	b.
		Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)	c.
		Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster	d.
		Skin desensitized to pain or pressure	e.
		Skin tears or cuts (other than surgery)	f.
		Surgical wounds	g.
		NONE OF ABOVE	h.
5.	SKIN	(Check all that apply during last 7 days)	
	TREAT-	Pressure relieving device(s) for chair	a.
	MENTS	Pressure relieving device(s) for bed	b.
		Turning/repositioning program	c.
		Nutrition or hydration intervention to manage skin problems	d.
		Ulcer care	e.
		Surgical wound care	f.
		Application of dressings (with or without topical medications) other than to feet	g.
		Application of ointments/medications (other than to feet)	h.
		Other preventative or protective skin care (other than to feet) NONE OF ABOVE	i. j.
6.	FOOT	(Check all that apply during last 7 days)	•
	PROBLEMS AND CARE	Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems	a.
		Infection of the foot—e.g., cellulitis, purulent drainage	b.
		Open lesions on the foot	C.
		Nails/calluses trimmed during last 90 days	d.
		Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)	<u>а.</u> е.
		Application of dressings (with or without topical medications)	f.
		NONE OF ABOVE	

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	(Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour			
		per time period) in the: Morning	a.	Evening	c.
		Afternoon	b.	NONE OF ABOVE	d.
(lf r	esident is co	matose, skip to Se	ction C	0)	
2.	AVERAGE TIME	(When awake and not	receivi	ng treatments or ADL care)	
	INVOLVED IN	0. Most—more than 2/3 1. Some—from 1/3 to 2			
3.	PREFERRED	(Check all settings in	which a	ctivities are preferred)	
	ACTIVITY	Own room	a.	Outside facility	
	SETTINGS	Day/activity room	b.	Outside facility	d.
		Inside NH/off unit	c.	NONE OF ABOVE	e.
4.	GENERAL		VCES w	hether or not activity is currently	
	ACTIVITY PREFER-	available to resident) Cards/other games	_	Trips/shopping	g.
	ENCES	Crafts/arts	a.	Walking/wheeling outdoors	h.
	(adapted to resident's	Exercise/sports	b.	Watching TV	i.
	current	Music	c. d.	Gardening or plants	j.
	abilities)	Reading/writing		Talking or conversing	k.
		Spiritual/religious	e.	Helping others	
		activities	f.	NONE OF ABOVE	I. m.

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5.	PREFERS	Code for resident preferences in daily routines				
	CHANGE IN	0. No change	Slight change	Major change		
	DAILY ROUTINE	ILY a. Type of activities in which resident is currently involved				
		b. Extent of resident invo	lvement in activities			

SECTION O. MEDICATIONS

<u></u>	SECTION C. MEDICATIONS						
1.	NUMBER OF MEDICA- TIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used)					
2.	NEW MEDICA- TIONS	Resident currently receiving medications that were initiated during the ast 90 days) . No 1. Yes					
3.	INJECTIONS	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)					
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly) a. Antipsychotic b. Antianxiety c. Antidepressant (Record the number of DAYS during last 7 days; enter "0" if not used. less than weekly) d. Hypnotic e. Diuretic					

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1.	SPECIAL TREAT- MENTS.	a. SPECIAL CARE — Check to the last 14 days	eatmen	ts or programs receiv	ed dur	ing		
	PROCE-	TREATMENTS		Ventilator or respira	tor		I.	
	DURES, AND PROGRAMS	Chemotherapy	a.	PROGRAMS			i.	
		Dialysis	b.	Alcohol/drug treatm	ent			
		IV medication	c.	program			m.	
		Intake/output	d.	Alzheimer's/demen care unit	tia spe	cial	_	
		Monitoring acute medical condition	e.	Hospice care			n. o.	
		Ostomy care	f.	Pediatric unit			p.	_
		Oxygen therapy	g.	Respite care			q.	
		Radiation	h.	Training in skills req return to the comm				
		Suctioning	i.	taking medications,	house	0 /	r.	
		Tracheostomy care	j.	work, shopping, trai ADLs)	nsporta	ation,		
		Transfusions	k.	NONE OF ABOVE			s.	
		b.THERAPIES - Record the number of days and total minutes each following therapies was administered (for at least 15 minutes a day the last 7 calendar days (Enter 0 if none or less than 15 min. daily [Note—count only post admission therapies] (A) = # of days administered for 15 minutes or more DAYS MIN					ay) ii iily) I N	
		(B) = total # of minutes pro			(A)	(B)	
		a. Speech - language patholo	gy and	audiology services				
		b. Occupational therapy						
		c. Physical therapy						
		d. Respiratory therapy						
		e. Psychological therapy (by a health professional)	any lice	nsed mental				
2.	INTERVEN- TION	(Check all interventions or s matter where received)	trategie	es used in last 7 day	s-no			
	PROGRAMS FOR MOOD.	Special behavior symptom eva	aluation	program			a.	
	BEHAVIOR,	Evaluation by a licensed ment	al health	n specialist in last 90	days		b.	
	COGNITIVE	Group therapy					c.	\dashv
			hanges in the environment to address ., providing bureau in which to rummage					_
		Reorientation—e.g., cueing					d. e.	
		NONE OF ABOVE					f.	
3.	NURSING REHABILITA- TION/ RESTOR-	Record the NUMBER OF DA restorative techniques or pra more than or equal to 15 m (Enter 0 if none or less than	ctices v inutes	vas <mark>provided to</mark> the per day in the last	resid	ent fo		
	ATIVE CARE	a. Range of motion (passive)		f. Walking				
		b. Range of motion (active)		g. Dressing or groot	ming			
		c. Splint or brace assistance		h. Eating or swallow	ing			
		TRAINING AND SKILL PRACTICE IN:		i. Amputation/prost	hesis c	are		
		d. Bed mobility		j. Communication				
		e. Transfer		k. Other				

4.	DEVICES	(Use the following codes for last 7 days:) 0. Not used							
	AND	Not used Used less than daily							
	RESTRAINTS	2. Used daily							
		Bed rails							
		a. — Full bed rails on all open sides of bed							
		b. — Other types of side rails used (e.g., half rail, one side)							
		c. Trunk restraint							
		d. Limb restraint							
		e. Chair prevents rising							
5.	HOSPITAL	Record number of times resident was admitted to hospital with an							
	STAY(S)	overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no hospital admissions)							
_	EMEDOENOV								
6.		Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days).							
		(Enter 0 if no ER visits)							
7.	PHYSICIAN	In the LAST 14 DAYS (or since admission if less than 14 days in							
	VISITS	facility) how many days has the physician (or authorized assistant or							
		practitioner) examined the resident? (Enter 0 if none)							
8.	PHYSICIAN	In the LAST 14 DAYS (or since admission if less than 14 days in							
	ORDERS	facility) how many days has the physician (or authorized assistant or							
		practitioner) changed the resident's orders? Do not include order renewals without change. (Enter 0 if none)							
9.	ABNORMAL	Has the resident had any abnormal lab values during the last 90 days							
	LAB VALUES	(or since admission)?							
		0. No 1. Yes							
	ļ.								

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE POTENTIAL	SCHARGE a. Resident expresses/indicates preference to return to the community DTENTIAL							
		0. No	1. Yes						
		b. Resident has a support person who is positive towards discharge							
		0. No	1. Yes						
			Stay projected to be of a short duration— discharge projected within 90 days (do not include expected discharge due to death) O. No 2. Within 31-90 days						
			days 3. Disc						
2.	OVERALL CHANGE IN	compared to s	rall self sufficiend tatus of 90 days	cy has chang ago (or since	ed significantly as last assessment if less				
	CARE NEEDS	than 90 days)							
		U. No change	 Improved—re supports, nee restrictive leve 	eds less	Deteriorated—receives more support	6			

ASSESS-	b. Family:	0. No	1. Yes	No family			
MENT	c. Significant other	: 0. No	1. Yes	2. None			
2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:							
gnature of RN A	Assessment Coord	inator (sign on	above line)				
		Month —	- Dav	— Year			
	ASSESS-MENT SIGNATURE (gnature of RN A ate RN Assessi	ASSESS-MENT c. Significant other SIGNATURE OF PERSON COO	ASSESS-MENT c. Significant other: 0. No SIGNATURE OF PERSON COORDINATING: gnature of RN Assessment Coordinator (sign on ate RN Assessment Coordinator gned as complete	ASSESS- MENT c. Significant other: 0. No 1. Yes SIGNATURE OF PERSON COORDINATING THE ASSESS gnature of RN Assessment Coordinator (sign on above line) ate RN Assessment Coordinator gned as complete	ASSESS-MENT c. Significant other: 0. No 1. Yes 2. None SIGNATURE OF PERSON COORDINATING THE ASSESSMENT: gnature of RN Assessment Coordinator (sign on above line) ate RN Assessment Coordinator gned as complete		

1. Yes

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COTIONIT THE	ADV ELIDDI	MEDICARE PPS

1.	SPECIAL							er number o						
	TREAT- MENTS AND	recreation						for at leas	1 15 n		<i>tes a</i> DAYS) IN TI MIN	76
	PROCE- DURES		• `							Г	(A)		(B)	_
	501120							minutes or last 7 days		, -			Ť	Γ
		Skip unles				dica	re 5 c	lay or Medi	care	reac	lmis	sion	1	
		following	ther	apie	s to b nal ti	egin	in FİI	physician or RST 14 day speech pati	s of s	tay-	-phys			
		If not orde	ered,	skip	to it	em 2	•							
			leas					nate of the r can be expe						
			minu	tes (a	acros	s the		nate of the r apies) that o						
2.	WALKING WHEN MOST SELF							mance sco one of the				ER		
	SUFFICIENT	Reside	al the	rapy				py involving the residen	_		٠,	l.b.c)		
		Reside	ent re al the	ceive rapy	involv	_		ilitation for w g has been	•	• •	,	thin		
		Skip to ite	m 3 i	f resi	ident	did ı	not w	alk in last 7	days					
		EPISODE	WHE SITT	NTH ING	IE RE Dow	SIDI /N. IN	ENT V ICLU	ASE CODIN VALKED TH DE WALKIN	IE FA	RTH	EST			
		a. Furth		istar	ice w	alke	d with	out sitting do	own d	uring	this			
		0. 150 1. 51- 2. 26-	149 fe	eet				3. 10-25 fe 4. Less tha		feet				
		b. Time	walk	ed w	ithout	sittin	g dov	vn during thi	s epis	ode.				
		0. 1-2 1. 3-4 2. 5-10	minu	tes				3. 11-15 m 4. 16-30 m 5. 31+ min	inutes					
		c. Self-P	Perfo	rman	ice in	wall	king (luring this ep	oisode	Э.				
		1. <i>SUI</i>	PER\	/ISIC				oversight encouragem	ent o	rcue	ing			
		2. LIM rece	eived	ASS phys	ical h	elp ir	n guid	sident highly ed maneuve						
		nonweight bearing assistance 3. EXTENSIVE ASSISTANCE—Resident received weight bearing assistance while walking												
								sociated with ormance cla				ode		
		0. No: 1. Set 2. One	up he e pers	elp or son p	ılý hysic	al as	sist							
		3. Two e. Parall	•		. ,			n associatio	n with	this	episo	de.		
		0. No			1.Yes									
3.	CASE MIX GROUP	Medicare						State]
		i												

Resident	Numeric Identifier

1.	National Provider ID	Enter for all assessments and tracking forms, if available.	
		his assessment or the discharge date of this discharge s between July 1 and September 30, skip to W3.	
2.	Influenza Vaccine	 a. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3) b. If Influenza vaccine not received, state reason: 1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine 	
3.	Pneumo- coccal Vaccine	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

Numeric Identifier SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY Resident's Name: Medical Record No.: 1. Check if RAP is triggered. 2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status. · Describe: Nature of the condition (may include presence or lack of objective data and subjective complaints). Complications and risk factors that affect your decision to proceed to care planning. Factors that must be considered in developing individualized care plan interventions. Need for referrals/further evaluation by appropriate health professionals. Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident. Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.). 3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found. 4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs). (b) Care Planning Decision-check (a) Check if Location and Date of if addressed in A. RAP PROBLEM AREA triggered **RAP Assessment Documentation** care plan 1. DELIRIUM 2. COGNITIVE LOSS 3. VISUAL FUNCTION 4. COMMUNICATION 5. ADL FUNCTIONAL **REHABILITATION POTENTIAL** 6. URINARY INCONTINENCE AND **INDWELLING CATHETER** 7. PSYCHOSOCIAL WELL-BEING 8. MOOD STATE 9. BEHAVIORAL SYMPTOMS 10. ACTIVITIES 11. FALLS 12. NUTRITIONAL STATUS 13. FEEDINGTUBES 14. DEHYDRATION/FLUID MAINTENANCE 15. DENTAL CARE 16. PRESSURE ULCERS 17. PSYCHOTROPIC DRUG USE 18. PHYSICAL RESTRAINTS 1. Signature of RN Coordinator for RAP Assessment Process Month Day Yea

Month

ET COMINGO GARANTON COMINGO AND COMINGO AN RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0) = One item required to trigger 2= Two items required to trigger | 40,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 10,180 | 1 | 40, 11 amino ano 11 ao 12 ao 18 ao Comoration Fluio Maintenance ¥ = One of these three items, plus at least one other item required to trigger @=When both ADL triggers present, maintenance takes Comine Los Donomia Psychologic Drug Use precedence Benedical Smitting 4 Restraints 3 Tri 9067 A Waniona Saus - Prosume Urons 1 Visual Function | Communication J. Jogo Footing Tibes Proceed to RAP Review once triggered Activities 7 Lalls MDS ITEM CODE B2a Short term memory B2a Long term memor Decision making Indicators of delirium Understand others 4eA Behavioral symptoms///Charge in behavioral symptoms Change in behavioral symptoms Establishes ovyr goels/ Unsettled relationships Strong vit, mast roles Lost roles Delly routing different ADL self-performance G16A · G Balance Bedfast Glaucoma 1111 Denydration diagnosis

Hallucinations

Lung aspirations

The state of the s RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0) Key: = One item required to trigger 2= Two items required to trigger \bigstar = One of these three items, plus at least one other item 1 40, 1/8 info letto 1/3 60 4 8 A Dervariantivi Wainerance required to trigger @=When both ADL triggers present, maintenance takes 1 Coming Loss Donomia A Psychologic Drug Use precedence A Baharioal Smittons 3 Migor 8 " Pestaints 1 Numional Salus 3. Trigger A A Pessure Urors J Communication 1 Visual Function A Footing Tibes Proceed to RAP Review once triggered Aoiviies 7 MDS ITEM CODE Swallowing problem Previous pressure ulce M3 Hygaijeji taciile seps Awake morning Involved in activitie Antipsychotics Antidepréssants

ML	OS QUARI	ERLY ASSESSME	NT FORM	
A1.	RESIDENT NAME			
• •	POOM	a. (First) b. (Mid	ddle Initial) c. (Las	st) d. (Jr/Sr)
A2.	ROOM NUMBER			
АЗ.	ASSESS- MENT REFERENCE DATE	a. Last day of MDS observation Month Day Original (0) or corrected co	Year	correction)
\4 a	DATE OF	Date of reentry from most	ecent temporary dischar	ge to a hospital in
	REENTRY	last 90 days (or since last a		if less than 90 days)
A6.	MEDICAL RECORD NO.	Month Day	Year	
B1.	COMATOSE	Persistent vegetative state/n		
B2.	MEMORY	Recall of what was learned o	· (-)	<i>a</i>)
		Long-term memory OK—: 0. Memory OK 1. M	emory problem seems/appears to recall lon emory problem	
B4.	COGNITIVE SKILLS FOR	Made decisions regarding to	,	
	DAILY DECISION- MAKING	 INDEPENDENT—decision MODIFIED INDEPENDER only MODERATELY IMPAIRED required 	VCE—some difficulty in new	
	INIDIO ATODO	3. SEVERELY IMPAIRED—I Code for behavior in the las t		
В5.	INDICATORS OF DELIRIUM— PERIODIC DISOR- DERED	requires conversations with of resident's behavior over b. Behavior not present c. Behavior present, not of re	h staff and family who have this time]. cent onset	ve direct knowledge
	THINKING/ AWARENESS	 Behavior present, over las functioning (e.g., new onse a. EASILY DISTRACTED—(et or worsening)	
		present; believes he/she is	PERCEPTION OR AWARI , moves lips or talks to som somewhere else; confuses	eone not
		 day) EPISODES OF DISORG, incoherent, nonsensical, in subject; loses train of thou 	relevant, or rambling from s	
		d.PERIODS OF RESTLESS clothing, napkins, etc; freq movements or calling out)	SNESS—(e.g., fidgeting or uent position changes; repe	picking at skin, titive physical
		e. PERIODS OF LETHARG difficult to arouse; little bod		ing into space;
		sometimes present, some	etter, sometimes worse; beh times not)	
C4.	MAKING SELF	(Expressing information cont D. UNDERSTOOD	ent—however able)	
	UNDER- STOOD	 USUALLY UNDERSTOOL thoughts SOMETIMES UNDERSTORM 	, ,	
C6.	ABILITYTO	requests 3. RARELY/NEVER UNDEF Understanding verbal inforn		ole)
00.	UNDER- STAND OTHERS	D. UNDERSTANDS 1. USUALLY UNDERSTAND message	S—may miss some part/in	tent of
		 SOMETIMES UNDERST/ direct communication RARELY/NEVER UNDER 	STANDS	
E1.	INDICATORS OF	(Code for indicators obser assumed cause)		ective of the
	DEPRES- SION, ANXIETY,	Indicator not exhibited in la Indicator of this type exhib Indicator of this type exhib	ited up tó five days a week ited daily or almost daily (6,	
	SAD MOOD	/ERBAL EXPRESSIONS OF DISTRESS a. Resident made negative	c. Repetitive verb e.g., calling ou ("God help me	t for help,
		statements—e.g., "Nothing matters; Would rather be	otners—e.g., e	easily annoyed,
		dead;What's the use; Regrets having lived so long; Let me die'	anger at place nursing home; received	anger at care
		b. Repetitive questions—e.g. "Where do I go; What do I	e. Self deprecation nothing; I am of a serional!	

_		ALEED AVAILE MALLES	
E1.	OF	VERBAL EXPRESSIONS OF DISTRESS SLEEP-CYCLE ISSUES j. Unpleasant mood in morning	
	DEPRES- SION,	f. Expressions of what appear to be unrealistic sleep pattern	
	ANXIETY, SAD MOOD (cont.)	fears—e.g., fear of being abandoned, left alone, being with others SAD, APATHETIC, ANXIOUS APPEARANCE	
		g. Recurrent statements that something terrible is about	
		to happen—e.g., believes he or she is about to die, m. Crying, tearfulness	
		h. Repetitive health n. Repetitive health n. Repetitive physical movements—e.g., pacing,	
		complaints—e.g., persistently seeks medical fideting, picking	
		attention, obsessive concern with body functions Mith descriptions	
		i. Repetitive anxious complaints/concerns (non-	
		health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry,	
E2.	MOOD	clothing, relationship issues One or more indicators of depressed, sad or anxious mood were	
LZ.	PERSIS- TENCE	not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days	
		No mood 1. Indicators present, 2. Indicators present, indicators easily altered not easily altered	
E4.	BEHAVIORAL SYMPTOMS	0. Behavior not exhibited in last 7 days	
		Behavior of this type occurred 1 to 3 days in last 7 days Behavior of this type occurred 4 to 6 days, but less than daily Behavior of this type occurred daily	
		(B) Behavioral symptom alterability in last 7 days 0. Behavior not present OR behavior was easily altered	(B)
		Behavior was not easily altered A WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	(B)
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)	
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)	
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming,	
		self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)	
		RESISTS CARE (resisted taking medications/injections, ADL assistance, or eating)	
G1.		F-PERFORMANCE—(<i>Code for resident's PERFORMANCE OVER AL</i> l luring last 7 days—Not including setup)	L
	INDEPEN during last	IDENT—No help or oversight —OR— Help/oversight provided only 1 or 2 7 days	2 times
	last7 days	SION—Oversight, encouragement or cueing provided 3 or more times d —OR— Supervision (3 or more times) plus physical assistance provide as during last 7 days	uring d only
	guided ma	ASSISTANCE—Resident highly involved in activity; received physical hel aneuvering of limbs or other nonweight bearing assistance 3 or more time be help provided only 1 or 2 times during last 7 days	
	period, hel — Weight-	VE ASSISTANCE—While resident performed part of activity, over last 7- lp of following type(s) provided 3 or more times: bearing support	day
	— Full sta	ff performance during part (but not all) of last 7 days EPENDENCE—Full staff performance of activity during entire 7 days	
		CITE NOT OCCUR during entire 7 days	(A)
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed	
b.	TRANSFER	How resident moves between surfaces—to/from:bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	
C.	WALK IN ROOM	How resident walks between locations in his/her room.	
d.	WALK IN CORRIDOR	How resident walks in corridor on unit.	
e.	LOCOMO- TION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	
f.	LOCOMO- TION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis	
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of	
		nourishment by other means (e.g., tube feeding, total parenteral nutrition).	

i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes								
j.	PERSONAL HYGIENE	brushing teeth, shaving, applyi	low resident maintains personal hygiene, including combing hair, rushing teeth, shaving, applying makeup, washing/drying face, hands, nd perineum (EXCLUDE baths and showers)							
G2.	BATHING	How resident takes full-body b transfers in/out of tub/shower (d hair.)					
		Code for most dependent in (A) BATHING SELF PERFOR	self-per	formance.						
		Independent—No help pro		_ codes appear below		(A)				
			Supervision—Oversight help only							
			Physical help limited to transfer only							
		3. Physical help in part of bat	thing ac	tivity						
		Total dependence Activity itself did not occur	during	antiro 7 dave						
G4.	FUNCTIONAL	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			ilv function	ns or				
-	LIMITATION IN RANGE OF	placed residents at risk of injur		(B) VOLUNTARY MC	•					
	MOTION	Ò. No limitation		Ò. No loss	'V LIVILI V I					
		Limitation on one side Limitation on both sides		 Partial loss Full loss 	(A	A) (B)				
		a. Neck								
		b. Arm—Including shoulder or								
		c. Hand—Including wrist or fine d. Leg—Including hip or knee	gers			+				
		e. Foot—Including ankle or too	es			+				
		f. Other limitation or loss								
G6.	MODES OF	(Check all that apply during l	ast 7 da	iys)						
	TRANSFER	Bedfast all or most of time	a.	NONE OF ABOVE		f.				
		Bed rails used for bed mobility or transfer			·					
H1.	CONTINENCE	SELF-CONTROL CATEGOR	IFS							
		dent's PERFORMANCE OVE		SHIFTS)						
	CONTINEN device that c	IT—Complete control [includes does not leak urine or stool]	use of i	ndwelling urinary cathet	er or ostor	my				
		CONTINENT—BLADDER, incost than weekly	ntinent	episodes once a week o	or less;					
	2. OCCASION BOWEL, on	VALLY INCONTINENT—BLADI ce a week	DER, 2	or more times a week b	ut not daily	/ ;				
	3. FREQUENT	TLY INCONTINENT—BLADDE ent (e.g., on day shift); BOWEL,	R, tend	ed to be incontinent dail	ly, but som	ne				
	4. INCONTINE	ENT—Had inadequate control E (or almost all) of the time			des;					
a.	BOWEL	Control of bowel movement, w	ith appl	iance or bowel continen	ce					
b.	CONTI- NENCE BLADDER	programs, if employed Control of urinary bladder fund	ction (if o	dribbles, volume insuffici	ent to					
H2.	CONTI- NENCE BOWEL	soak through underpants), wit programs, if employed	h applia	I	tinence					
	ELIMINATION PATTERN	Fecal impaction	d.	NONE OF ABOVE		e.				
Н3.	APPLIANCES AND	Any scheduled toileting plan	a.	Indwelling catheter		d.				
	PROGRAMS	Bladder retraining program	b.	Ostomy present		i.				
		External (condom) catheter	c.	NONE OF ABOVE		i.				
12.	INFECTIONS	Urinary tract infection in last 30 days		NONE OF ABOVE		m.				
13.	OTHER	(Include only those diseases				e a				
	CURRENT DIAGNOSES	relationship to current ADL s medical treatments, nursing m			behavior s	status,				
	AND ICD-9	3		J, ,						
	CODES	a		1 1	•					
		b.			•					
J1.	PROBLEM CONDITIONS	(Check all problems present Dehydrated; output exceeds	ın ıas t	7 days) Hallucinations	ı					
			c.	NONE OF ABOVE	l	i.				
J2.	PAIN	(Code the highest level of pa	in prese			p.				
	SYMPTOMS	a. FREQUENCY with which		b. INTENSITY of pain						
		resident complains or shows evidence of pain		1. Mild pain						
		0. No pain (<i>skip to J4</i>)		2. Moderate pain						
		1. Pain less than daily		3. Times when pain is hor excrutiating	norrible					
		2. Pain daily		or excrutiality						
J4.	ACCIDENTS	(Check all that apply)		Hip fracture in last 180) days	c.				
		Fell in past 30 days	a.	Other fracture in last 1	- 1	d.				
		Fell in past 31-180 days	b.	NONE OF ABOVE		e.				

.15	CTADII ITV	Conditions/diseases make resident's cognitive, ADL, mood or behavior									
J5.	OF	status unstable — (fluctuating, precarious, or deteriorating)									
	CONDITIONS	Resident experiencing an acute episode or a flare-up of a recurrent or									
		chronic problem End-stage disease, 6 or fewer months to live									
		NONE OF ABOVE d.									
K3.	WEIGHT	a. Weight loss-5% or more in last 30 days; or 10% or more in last									
	CHANGE	180 days 0. No 1. Yes									
		b. Weight gain—5 % or more in last 30 days; or 10 % or more in last									
		180 days 0. No 1. Yes									
K5.	NUTRI-	Feeding tube b	<u> </u>								
	TIONAL APPROACH-	On a planned weight change program									
	ES	NONE OF ABOVE i.									
М1.	ULCERS	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply	age tage								
	(Due to any	during last 7 days. Code 9 = 9 or more.) [Rèquires full body exam.]	Number at Stage								
	cause)	a. Stage 1. A persistent area of skin redness (without a break in the									
		skin) that does not disappear when pressure is relieved.									
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.									
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous									
		tissues - presents as a deep crater with or without undermining adjacent tissue.									
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.									
M2.	TYPE OF	(For each type of ulcer, code for the highest stage in the last 7 days us	sing								
	ULCER	scale in item M1—i.e., 0=none; stages 1, 2, 3, 4) a. Pressure ulcer—any lesion caused by pressure resulting in damage									
		of underlying tissue									
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities									
N1.	TIME	(Check appropriate time periods over last 7 days)									
	AWAKE	Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Evening									
		Morning a. b. NONE OF ABOVE d									
(lf r	esident is co	omatose, skip to Section 0)	<i>.</i> .								
N2.		(When awake and not receiving treatments or ADL care)									
	TIME INVOLVED IN	0. Most—more than 2/3 of time 2. Little—less than 1/3 of time									
01.	ACTIVITIES NUMBER OF										
٥١.	MEDICA-	enter "0" if none used)									
04.	TIONS	(Record the number of DAYS during last 7 days; enter "0" if not									
0 4.	RECEIVED	used. Note—enter "1" for long-acting meds used less than weekly)									
	THE FOLLOWING	a. Antipsychotic d. Hypnotic									
	MEDICATION	b. Antianxiety c. Antidepressant e. Diuretic									
P4.	DEVICES	Use the following codes for last 7 days :									
	AND RESTRAINTS	0. Not used									
	DESTRAINTS	2. Used daily									
		Bed rails									
		a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) —									
		c. Trunk restraint									
		d. Limb restraint									
		e. Chair prevents rising									
Q2.	OVERALL CHANGE IN	Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less									
	CARE NEEDS	than 90 days) 0. No change 1. Improved—receives fewer 2. Deteriorated—receives									
		supports, needs less more support restrictive level of care									
R2.	SIGNATURE	OF PERSON COORDINATING THE ASSESSMENT:									
a. S		Assessment Coordinator (sign on above line)									
	ignature of RN	Assessment Coordinator (sign on above line)									
	ate RN Assess	sment Coordinator									
	•	sment Coordinator lete									
	ate RN Assess	sment Coordinator lete									
	ate RN Assess	sment Coordinator lete									

Resident	Numeric Identifier

1.	National Provider ID	Enter for all assessments and tracking forms, if available.	
		his assessment or the discharge date of this discharge s between July 1 and September 30, skip to W3.	
2.	Influenza Vaccine	 a. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3) b. If Influenza vaccine not received, state reason: 1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine 	
3.	Pneumo- coccal Vaccine	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

MDS QUARTERLY ASSESSMENT FORM (OPTIONAL VERSION FOR RUG-III)

	(OF I	IONAL VERSION FOR RUG-III)
A1.	RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
A2.	ROOM NUMBER	a. (i iist) b. (iviidule ii iiiai) c. (East) d. (oino)
A3.	ASSESS- MENT	a. Last day of MDS observation period
	DATE DATE	Month Day Year
		b. Original (0) or corrected copy of form (enter number of correction)
A4.	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days
		Month Day Year
A6.	MEDICAL RECORD NO.	
B1.	COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (Skip to Section G)
B2.	MEMORY	(Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes
		D. Memory OK 1. Memory problem Long-term memory OK—seems/appears to recall long past
		0. Memory OK 1. Memory problem
B3.	MEMORY/ RECALL ABILITY	(Check all that resident was normally able to recall during last 7 days) Current season a.
		Location of own room b.
B4.	COGNITIVE	Staff names/faces c. NONE OF ABOVE are recalled e. (Made decisions regarding tasks of daily life)
J4.	SKILLS FOR DAILY	INDEPENDENT—decisions consistent/reasonable
	DECISION- MAKING	MODIFIED INDEPENDENCE—some difficulty in new situations only
		MODERATELY IMPAIRED—decisions poor; cues/supervision required SEVERELY IMPAIRED—never/rarely made decisions
B5.	INDICATORS	10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	OF DELIRIUM— PERIODIC	of resident's behavior over this time].
	DISOR- DERED	Behavior not present Behavior present, not of recent onset
	THINKING/ AWARENESS	Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)
		a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)
		b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
		c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
		d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)
		e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)
		f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)
C4.	MAKING SELF	(Expressing information content—however able)
	UNDER- STOOD	O. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts
		SOMETIMES UNDERSTOOD—ability is limited to making concrete requests
C6.	ABILITYTO	3. RARELY/NEVER UNDERSTOOD (Understanding verbal information content—however able)
	UNDER- STAND	UNDERSTANDS UNDERSTANDS—may miss some part/intent of
	OTHERS	message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication
F1	INDICATORS	3. RARELY/NEVER UNDERSTANDS
	OF DEPRES-	(Code for malcators observed in last 30 days, irrespective of the assumed cause) [0. Indicator not exhibited in last 30 days]
	SION, ANXIETY, SAD MOOD	Indicator of this type exhibited up to five days a week Indicator of this type exhibited daily or almost daily (6, 7 days a week)

	Numeric Ident	fier								
E1.		VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die" b. Repetitive questions—e.g., "Where do I go; What do I do?" c. Repetitive verbalizations—e.g., calling out for help, ("God help me") d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received e. Self deprecation—e.g., "I am nothing; I am of no use to anyone" f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others	h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues SLEEP-CYCLE ISSUES j. Unpleasant mood in morning k. Insomnia/change in usual sleep pattern SAD, APATHETIC, ANXIOUS APPEARANCE I. Sad, pained, worried facial expressions—e.g., furrowed brows m. Crying, tearfulness n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking							
E2.	MOOD	g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack One or more indicators of depress	O. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends p. Reduced social interaction sed sad or anxious mood were							
E2.	PERSIS- TENCE	not easily altered by attempts to the resident over last 7 days O. No mood I. Indicators presen indicators easily altered	"cheer up", console, or reassure							
	SYMPTOMS	(A) Behavioral symptom frequent 0. Behavior not exhibited in last 7 1. Behavior of this type occurred 2. Behavior of this type occurred 3. Behavior of this type occurred 3. Behavior of this type occurred 6. Behavioral symptom alterabili 0. Behavior not present OR beha 1. Behavior was not easily altere a. WANDERING (moved with no ra oblivious to needs or safety) b. VERBALLY ABUSIVE BEHAVIC were threatened, screamed at, c c. PHYSICALLY ABUSIVE BEHAVIC were hit, shoved, scratched, sext d. SOCIALLY INAPPROPRIATE/D SYMPTOMS (made disruptive self-abusive acts, sexual behavic smeared/threw food/feces, hoard belongings) e. RESISTS CARE (resisted taking assistance, or eating)	Todays 1 to 3 days in last 7 days 4 to 6 days, but less than daily daily ity in last 7 days axior was easily altered d (A) (B) DRAL SYMPTOMS (others cursed at) MORAL SYMPTOMS (others ually abused) USRUPTIVE BEHAVIORAL ounds, noisiness, screaming, or or disrobing in public, ding, rummaged through others'							
G1.	SHIFTS doINDEPEN during lastSUPERVIS last7 days	<i>uring last 7 days—Not including se</i> DENT—No help or oversight —OR- 7 days SION—Oversight, encouragement o	ident's PERFORMANCE OVER ALL http) — Help/oversight provided only 1 or 2 times or cueing provided 3 or more times during es) plus physical assistance provided only							
	2. LIMITED A guided ma OR—More 3. EXTENSI	ED ASSISTANCE—Resident highly involved in activity; received physical help in a maneuvering of limbs or other nonweight bearing assistance 3 or more times—More help provided only 1 or 2 times during last 7 days NSIVE ASSISTANCE—While resident performed part of activity, over last 7-day thelp of following type(s) provided 3 or more times: ght-bearing support staff performance during part (but not all) of last 7 days DEPENDENCE—Full staff performance of activity during entire 7 days								
	— Weight-— Full stat4. TOTAL DE									
	(B) ADL SUPPORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification) 0. No setup or physical help from staff									
a.	3. Two+ perso		8. ADL activity itself did not occur during entire 7 days ing position, turns side to side,							
	MOBILITY	and positions body while in bed								
b.	TRANSFER	How resident moves between surfa wheelchair, standing position (EXC	ces—to/from: bed, chair, :LUDE to/from bath/toilet) MDS 2.0. September, 2000							

G1.					(A)	(B)							
c.	WALK IN ROOM	How resident walks between lo	cations	in his/her room									
d.	WALK IN CORRIDOR	How resident walks in corridor on unit											
e.	LOCOMO- TION ON UNIT	How resident moves between adjacent corridor on same floor once in chair											
f.	LOCOMO- TION OFF UNIT	areas set aside for dining, activ only one floor, how resident m	ow resident moves to and returns from off unit locations (e.g., eas set aside for dining, activities, or treatments). If facility has ally one floor, how resident moves to and from distant areas on e floor. If in wheelchair, self-sufficiency once in chair										
g.	DRESSING	How resident puts on, fastens, clothing, including donning/rer											
h.	EATING	How resident eats and drinks (nourishment by other means (nutrition)	ow resident eats and drinks (regardless of skill). Includes intake of burishment by other means (e.g., tube feeding, total parenteral utrition)										
i.	TOILET USE	How resident uses the toilet root transfer on/off toilet, cleanses, ocatheter, adjusts clothes											
j.	PERSONAL HYGIENE	How resident maintains persor brushing teeth, shaving, applyin hands, and perineum (EXCLU	ng make DE bath	eup, washing/drying face, is and showers)									
G2.	BATHING	How resident takes full-body be transfers in/out of tub/shower (I Code for most dependent in a (A) BATHING SELF PERFOR 0. Independent—No help pro	EXCLU self-per MANCE	DE washing of back and hair.) formance.		(A)							
		Supervision—Oversight he	elp only										
		 Physical help limited to trai Physical help in part of bat Total dependence 		•									
		Activity itself did not occur	_	-									
G3.	TEST FOR BALANCE	(Code for ability during test in to											
	(see training manual)	 Maintained position as requi Unsteady, but able to rebala Partial physical support duri or stands (sits) but does not Not able to attempt test with 	nce self ng test; follow d	without physical support irections for test									
		Not able to attempt test without physical help Balance while standing											
		b. Balance while sitting—positi											
G4.	FUNCTIONAL LIMITATION	(Code for limitations during las placed residents at risk of injur		that interfered with daily funct	ions	or							
	IN RANGE OF	(A) RANGE OF MOTION	,,	(B) VOLUNTARY MOVEME	NT								
	MOTION	No limitation Limitation on one side		No loss Partial loss									
		Limitation on both sides		2. Full loss	(A)	(B)							
		a. Neck b. Arm—Including shoulder or	alhow			\vdash							
		c. Hand—Including wrist or find											
		d. Leg—Including hip or knee	J 010			\vdash							
		e. Foot—Including ankle or toe	s			П							
		f. Other limitation or loss											
G6.	MODES OF	(Check all that apply during la	ast 7 da	ys)									
	TRANSFER	Bedfast all or most of time	a.	NONE OF ABOVE	f.								
		Bed rails used for bed mobility or transfer	b.		i								
G7.	TASK SEGMENTA- TION	Some or all of ADL activities w days so that resident could per 0. No 1. Yes	ere brol rform th										
H1.	CONTINENCE	SELF-CONTROL CATEGOR		SHIFTS)		\neg							
		IT—Complete control [includes does not leak urine or stool]	use of ii	ndwelling urinary catheter or os	stomy	,							
		CONTINENT—BLADDER, incomes than weekly	ntinent e	episodes once a week or less;									
	2. OCCASION BOWEL, on	IALLY INCONTINENT—BLADI ce a week	DER, 2	or more times a week but not d	laily;								
		TLY INCONTINENT—BLADDE ent (e.g., on day shift); BOWEL,			ome								
	 INCONTINE BOWEL, all 	ENT—Had inadequate control E (or almost all) of the time	BLADDE	ER, multiple daily episodes;									
a.	BOWEL CONTI- NENCE	Control of bowel movement, w programs, if employed	ith appli	ance or bowel continence									
b.		Control of urinary bladder fund	tion (if c	21.1.1									
L	BLADDER CONTI- NENCE		ntrol of urinary bladder function (if dribbles, volume insufficient to ak through underpants), with appliances (e.g., foley) or continence grams, if employed urhea c. NONE OF ABOVE e.										

Н3.	APPLIANCES	Any scheduled toileting plan	a.	Indwelling catheter	d.					
	AND PROGRAMS	Bladder retraining program		Ostomy present						
		External (condom) catheter	b.	NONE OF ABOVE	i.					
Che	ock only those	, ,	c.	current ADL status, cognitive stati	j.					
mod	od and behavior			onitoring, or risk of death. (Do not						
Inac	tive diagnoses)	(If none apply, CHECK the N	IONE O	F AROVE box						
٠٠٠.	DISEASES	MUSCULOSKELETAL	ONL O	Multiple sclerosis	w.					
			m.	Quadriplegia	z.					
		NEUROLOGICAL		PSYCHIATRIC/MOOD						
		Aphasia	r.	Depression	ee.					
			s.	Manic depressive (bipolar						
		Cerebrovascular accident (stroke)	t.	disease) OTHER	ff.					
		Hemiplegia/Hemiparesis	v.	NONE OF ABOVE	rr.					
12.	INFECTIONS	(If none apply, CHECK the N	IONE O	F ABOVE box)						
		Antibiotic resistant infection		Septicemia	g.					
		(e.g., Methicillin resistant staph)	a.	Sexually transmitted diseases	h.					
		Clostridium difficile (c. diff.)	b.	Tuberculosis	i.					
		Conjunctivitis	c.	Urinary tract infection in last 30 days	j.					
		HIV infection	d.	Viral hepatitis	k.					
		Pneumonia	e.	Wound infection	l.					
		Respiratory infection	f.	NONE OF ABOVE	m.					
13.	OTHER CURRENT DIAGNOSES		tatus, co	osed in the last 90 days that have gnitive status, mood or behavior g, or risk of death)						
	AND ICD-9 CODES									
	00220	a		•						
J1.	PROBLEM	b. (Check all problems presen	t in last	7 days unless other time frame is	<u> </u>					
٥١.	CONDITIONS	indicated)								
		INDICATORS OF FLUID STATUS		OTHER Delusions						
				Edema	e. g.					
		Weight gain or loss of 3 or more pounds within a 7 day		Fever	h.					
		period	a.	Hallucinations	i.					
		Inability to lie flat due to shortness of breath	b.	Internal bleeding	j.					
		Dehydrated; output exceeds		Recurrent lung aspirations in last 90 days	k.					
		input	c.	Shortness of breath	l.					
		Insufficient fluid; did NOT consume all/almost all liquids		Unsteady gait	n.					
		provided during last 3 days	d.	Vomiting	о.					
		(Code the highest level of p a	in proce	NONE OF ABOVE	p.					
J2.	PAIN SYMPTOMS	` .	iiii prese	b. INTENSITY of pain						
		a. FREQUENCY with which resident complains or		1. Mild pain						
		shows evidence of pain		2. Moderate pain						
		0. No pain (<i>skip to J4</i>) 1. Pain less than dailv		3. Times when pain is horrible						
		2. Pain daily		or excrutiating						
J4.	ACCIDENTS	(Check all that apply)		Hip fracture in last 180 days	c.					
		Fell in past 30 days	a.	Other fracture in last 180 days	d.					
		Fell in past 31-180 days	b.	NONE OF ABOVE	e.					
J5.	STABILITY OF	status unstable—(fluctuating,		cognitive, ADL, mood or behavior us, or deteriorating)	a.					
	CONDITIONS	Resident experiencing an acu chronic problem	te episo	de or a flare-up of a recurrent or	b.					
		End-stage disease, 6 or fewer	months	to live	C.					
K1.	ORAL	NONE OF ABOVE Chewing problem			d. a.					
KI.	PROBLEMS	Swallowing problem			b.					
		NONE OF ABOVE d.								
K2.	HEIGHT AND	Record (a.) height in inches recent measure in last 30 day	and (b.) /s ; meas	weight in pounds. Base weight sure weight consistently in accord	on mosi 'with					
	WEIGHT	standard facility practice—e.g.	., in a.m.	after voiding, before meal, with s	hoes					
		off, and in nightclothes	9 1	HT (in.) b. WT (lb.)						
K3.	WEIGHT	a.Weight loss-5 % or more		0 days; or 10 % or more in last						
	CHANGE	180 days 0. No 1. Yes								
				0 days; or 10 % or more in last						
		180 days		<u>.</u>						
		0. No 1. Yes	3							

K5.	NUTRI-	(Check all that apply in last 7 days)									
	TIONAL APPROACH-	Parenteral/	IV		a.	On a planned weight change					
	ES ES	Feeding tub	ре		b.	program	h.				
M1.	ULCERS	(Record the	e number of i	ulcers a	at each i	NONE OF ABOVE ulcer stage—regardless of	Number at Stage				
IVI I .	(Due to any	cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.]									
	cause)	a. Stage 1.	A. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.								
		b. Stage 2.				skin layers that presents lister, or shallow crater.					
		c. Stage 3.	A full thickn tissues - pre underminin	esents	as a dee	est, exposing the subcutaneous ep crater with or without ue.					
		d. Stage 4.	A full thickn exposing m			subcutaneous tissue is lost,					
M2.	TYPE OF ULCER	using sc	ale in item M	11 — i.e.	, 0=non	nighest stage in the last 7 day: e;stages 1, 2, 3, 4)					
		of underl	ying tissue			by pressure resulting in damage					
		extremiti	es			y poor circulation in the lower					
M4.	OTHER SKIN PROBLEMS	Abrasions,	that apply d bruises	iuring i a	ast / da	ys)					
	OR LESIONS		ond or third o	learee)			a. b.				
	PRESENT	,		• ,		s, cuts (e.g., cancer lesions)	c.				
		Rashes-e	.g., intertrigo	, eczer	na, drug	rash, heat rash, herpes zoster	d.				
		Skin desen	sitized to pai	n or pre	essure		e.				
			or cuts (other	than s	urgery)		f.				
		Surgical wo					g.				
	OKINI	NONE OF	that apply	durina	last 7 da	avs)	h.				
M5.	SKIN TREAT-	1	elieving devi	•		ays)	a.				
	MENTS		elieving devi	. ,			b.				
		Turning/rep	oositioning p	rogram			c.				
		Nutrition or	hydration in	tervent	ion to m	anage skin problems	d.				
		Ulcer care					e.				
		Surgical wo	ound care				f.				
		Application to feet	of dressings	s (with o	or withou	ut topical medications) other tha	n g.				
						other than to feet) are (other than to feet)	h. i.				
		NONE OF					j.				
M6.	FOOT PROBLEMS	l '	that apply	_		• •					
	AND CARE	bunions, ha	ammer toes,	overlap	ping to	ns—e.g., corns, callouses, es, pain, structural problems	a.				
		l	ns on the foc		ilitis, pur	rulent drainage	b.				
			ses trimmed		last 90 d	davs	C.				
				•		ot care (e.g., used special shoes	d				
			ds, toe separ			5. ca. c (c.g., acca special c. lect	e.				
			•	s (with o	or withou	ut topical medications)	f.				
		NONE OF ABOVE									
N1.	TIME AWAKE					<i>er last 7 days</i>) ., naps no more than one hour					
	AVAIL	per time pe	riod) in the:		Eveni	• •	c.				
		Morning Afternoon	+	a. b.	NON	E OE ABOVE	d.				
(If r	esident is co					E OF ABOVE	u.				
N2.	AVERAGE					tments or ADL care)					
	TIME INVOLVED IN	0. Most—m	ore than 2/3	of time	. 2	2. Little—less than 1/3 of time					
01.	ACTIVITIES NUMBER OF	1. Some—from 1/3 to 2/3 of time 3. None (Record the number of different medications used in the last 7 days;									
01.	MEDICA- TIONS	(Hecord the number of different medications used in the last / days, enter "0" if none used)									
	INJECTIONS	the last 7 c	lays ; enter "t	O" if nor	ne úsed)						
O4.	DAYS RECEIVED THE	used. Note	—enter "1" f	of DAYS or long	during acting r	l last 7 days ; enter "0" if not meds used less than weekly)					
	FOLLOWING	a. Antipsyc				d. Hypnotic					
	MEDICATION	b. Antianxie c. Antidepr	•			e. Diuretic					

P1.	TREAT-	a. SPECIAL CARE—Check to the last 14 days	reatmen	ts or programs receiv	ed dur	ing				
	MENTS, PROCE-	TDEATMENTO		Marilla Landers Carter						
	DURES, AND	TREATMENTS		Ventilator or respira	l.					
	PROGRAMS	Chemotherapy	a.	PROGRAMS						
		Dialysis	b.	Alcohol/drug treatm program						
		IV medication	C.		tio ono	oiol	m.			
		Intake/output	d.	Alzheimer's/demen care unit	ilia spe	Ciai	n.			
		Monitoring acute medical condition	e.	Hospice care			о.			
		Ostomy care	f.	Pediatric unit			p.			
		Oxygen therapy	g.	Respite care			q.			
		Radiation	h.	Training in skills req						
		Suctioning	i.	return to the comm taking medications.			r.			
		Tracheostomy care		work, shopping, trai ADLs)	nsporta	ation,	Ë			
		Transfusions	j.	NONE OF ABOVE						
		b.THERAPIES - Record the	k.			C 02/	s.	nf.		
		the following therapies wa in the last 7 calendar day [Note—count only post a (A) = # of days administere (B) = total # of minutes pro	s admir ys (Ente admiss d for 15	nistered (for at least er 0 if none or less to ion therapies] minutes or more	15 mii han 15 DAYS	nutes min N	a	day)		
		` '			(A)		, <u>P)</u>			
		a. Speech - language patholo	gy and	audiology services	igwdaps	\perp	+	Ш		
		b. Occupational therapy								
		c. Physical therapy					\perp			
		d. Respiratory therapy								
		e. Psychological therapy (by a health professional)	any lice	nsed mental						
P3.	NURSING REHABILITA- TION/	Record the NUMBER OF DA restorative techniques or pra more than or equal to 15 m	ctices v	vas provided to the	resid	lent i		_		
	RESTOR- ATIVE CARE	(Enter 0 if none or less than	15 min.							
	ATIVE CARE	a. Range of motion (passive)		f. Walking						
		b. Range of motion (active)		g. Dressing or groot	ming					
		c. Splint or brace assistance TRAINING AND SKILL		h. Eating or swallow	/ing					
		PRACTICE IN:		i. Amputation/pros	thesis o	care				
		d. Bed mobility		j. Communication						
		e. Transfer		k. Other						
P4.	DEVICES AND RESTRAINTS	Use the following codes for It 0. Not used 1. Used less than daily 2. Used daily Bed rails	ast 7 da	ays:						
		a. — Full bed rails on all ope	n sides (of bed						
		b. — Other types of side rails	s used (e	e.g., half rail, one side	9)					
		c. Trunk restraint								
		d. Limb restraint					\vdash	_		
D7	DUVOICIAN	e. Chair prevents rising	0 04:	oion if loss there 4.4.1	m /c :-		\vdash			
P7.	PHYSICIAN VISITS	In the LAST 14 DAYS (or sinc facility) how many days has th practitioner) examined the res	e physic	ian (or authorized as		or				
P8.	PHYSICIAN ORDERS	In the LAST 14 DAYS (or sinc facility) how many days has th practitioner) changed the resic renewals without change. (En	e physic dent's or	ian (or authorized as ders? <i>Do not include</i>	sistant	or				
Q2.	OVERALL	Resident's overall level of self s	sufficien	cy has changed sign						
	CHANGE IN CARE NEEDS	compared to status of 90 days ago (or since last assessment if less sthan 90 days) 0. No change 1. Improved—receives fewer 2. Deteriorated—receives								
		supports, ne restrictive lev	eds less	more suppo		eives				
R2.	SIGNATURE	OF PERSON COORDINATIN	GTHE A	ASSESSMENT:						
	•	Assessment Coordinator (sign	on above	e line)						
	ate RN Assessi gned as comple	ment Coordinator ete Month		Day Y	éar					

Resident	Numeric Identifier

1.	National Provider ID	Enter for all assessments and tracking forms, if available.	
		his assessment or the discharge date of this discharge s between July 1 and September 30, skip to W3.	
2.	Influenza Vaccine	 a. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3) b. If Influenza vaccine not received, state reason: 1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine 	
3.	Pneumo- coccal Vaccine	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

MDS QUARTERLY ASSESSMENT FORM (OPTIONAL VERSION FOR RUG-III 1997 Update)

	(0	1014				J. 1 .	U		<i>-</i>		J.	Opt	auto	,
A1.	RESIDENT NAME													
		a. (Fi	rst)			b. (Mid	dle Init	ial)		c.	(Las	t)	(d. (Jr/Sr)
A2.	ROOM NUMBER													
А3.	ASSESS- MENT	a. Last	day	of ME	S ob	servatio	n peri	od						
	REFERENCE DATE						-	-						
	DAIL		Mo	onth		Day			Y	éar				
			, ,			cted cop		•						
A4a.	DATE OF REENTRY													pital in 190 days
				<u> </u>	_		- I							-
		L		_]-	$ \lfloor$]-							
A6.	MEDICAL		Mon	th		Day	_		Yea	ar	_			
	RECORD NO.													
B1. B2.	COMATOSE	Ò. No				state/no 1.Yes arned oi	S	(Ski		cious Secti				
B2.	MEMORY	Ι'				OK-s		•	ars to	reca	ıll afte	r 5 m	inutes	;
			lemor	•			emory	•						
			g-terr Iemor			OK-s 1.Me	eems/ emory			reca	II long	j past		
В3.	MEMORY/ RECALL	last 7	days))	esider	nt was n	norma	lly ab	le to	recal	ll dur	ing		
	ABILITY	Currer Location			nom	a. b.	Tha	t he/s	he is	inaı	nursir	ng ho	me	d.
		Staff n				C.	NO	NE O	FAE	OVE	are r	ecalle	ed	e.
B4.	COGNITIVE SKILLS FOR	(Made	e deci.	sions	regai	rding ta	sks of	daily l	ife)					
	DAILY DECISION-					decision ENDEN						situa	tions	
	MAKING	only	1			AIRED				-				
		requ	uired			<i>RED</i> —n								
B5.	INDICATORS	(Code	for be	ehavi	or in ti	he last	7 days	.) [N	ote:	Accu	rate a	asses		nt owledge
	OF DELIRIUM— PERIODIC					r over i			y	******	, may	cunc	OL ALL	owicago
	DISOR- DERED		avior	pres	ent, n	ot of rec								
	THINKING/ AWARENESS					ver last w onset				liffere	nt fro	m res	ident'	s usual
	AWAIILIILOO		SILY E etrack		RACT	ED—(e	e.g., dif	ficulty	payi	ng at	tentio	n;get	ts	
		SUI	RROU sent; l	JNDI	NGS-	ERED F —(e.g., e/she is	moves	s lips o	or talk	s to	some	one r	ot	
		c. EPI		ESO	F DIS	ORGA	NIZED	SPE	ECH	l—(e.	a sr	eech	is	
		inco	here	nt, no	nsen	sical, irr of thoug	elevan							
		clot	hing,	napki	ins, et	TLESS c; frequ g out)								
						HARGY tle body				ness	;stari	ng int	o spac	с е;
						N VAR nes bet								
C4.	MAKING					, someti on conte			erabl	e)				
	SELF UNDER-	0. UNI				27000	-1:cc					£-:		
	STOOD	tho	ughts			STOOD CDOTO		•					•	
		req	uests			ERSTC		•	IS IIIT	iitea i	to ma	ıkıng (concre	∌te
C6.	ABILITYTO					INDERS I informa			t—h	oweve	er abl	<i>e</i>)		
	UNDER- STAND	0. <i>UNI</i>				STANDS	S—ma	v mie	s son	ne na	art/int	ent of		
	OTHERS	mes	ssage			ERSTA		•		•				
		dire	ct cor	nmur	nicatio				J. 140	2000	14410	.,	, pic,	
E1.	INDICATORS OF		for i	ndica	tors	observ			0 day	s, irr	espe	ctive	of the	e
	DEPRES- SION,	0. Indi	cator	not e	xhibit	ed in la: exhibit			ייבף י	s a w*	ppk			
	ANXIETY, SAD MOOD					exhibit						7 day	s a we	ek)
	272 111000	l												

	Numeric Identi	fier						
E1.	INDICATORS OF DEPRES- SION, ANXIETY, SAD MOOD	VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use;	h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concer with body functions i. Repetitive anxious	n				
		b. Repetitive questions—e.g., "Where do I go; What do I do?"	complaints/concerns (non- health related) e.g., persistently seeks attention reassurance regarding schedules, meals, laundry, clothing, relationship issues					
		c. Repetitive verbalizations— e.g., calling out for help, ("God help me")	SLEEP-CYCLE ISSUES j. Unpleasant mood in mornin	ıg				
		d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received	k. Insomnia/change in usual sleep pattern SAD, APATHETIC, ANXIOUS APPEARANCE	6				
		e. Self deprecation—e.g.,"I am nothing; I am of no use to anyone"	Sad, pained, worried facial expressions—e.g., furrowed brows Crying, tearfulness	t t				
		f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others	n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness fidgeting, picking	ò,				
		g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack	O. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends Planting activities or being with family/friends Planting activities or being with family/friends					
E2.	MOOD	One or more indicators of depres						
	PERSIS- TENCE	not easily altered by attempts to the resident over last 7 days 0. No mood 1. Indicators preser indicators easily altered	• •	-				
E4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequen 0. Behavior not exhibited in last 1. Behavior of this type occurred 2. Behavior of this type occurred 3. Behavior of this type occurred	7 days I 1 to 3 days in last 7 days I 4 to 6 days, but less than daily					
		(B) Behavioral symptom alterabil 0. Behavior not present OR beh 1. Behavior was not easily altere a. WANDERING (moved with no ra oblivious to needs or safety)	avior was easily altered	A) (B)				
		b. VERBALLY ABUSIVE BEHAVIOUS were threatened, screamed at, or	cursed at)					
		c. PHYSICALLY ABUSIVE BEHAN were hit, shoved, scratched, sex d. SOCIALLY INAPPROPRIATE/E	ually abused) DISRUPTIVE BEHAVIORAL					
		SYMPTOMS (made disruptive s self-abusive acts, sexual behavid smeared/threw food/feces, hoard belongings)						
		e. RESISTS CARE (resisted taking assistance, or eating)	g medications/ injections, ADL					
G1.	` SHIFTS do	FPERFORMANCE—(Code for resuring last 7 days—Not including se	etup)					
	during last 1. SUPERVIS	SION—Oversight, encouragement	or cueing provided 3 or more times	during				
	1 or 2 time	—OR— Supervision (3 or more tim s during last 7 days ASSISTANCE—Resident highly invo		•				
	guided ma OR—More	neuvering of limbs or other nonweig help provided only 1 or 2 times du	pht bearing assistance 3 or more tir ring last 7 days	nės –				
	EXTENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: Weight-bearing support Full staff performance during part (but not all) of last 7 days							
4. TOTAL DEPENDENCE—Full staff performance of activity during entire 7 days 8. ACTIVITY DID NOT OCCUR during entire 7 days								
	OVER ALL	ORT PROVIDED—(<i>Code for MO</i> . SHIFTS during last 7 days; code ce classification)		(A) (B)				
	 Setup help One persor 		ADL activity itself did not occur during entire 7 days	SELF-PERF SUPPORT				
a.	BED MOBILITY	How resident moves to and from ly and positions body while in bed	ing position, turns side to side,					
		How resident moves between surfa						

G1.					(A)	(B)			
C.	WALK IN ROOM	How resident walks between k	ocations	in his/her room					
d.	WALK IN CORRIDOR	How resident walks in corridor	on unit						
e.	LOCOMO- TION ON UNIT	How resident moves between adjacent corridor on same floo once in chair							
f.	LOCOMO- TION OFF UNIT	How resident moves to and rel areas set aside for dining, activ only one floor , how resident r the floor. If in wheelchair, self-s	rities, or noves to	treatments). If facility has and from distant areas on					
g.	DRESSING	How resident puts on, fastens, clothing, including donning/re	and tak moving	es off all items of street prosthesis					
h.	EATING	How resident eats and drinks (nourishment by other means (nutrition)							
i.	TOILET USE		w resident uses the toilet room (or commode, bedpan, urinal); nsfer on/off toilet, cleanses, changes pad, manages ostomy or heter, adjusts clothes						
j.	PERSONAL HYGIENE	How resident maintains person brushing teeth, shaving, applyi hands, and perineum (EXCLU	w resident maintains personal hygiene, including combing hair, ushing teeth, shaving, applying makeup, washing/drying face, nds, and perineum (EXCLUDE baths and showers)						
G2.	BATHING	ow resident takes full-body bath/shower, sponge bath, and ansfers in/out of tub/shower (EXCLUDE washing of back and hair.) bode for most dependent in self-performance. A) BATHING SELF PERFORMANCE codes appear below							
		 Independent—No help pro Supervision—Oversight h 			Г	(A)			
		Physical help limited to tra		у					
		 Physical help in part of bat Total dependence 	hing act	ivity					
		Activity itself did not occur	during e	entire 7 days					
G3.	TEST FOR BALANCE	(Code for ability during test in t		• /					
	(see training	0. Maintained position as requ1. Unsteady, but able to rebala	nce self	est without physical support					
	manual)	Partial physical support duri or stands (sits) but does not Not able to attempt test with	follow d	irections for test sical help					
		a. Balance while standingb. Balance while sitting — posit	ion. trun	k control	\vdash	\dashv			
G4.	FUNCTIONAL	(Code for limitations during las	t 7 days		tions	or			
	LIMITATION IN RANGE OF		(y)	(B) VOLUNTARY MOVEME	NT				
	MOTION	No limitation Limitation on one side		No loss Partial loss					
		Limitation on both sides Neck		2. Full loss	(A)	(B)			
		b. Arm—Including shoulder or	elbow						
		c. Hand—Including wrist or fine	gers						
		d. Leg — Including hip or kneee. Foot — Including ankle or toe	s			\vdash			
		f. Other limitation or loss							
G6.	MODES OF TRANSFER	(Check all that apply during la	ast 7 da	ys)					
	INANSFER	Bedfast all or most of time	a.	NONE OF ABOVE	f.				
		Bed rails used for bed mobility or transfer	b.		_8				
G7.	TASK SEGMENTA- TION	Some or all of ADL activities w days so that resident could pe 0. No 1. Yes	rform the						
H1.	CONTINENCE	SELF-CONTROL CATEGOR		SHIFTS)		\neg			
	` 0. <i>CONTINEN</i>	IT—Complete control [includes does not leak urine or stool]		,	stomy	v			
		CONTINENT—BLADDER, inco	ntinent e	episodes once a week or less;					
	2. OCCASION BOWEL, on	IALLY INCONTINENT—BLADI ce a week	DER, 20	or more times a week but not c	laily;				
	control prese	TLY INCONTINENT—BLADDE ent (e.g., on day shift); BOWEL,	2-3 time	es a week	ome				
	BOWEL, all	ENT—Had inadequate control E (or almost all) of the time	BLADDE	R, multiple daily episodes;					
a.	BOWEL CONTI- NENCE	Control of bowel movement, w programs, if employed							
b.	BLADDER CONTI- NENCE	Control of urinary bladder fund soak through underpants), wit programs, if employed)				
H2.	BOWEL ELIMINATION	Diarrhea	c.	NONE OF ABOVE	e.				
	PATTERN	Fecal impaction	d.						

Пo	ADDI IANOTO	American Institution of		Induction "	noto:				
п3.	AND	Any scheduled toileting plan	a.	Indwelling cath	ieter				d.
	PROGRAMS	Bladder retraining program	b.	Ostomy prese	nt				i.
		External (condom) catheter		NONE OF AB	OVE				
Che	ck only those	diseases that have a relation	ship to a	urrent ADL sta	itus, co	gnit	ive st	atı	JS,
	od and behavior tive diagnoses)	status, medical treatments, nu	rsing mo	onitoring, or risk	of dea	ath. (Do no	ot l	ist
11.	DISEASES	(If none apply, CHECK the N	ONF O	F ABOVE hox					
	DISEASES	ENDOCRINE/METABOLIC/	0112 01	Hemiplegia/He	emina	resis			v.
		NUTRITIONAL		Multiple sclero		0010			
		Diabetes mellitus	a.	Quadriplegia	,010				w. z.
		MUSCULOSKELETAL		PSYCHIATRI	C/MO	OD			۷.
		Hip fracture	m.	Depression					
		NEUROLOGICAL		Manic depress	sive (b	inola	ar		ee.
		Aphasia	r.	disease)	J. 10 (J	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			ff.
		l	s.	OTHER					
		Cerebrovascular accident (stroke)	_	NONE OF AE	OVE				rr.
12.	INFECTIONS	(If none apply, CHECK the N	t. IONE O	E ABOVE hov				_	
12.	INFECTIONS		CIVE O	Septicemia					
		Antibiotic resistant infection (e.g., Methicillin resistant		Sexually trans	mitted	اطنود	2222		g.
		staph)	a.	Tuberculosis	milleu	uisc	<i>7</i> 4303	,	h. :
		Clostridium difficile (c.diff.)	b.	Urinary tract in	nfection	n in	laet 3	RΩ	i.
		Conjunctivitis	c.	days	iicotioi		iasto	,	j.
		HIV infection	d.	Viral hepatitis					k.
		Pneumonia	e.	Wound infection	on				l.
		Respiratory infection	f.	NONE OF AB	-				m.
13.	OTHER CURRENT	(Include only those diseases relationship to current ADL s							
	DIAGNOSES	medical treatments, nursing m							,
	AND ICD-9 CODES			ı					
	CODES	a						•	
		b.				<u></u>	Ш	•	
J1.	PROBLEM CONDITIONS	(Check all problems present indicated)	t in last i	7 days unless d	other ti	me i	rame	is	
	CONDITIONS	INDICATORS OF FLUID		OTHER					
		STATUS		Delusions					e.
		Weight gain or loss of 3 or		Edema					g.
		more pounds within a 7 day period	a.	Fever					h.
		Inability to lie flat due to		Hallucinations					i.
		shortness of breath	b.	Internal bleedi	Ü				j.
		Dehydrated; output exceeds		Recurrent lung	gaspir	ation	ns in		k.
		input	c.	Shortness of b	reath				l.
		Insufficient fluid; did NOT consume all/almost all liquids		Unsteady gait					n.
		provided during last 3 days	d.	Vomiting					О.
				NONE OF AB	OVE				p.
J2.	PAIN	(Code the highest level of pa	in prese	ent in the last 7	days)				
	SYMPTOMS	a. FREQUENCY with which		b. INTENSITY	of pai	n			
		resident complains or shows evidence of pain		1. Mild pain					
		0. No pain (skip to J4)		2. Moderate pa	ain				
		Pain less than daily		Times when or excrutiatir		s ho	rrible		
		2. Pain daily		OI CAGIGUIGUI	19				
J4.	ACCIDENTS	(Check all that apply)		Hip fracture in	last 1	80 d	ays		c.
		Fell in past 30 days	a.	Other fracture	in last	180) days	S	d.
		Fell in past 31-180 days	b.	NONE OF AB					e.
J5.	STABILITY OF	Conditions/diseases make res status unstable—(fluctuating, p				or be	ehavi	or	a.
	CONDITIONS	Resident experiencing an acu				CUR	rent o	r	
		chronic problem	io opioo	ao or a naro ap	orare	,oui i	0.11.0	•	b.
		End-stage disease, 6 or fewer	months	to live					c.
		NONE OF ABOVE							d.
K1.	ORAL	Chewing problem							a.
	PROBLEMS	Swallowing problem NONE OF ABOVE							b.
K2.	UEIGUT	Record (a.) height in inches	and (b .)	weiaht in noui	nds B	ase	weial	ht i	d. on mosi
1.2.	HEIGHT AND	recent measure in last 30 day	's ; meás	ure weight con:	sistent	tly in	acco	rd	with
	WEIGHT	standard facility practice—e.g. off, and in nightclothes	, ın a.m.	atter voiding, b	etore r	nea	, with	sl	noes
		, <u></u>	a. ⊦	HT (in.)	b. v	VT (lb).)		
K3.	WEIGHT	a.Weight loss-5 % or more				_	_	t	
	CHANGE	180 days							
		0. No 1. Yes b. Weight gain — 5 % or more		0 days: or 10 %	4 or m	oro i	n last		
		180 days	ast 3	- uay 3 , ∪ 10 %	o or III	oi e I	idS		
l		0. No 1. Yes	;						

	NUITOI	(Check all that apply in last 7 days)	
K5.	NUTRI- TIONAL		
	APPROACH-	Parenteral/IV a. On a planned weight change program	h.
	ES	Feeding tube b. NONE OF ABOVE	i.
K6.	PARENTERAL		
	OR ENTERAL	a. Code the proportion of total calories the resident received through	
	INTAKE	parenteral or tube feedings in the last 7 days 0. None 3. 51% to 75%	
		1. 1% to 25% 4. 76% to 100%	
		2. 26% to 50%	
		b. Code the average fluid intake per day by IV or tube in last 7 days	
		0. None 3. 1001 to 1500 cc/day 1. 1 to 500 cc/day 4. 1501 to 2000 cc/day	
		2.501 to 1000 cc/day 5.2001 or more cc/day	
M1.	ULCERS	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply	ipei age
	(Due to any	during last 7 days. Code 9 = 9 or more.) [Requires full body exam.]	Number at Stage
	cause)	a. Stage 1. A persistent area of skin redness (without a break in the	_ "
		skin) that does not disappear when pressure is relieved.	
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
		Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	
M2.	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)	
		Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue	
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
MΔ	OTHER SKIN		a.
IVI-T.	PROBLEMS	Burns (second or third degree)	b.
	OR LESIONS PRESENT	Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)	C.
	(Check all	Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster	d.
	that apply	Skin desensitized to pain or pressure	e.
	during last 7 days)	Skin tears or cuts (other than surgery) Surgical wounds	f.
	,	NONE OF ABOVE	g.
M5.	SKIN	Pressure relieving device(s) for chair	h. a.
	TREAT-	Pressure relieving device(s) for bed	b.
	MENTS	Turning/repositioning program	C.
	(Check all that apply	Nutrition or hydration intervention to manage skin problems	d.
	during last 7	Ulcer care	e.
	days)	Surgical wound care Application of dressings (with or without topical medications) other than	f.
		to feet	
		toleet	g.
		Application of ointments/medications (other than to feet)	
		Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet)	g.
		Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE	g. h.
M6.	FOOT PROBLEMS	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses,	g. h. i.
M6.	FOOT PROBLEMS AND CARE	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems	g. h. i. j.
M6.	PROBLEMS	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses,	g. h. i. j.
M6.	PROBLEMS AND CARE (Check all that apply	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage	g. h. i. j. a. b.
M6.	PROBLEMS AND CARE (Check all	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes,	g. h. i. j. a. b.
M6.	PROBLEMS AND CARE (Check all that apply during last 7	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)	g. h. i. j. a. b. c.
M6.	PROBLEMS AND CARE (Check all that apply during last 7	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)	g. h. i. j. a. b. c. d.
M6.	PROBLEMS AND CARE (Check all that apply during last 7 days)	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days)	g. h. i. j. a. b. c. d.
	PROBLEMS AND CARE (Check all that apply during last 7 days)	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:	g. h. i. j. a. b. c. d. e. f.
	PROBLEMS AND CARE (Check all that apply during last 7 days)	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Evening	g. h. i. j. a. b. c. d. g. g.
N1.	PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Afternoon NONE OF ABOVE	g. h. i. j. a. b. c. d. e. f.
N1.	PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Afternoon NONE OF ABOVE OMATOR OF ABOVE Dematose, skip to Section O)	g. h. i. j. a. b. c. d. g. g.
N1.	PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE AVERAGE TIME	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Afternoon Evening Afternoon NONE OF ABOVE Omatose, skip to Section O) (When awake and not receiving treatments or ADL care)	g. h. i. j. a. b. c. d. g. g.
N1.	PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE AVERAGE TIME	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Afternoon Evening NONE OF ABOVE Omatose, skip to Section O) (When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None	g. h. i. j. a. b. c. d. e. f. g.
N1.	PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is co AVERAGE TIME INVOLVED IN ACTIVITIES NUMBER OF MEDICA-	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Afternoon D. NONE OF ABOVE When awake and not receiving treatments or ADL care) O. Most—more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None	g. h. i. j. a. b. c. d. e. f. g.
N1.	PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is co AVERAGE TIME INVOLVED IN ACTIVITIES NUMBER OF MEDICATIONS	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Afternoon Evening Afternoon NONE OF ABOVE Omatose, skip to Section O) (When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None (Record the number of different medications used in the last 7 days; enter "0" if none used)	g. h. i. j. a. b. c. d. e. f. g.
N1. (If ro N2. O1. O3.	PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is co AVERAGE TIME INVOLVED IN ACTIVITIES NUMBER OF MEDICATIONS INJECTIONS	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Afternoon Evening Afternoon When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None (Record the number of different medications used in the last 7 days; enter "0" if none used) (Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)	g. h. i. j. a. b. c. d. e. f. g.
N1.	PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is concentrated and the concentration of the concentr	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Afternoon Evening Afternoon When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None (Record the number of different medications used in the last 7 days; enter "0" if none used) (Record the number of DAYS injections of any type received during	g. h. i. j. a. b. c. d. e. f. g.
N1. (If ro N2. O1. O3.	PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is considered and a side and	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Afternoon Evening NONE OF ABOVE Omatose, skip to Section O) (When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None (Record the number of different medications used in the last 7 days; enter "0" if none used) (Record the number of DAYS injections of any type received during the last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly) a. Antipsychotic d. Hypnotic	g. h. i. j. a. b. c. d. e. f. g.
N1. (If ro N2. O1. O3.	PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is co AVERAGE TIME INVOLVED IN ACTIVITIES NUMBER OF MEDICATIONS INJECTIONS DAYS RECEIVED THE	Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Afternoon Evening NONE OF ABOVE Omatose, skip to Section O) (When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None (Record the number of different medications used in the last 7 days; enter "0" if none used) (Record the number of DAYS injections of any type received during the last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly) a. Antipsychotic d. Hypnotic	g. h. i. j. a. b. c. d. e. f. g.

_							_	_
P1.	SPECIAL TREAT- MENTS.	a. SPECIAL CARE—Check treatments or programs received during the last 14 days						
	PROCE-	TREATMENTS		Ventilator or respira	tor			
	DURES, AND PROGRAMS	Chemotherapy	a.	PROGRAMS			I.	
	T TIO GIT IJ GIII O	Dialysis	b.	Alcohol/drug treatm	ont			
		IV medication	С.	program	CIIL		m.	
		Intake/output	d.	Alzheimer's/demen	ļ			
		Monitoring acute medical	a.	care unit	n.			
		condition	e.	Hospice care			0.	
		Ostomy care	f.	Pediatric unit	p.			
		Oxygen therapy	g.	Respite care			q.	
		Radiation	h.	Training in skills req return to the comm	uired	to		
		Suctioning	i.	taking medications,	hous	е	r.	
		Tracheostomy care	i.	work, shopping, trar ADLs)	nsport	ation	,	
		Transfusions	k.	NONE OF ABOVE				
		b.THERAPIES - Record the				es ea	ich oi	f
		the following therapies wa in the last 7 calendar day [Note—count only post a	<i>is (Ente</i> admiss	er 0 if none or less th ion therapies]	nan 1.	5 mir	n. daii	
		(A) = # of days administered		illillutes of filore	DAYS	- 1	(B)	
		(B) = total # of minutes pro a. Speech - language patholo		•	(A)		(0)	\dashv
			yy and	audiology services		\vdash	+	H
		b. Occupational therapy				\dashv	+	\mathbb{H}
		c. Physical therapy d. Respiratory therapy						Н
		e. Psychological therapy (by a	any lico	nsed mental			+	
		health professional)						Щ
P3.	NURSING REHABILITA-	Record the NUMBER OF DA restorative techniques or pra	ctices v	vas provided to the	resid	dent	n or for	
	TION/	more than or equal to 15 m	inutes	per day in the last	7 day	/S		
	RESTOR- ATIVE CARE	(Enter 0 if none or less than a. Range of motion (passive)	15 min.	<i>dally.)</i> f. Walking				
	, <u>-</u> ,	b. Range of motion (active)		· ·			-	
		c. Splint or brace assistance		g. Dressing or groon	•			_
		TRAINING AND SKILL		h. Eating or swallow	•			
		PRACTICE IN:		i. Amputation/prost	hesis	care		
		d. Bed mobility		j. Communication				
		e. Transfer		k. Other				
P4.	DEVICES AND	Use the following codes for la 0. Not used	ast 7 da	ays:				
		1. Used less than daily						
		2. Used daily Bed rails					-	
		a. — Full bed rails on all ope	n cidoc (of bod				
		b. — Other types of side rails						
		c. Trunk restraint	useu (e	s.g., riaii raii, orie side	•)			-
		d. Limb restraint						
		e. Chair prevents rising						
P7.	PHYSICIAN	In the LAST 14 DAYS (or sinc	e admis	sion if less than 14 d	ays in			
	VISITS	facility) how many days has the practitioner) examined the resi			sistan	t or		
P8.	PHYSICIAN	In the LAST 14 DAYS (or sinc		,	avs in			
. 0.	ORDERS	facility) how many days has the	e physic	ian (or authorized as	sistan	t or		
		practitioner) changed the residence renewals without change. (Ent			order			
Q2.	OVERALL	Resident's overall level of self s			ificant	ly as		
	CHANGE IN CARE NEEDS	compared to status of 90 days	ago (o	r since last assessme	ent if le	ess		
	CARE NEEDS	No change 1. Improved—re	eceives	fewer 2. Deteriorate	d-re	ceive	s	
		supports, ner restrictive lev	eds less el of car	more suppo	ort			
R2.	SIGNATURE	OF PERSON COORDINATIN						\dashv
a. Si	gnature of RN	Assessment Coordinator (sign	on above	e line)				\dashv
	•	ment Coordinator		<u> </u>	1	l	1	
	gned as comple	ete		oxdotuoxdotu	<u> </u>			
		Month		Day Y	ear			

Resident	Numeric Identifier

1.	National Provider ID	Enter for all assessments and tracking forms, if available.	
		his assessment or the discharge date of this discharge s between July 1 and September 30, skip to W3.	
2.	Influenza Vaccine	 a. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3) b. If Influenza vaccine not received, state reason: 1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine 	
3.	Pneumo- coccal Vaccine	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

DISCHARGE TRACKING FORM [do not use for temporary visits home]

SECTION AA. IDENTIFICATION INFORMATION RESIDENT NAME® a. (First) d. (Jr/Sr) b. (Middle Initial) c. (Last) GENDER® 1. Male 2. Female 3. BIRTHDATE® Month Day Year 4. RACE/ 1. American Indian/Alaskan Native 4. Hispanic **ETHNICITY**® 2. Asian/Pacific Islander 5. White, not of 3. Black, not of Hispanic origin Hispanic origin SOCIAL a. Social Security Number SECURITY AND MEDICARE NUMBERS ® b. Medicare number (or comparable railroad insurance number) [C in 1st box if non med. no.] FACILITY 6. a. State No. PROVIDER NO.® SECTION R. ASSESSMENT/DISCHARGE INFORMATION b. Federal No. MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] € Note—Other codes do not apply to this form] 8. **REASONS** FOR a. Primary reason for assessment ASSESS-MENT 6. Discharged—return not anticipated7. Discharged—return anticipated 8. Discharged prior to completing initial assessment 9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued partici-pation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf. Signature and Title Sections Date a. b.

SECTION AB. DEMOGRAPHIC INFORMATION

		[Complete only for stays less than 14 days] (AA8a=8)
1.	DATE OF ENTRY	Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date
		Month Day Year
2.	ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other
SE	CTION A.	IDENTIFICATION AND BACKGROUND INFORMATION
6.	MEDICAL RECORD	

NO.

3.	DISCHARGE	a. Code for resident disposition upon discharge								
	STATUS 1. Private home/apartment with no home health services									
		2. Private home/apartment with home health services								
		3. Board and care/assisted living								
		4. Another nursing facility								
		5. Acute care hospital								
		6. Psychiatric hopital, MR/DD facility								
		7. Rehabilitation hospital								
		8. Deceased								
		9. Other								
		b. Optional State Code								
4	DISCHARGE	Date of death or discharge								
٦.	DATE	Date of death of districting								
		Month Day Year								

 $^{^{\}textcircled{*}}$ = Key items for computerized resident tracking

Resident	Numeric Identifier

1.	National Provider ID	Enter for all assessments and tracking forms, if available.	
		his assessment or the discharge date of this discharge s between July 1 and September 30, skip to W3.	
2.	Influenza Vaccine	 a. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3) b. If Influenza vaccine not received, state reason: 1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine 	
3.	Pneumo- coccal Vaccine	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

REENTRY TRACKING FORM

SE	ECTION A	A. IDEI	NTIFIC	ATION	INFO	RM/	ATION	l			
1.	RESIDENT NAME ®										
		a. (First)		b. (Midd	le Initial)		c.(L	ast)		d. (Jr	/Sr)
2.	GENDER®	1. Male		2. Fe	male						
3.	BIRTHDATE®			Day]-[Ye	ar				
4.	RACE/			/Alaskan N	ative		4. Hisp				
	ETHNICITY ®		Pacific Isla not of Hisp	ınder Danic origir	1		5. Whit Hisp	e, not panic d			
5.	SOCIAL	a. Social	Security N	lumber			'				
	SECURITY® AND			_							
	MEDICARE NUMBERS €	b. Medica	are numbe	er (or comp	 arable rai	lroad ir	nsurance	numb	oer)		
	[C in 1st box if			ÌÌ					ń		
	non med. no.]										
6.	FACILITY PROVIDER	a. State N	lo.					_			
	NO.®										
		•		i i		ÎΪ	Ì	İ	ÎÎ		
		b. Federa	l No								
7.	MEDICAID NO. ["+" if										
	pending,"N"										
	if not a Medicaid										
	recipient] ([N			.1 1 . 0.2	· · · · · 1					
8.	REASONS FOR	•		s do not ap		iormj					
	ASSESS- MENT	a. Primar	y reason i	or assessn	nent						
	IVIENI	9. Ree	ntry								
9.	Signatures of Tracking Form		who Con	npleted a l	Portion	f the A	ccomp	anyin	g Ass	essr	nent or
info date app bas fron pati- nes sub cert	ritify that the ac rmation for this as specified. To licable Medicar is for ensuring t n federal funds. on in the goverr s of this informa stantial crimina ify that I am au Signature and T	resident a the best of e and Me that reside I further unment-fundation, and the I, civil, and thorized to	nd that I confirm known dicaid required into the confirmation of t	collected or wledge, th juirements e appropri d that payn n care prog be person nistrative p	r coordination is information. I understate and content of surams is content of surams is content of surams is content of subject of the coordination.	ated co ation wat stand the juality of uch fed onditio ect to o for sul	ellection of the control of the cont	of this cted in nform d as a ds and ne according to the false	inform a acco ation i basis I conti curacy my org inform alf.	nation ordan is use for p nued and i ganiz	n on the ce with ed as a ayment partici- truthful- ation to
a.											
b.											

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

4a.	DATE OF REENTRY	Date of reentry Month Day Year
4b.	ADMITTED FROM (AT REENTRY)	Private home/apt. with no home health services Private home/apt. with home health services Board and care/assisted living/group home Nursing home Acute care hospital Psychiatric hospital, MR/DD facility Rehabilitation hospital Other
6.	MEDICAL RECORD NO.	

 $^{\scriptsize\textcircled{3}}$ = Key items for computerized resident tracking

	= When box blank, must enter number or letter	a.	= When letter in box, check if condition applies

Resident	Numeric Identifier

1.	National Provider ID	Enter for all assessments and tracking forms, if available.	
		this assessment or the discharge date of this discharge is between July 1 and September 30, skip to W3.	
2.	Influenza Vaccine	Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)?	
V	/2 i	O. No (If No, go to item W2b) D. If Influenza vaccine not received, state reason: Not in facility during this year's flu season Received outside of this facility Not eligible	
		Offered and declined Not offered Inability to obtain vaccine	
3.	Pneumo- coccal Vaccine	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b)	
V		h. If PPV not received, state reason: CENTIN 1. Not eligible 2. Offered and declined 3. Not offered	

MINIMUM DATA SET (MDS) — VERSION 2.0

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

Correction Request Form

Use this form (1) to request correction of error(s) in an MDS assessment record or error(s) in an MDS Discharge or Reentry Tracking form record that has been previously accepted into the State MDS database, (2) to identify the inaccurate record, and (3) to attest to the correction request. A correction request can be made to either MODIFY or INACTIVATE a record.

TO MODIFY A RECORD IN THE STATE DATABASE:

- 1. Complete a new corrected assessment form or tracking form. Include all the items on the form, not just those in need of correction;
- Complete and attach this Correction Request Form to the corrected assessment or tracking form;
 Create a new electronic record including the corrected assessment or tracking form AND the Correction Request Form; and
- 4. Electronically submit the new record (as in #3) to the MDS database at the State.

TO INACTIVATE A RECORD IN THE STATE DATABASE:

- 1. Complete this correction request form;
- 2. Create an electronic record of the Correction Request Form; and
- Electronically submit this Correction Request record to the MDS database at the State.

				CTIO	

THIS SECTION IDENTIFIES THE ASSESSMENT OR TRACKING FORM THAT IS IN ERROR. (In this section, reproduce the information EXACTLY as it appeared in the erroneous record, even if the information is wrong. This information is necessary in order to locate the record in the State database.)

Prior AA1.	RESIDENT NAME									
		a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)					
Prior AA2	GENDER	1. Male	2. Female							
Prior AA3.	BIRTHDATE	Month.	— Day	Year						
Prior	SOCIAL	a. Social Securit								
AA5.	SECURITY									
Prior AA8	REASONS FOR ASSESSMENT	ASSESSMEÑT 1. Admissior 2. Annual as 3. Significant 4. Significant 5. Quarterly 10. Significant 0. NONE OF DISCHARGETF 6. Discharge 7. Discharge 8. Discharge 8. Discharge 8. Discharge 1. Medicare 2. Medicare 2. Medicare 4. Medicare 5. Medicare 6. Other stat 7. Medicare	t change in status assess t correction of prior full as review assessment t correction of prior quarte	y day 14) sment ssessment erly assessment r Date item Prior R4 (al assessment ate item Prior A4a O Medicare PPS or the	NLY)					
	PRIOR DATE	5, 10, or 0. Complete Prior I	only) A3a if Primary Reason (P R4 if Primary Reason (Pri A4a if Primary Reason (Pr	or AA8a) equals 6, 7						
Pring	ASSESSMENT	'	IDS observation period	, 1 104) 044410 0.						
A3.	REFERENCE DATE	Month	Day	Year						
Prior R4.	DISCHARGE DATE	Date of discharg	ge Day	Year						
Prior A4a.	DATE OF REENTRY	Date of reentry Month		Year						

CORRECTION ATTESTATION SECTION.
COMPLETE THIS SECTION TO EXPLAIN AND ATTEST TO THE CORRECT REQUEST

	QULU1		
AT1.	ATTESTATION SEQUENCE NUMBER	(Enter total number of attestations for this record, including the present one)	
AT2.	ACTION REQUESTED	MODIFY record in error (Attach and submit a COMPLETE assessment or tracking form. Do NOT submit the corrected items ONLY. Proceed to item AT3 below.) NACTIVE record in error. (Do NOT submit an assessment or tracking form. Submit the correction request only. Skip to item AT4.)	

A13.	REASONS FOR MODIFICA-	(If AT2=1, check at least one of the following reasons; check all that apply, then skip to AT5)	
	TION	a. Transcription error	
		b. Data entry error	
		c. Software product error	
		d. Item coding error	
		e. Other error If "Other" checked, please specify:	
AT 4.	REASONS FOR INACTIVATION	(If AT2=2, check at least one of the following reasons; check all that apply.)	
		a. Test record submitted as production record	
		a. Test record submitted as production record b. Event did not occur	
		' ·	
		b. Event did not occur	

		RN COORDINATOR ATTESTATION OF COMPLETION
AT5.	ATTESTING INDIVIDUAL NAME	a. (First) b. (Last) c. (Title)
	SIGNATURE	
AT6.	ATTESTATION DATE	Month Day Year
AT7.		I OF ACCURACY AND SIGNATURES OF PERSONSWHO CORRECT A ASSESSMENT ORTRACKING INFORMATION

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthful-ness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Attestation Date
a.	
b.	
c.	
d.	
е.	
f.	

SECTION U. MEDICATIONS—CASE MIX DEMO

List all medications that the resident **received** during the last 7 days. Include scheduled medications that are used regularly, but less than weekly.

- 1. **Medication Name and Dose Ordered.** Record the name of the medication and dose ordered.
- 2. Route of Administration (RA). Code the Route of Administration using the following list:

1=by mouth (PO) 5=subcutaneous (SQ) 8=inhalation 2=sub lingual (SL) 6=rectal (R) 9=enteral tube 3=intramuscular (IM) 7=topical 10=other

4=intravenous (IV)

3. **Frequency.** Code the number of times per day, week, or month the medication is administered using the following list:

PR=(PRN) as necessary 2D=(BID) two times daily QO=every other day

 $\begin{array}{lll} 1H=(QH) \ every \ hour & (includes \ every \ 12 \ hrs) & 4W=4 \ times \ each \ week \\ 2H=(Q2H) \ every \ two \ hours & 3D=(TID) \ three \ times \ daily & 5W=five \ times \ each \ week \\ 3H=(Q3H) \ every \ three \ hours & 4D=(QID) \ four \ times \ daily & 6W=six \ times \ each \ week \\ \end{array}$

4H=(Q4H) every four hours 5D=five times daily 1M=(Q month) once every month

6H=(Q6H) every six hours 1W=(Q week) once each wk 2M=twice every month

8H=(Q8H) every eight hours 2W=two times every week C=continuous 1D=(QD or HS) once daily 3W=three times every week O=other

- 4. **Amount Administered (AA).** Record the number of tablets, capsules, suppositories, or liquid (any route) **per dose** administered to the resident. Code 999 for topicals, eye drops, inhalants and oral medications that need to be dissolved in water..
- 5. **PRN-number of days (PRN-n).** If the frequency code for the medication is "PR", record the number of times during the last 7 days each PRN medication was given. Code STAT medications as PRNs given once.
- 6. **NDC Codes.** Enter the National Drug Code for each medication given. Be sure to enter the correct NDC code for the drug name, strength, and form. The NDC code must match the drug dispensed by the pharmacy.

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN-n	6.	. NI	OC	Co	des	5	

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME®		a. (First) b. (Middle Initial) c. (Last) d. (Jr/Si															
		a. (F	First)			b. (l	Midd	le Ini	tial)	c. (Last) d. (J							r/Sr)	
2.	GENDER®	1. M	1. Male 2. Female															
3.	BIRTHDATE®									T			Т					
			L,															
	DAGE		Mo		P /	Di					Ye		1.65					
4.	RACE/® ETHNICITY		American Indian/Alaskan Native 4. Hispanic Asian/Pacific Islander 5. White, not of															
		3. BI	Black, not of Hispanic origin Hispanic origin															
5.	SOCIAL	a.S	Social Security Number															
	SECURITY® AND				_	_		.										
	MEDICARE	h M	 ledica	re nu	 mbai		omn		ا د ra	ilros	ad ir	201	ranc	וח בי	_ ımh	ωr)		
	NUMBERS®	O. IVI		i C Hu		1	П	arab	T		T	130	Taric	T	T			
	non med. no.]																	
6.	FACILITY	a. St	ate N	Ο.														
	PROVIDER NO.®																	
	110.									+	_		+	+	4			
		b. Fe	edera	No.														
7.	MEDICAID																	
	NO. ["+" if	╽┌					_	_			_	_			_	_	-	_
	pending, "N"																	
	Medicaid	-												l				
	recipient] (9																	
8.	REASONS FOR		e—Ot						o this	s fo	rm]							
	ASSESS-		riman Adn						iiroc	l bu	, da	, 1,	1\					
	MENT		Anr					(ieqi	JII GC	ι Оу	ua	y 1-	+)					
			Sign															
			Sigi							ass	ess	me	ent					
		10). Sigr	nificai	nt cor	rection	on of			rte	rly a	ISS	essn	nent				
		0.	NŌ	NE C	F AE	BOVE												
										for	Ме	dic	are	PPS	or	the	State	
			Me Me															
		3.	Med	dicare	e 60 c	day as	sess	smer	nt									
		4. 5	Med Med	dicare	90 c	iay as Imiss	sess ion/r	smer eturr	nt 1 ass	ess	sme	ent						
		6.	Oth	er sta	ite re	quire	d ass	essi	nen									
			Med Oth							mo	nt							
		0.	Our	CI IVIC	uica	16160	unec	ass	C331	iiei	ııı							

 Signatures of Persons who Completed a Portion of the Accompanying Assessment of Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		
i.		
j.		
k.		
I.		

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

MDS MEDICARE PPS ASSESSMENT FORM (VERSION JULY 2002)

AB5.	RESIDEN-	(Check all settings resident lived in during 5 years prior to date of entry.)						
ADO.	TIAL	a. Prior stay at this nursing home						
	HISTORY 5 YEARS	b. Stay in other nursing home						
	PRIOR TO	c. Other residential facility—board and care home, assisted living,						
	ENTRY	group home						
		d. MH/psychiatric setting						
		e. MR/DD setting						
		f. NONE OF ABOVE						
A1.	RESIDENT NAME							
	TUPANE	a. (First) b. (Middle Initial) c. (Last) d. (Ji	r/Sr)					
A2.	ROOM							
	NUMBER							
A3.	ASSESS-	a. Last day of MDS observation period						
	MENT REFERENCE							
	DATE							
44	DATE OF	Month Day Year						
A4a	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospita last 90 days (or since last assessment or admission if less than 90						
		days)						
		Month Dav Year						
A5.	MARITAL	Never married						
A.C.	STATUS	2. Married 4. Separated						
A6.	MEDICAL RECORD							
	NO.							
A10.	ADVANCED	(For those items with supporting documentation in the medical						
	DIRECTIVES	record, check all that apply)						
		b. Do not resuscitate c. Do not hospitalize						
B1.	COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (If Yes, skip to Section G)						
-	MEMORY	(Recall of what was learned or known)						
B2.	MEMORY	,						
		Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem						
		b. Long-term memory OK—seems/appears to recall long past						
		0. Memory OK 1. Memory problem						
B3.	MEMORY/	(Check all that resident was normally able to recall during last 7 days)						
	RECALL ABILITY	a. Current season d. That he/she is in a nursing home						
		h Location of own room						
		c. Staff names/faces e. NONE OF ABOVE are recalled						
B4.	COGNITIVE	(Made decisions regarding tasks of daily life)						
	SKILLS FOR DAILY	INDEPENDENT—decisions consistent/reasonable						
	DECISION-	1. MODIFIED INDEPENDENCE—some difficulty in new situations						
	MAKING	only 2. MODERATELY IMPAIRED—decisions poor; cues/supervision						
		required						
		SEVERELY IMPAIRED—never/rarely made decisions						
B5.	INDICATORS OF	(Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct know	lodao					
	DELIRIUM—	of resident's behavior over this time].	leuge					
	PERIODIC DISOR-	Behavior not present						
	DERED	Behavior present, not of recent onset						
	THINKING/ AWARENESS	Behavior present, over last 7 days appears different from resident's us functioning (e.g., new onset or worsening)	sual					
		6, 6,						
		a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)						
		b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF						
		SURROUNDINGS—(e.g., moves lips or talks to someone not						
		present; believes he/she is somewhere else; confuses night and day)						
		c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is						
		incoherent, nonsensical, irrelevant, or rambling from subject to						
		subject; loses train of thought)						
		d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical						
		movements or calling out)						
		e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into						
		space; difficult to arouse; little body movement)						
		f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors						
		sometimes present, sometimes not)						

C4.		(Expressing information content—however able)							
	SELF UNDER-	0. UNDERSTOOD							
	STOOD	USUALLY UNDERSTOOD—difficulty finding words or finishing							
		thoughts							
		SOMETIMES UNDERSTOOD—ability is limited to making concrete requests							
		3. RARELY/NEVER UNDERSTOOD							
C6.	ABILITY TO	(Understanding verbal informa							
00.	UNDER-	0.UNDERSTANDS	non comen newer abie,						
	STAND OTHERS		-may miss some part/intent of						
	OTHERS	message	may miss some partiment of						
		2.SOMETIMES UNDERSTAN	DS—responds adequately to simple,						
		direct communication							
		3.RARELY/NEVER UNDERS	-						
D1.	VISION	(Ability to see in adequate light	,						
		 ADEQUATE—sees fine deta newspapers/books 	ali, including regular print in						
			t, but not regular print in newspapers/						
		books							
		2. MODERATELY IMPAIRED-							
		newspaper headlines, but ca	an identify objects identification in question, but eyes						
		appear to follow objects	identification in question, but eyes						
		''	vision or sees only light, colors, or						
		shapes; eyes do not appear	to follow objects						
E1.		(Code for indicators observed in las	st 30 days, irrespective of the assumed cause)						
	OF DEPRES-	Indicator not exhibited in last	t 30 days						
	SION,	Indicator of this type exhibite	ed up to five days a week						
	ANXIETY, SAD MOOD	2. Indicator of this type exhibite	ed daily or almost daily (6, 7 days a week)						
П		VERBAL EXPRESSIONS	h. Repetitive health						
		OF DISTRESS	complaints—e.g., persistently seeks medical						
		a. Resident made negative	attention, obsessive						
		statements—e.g., "Nothing matters; Would rather be	concern with body functions						
		dead; What's the use; Regrets having lived so	i. Repetitive anxious complaints/concerns						
		long; Let me die"	(non-health related) e.g.,						
		b. Repetitive questions—e.g.,	persistently seeks attention/ reassurance regarding						
		"Where do I go; What do I	schedules, meals, laundry,						
		do?"	clothing, relationship issues						
		c. Repetitive verbalizations— e.g., calling out for help,	SLEEP-CYCLE ISSUES						
		("God help me")	j. Unpleasant mood in						
		d. Persistent anger with self	morning						
		or others—e.g., easily annoyed, anger at	k. Insomnia/change in usual sleep pattern						
		placement in nursing	SAD, APATHETIC, ANXIOUS						
		home; anger at care received	APPEARANCE						
		e. Self deprecation—e.g., "I	I. Sad, pained, worried facial						
		am nothing; I am of no use	expressions—e.g., furrowed brows						
		to anyone [™]	m. Crying, tearfulness						
		f. Expressions of what appear to be unrealistic	n. Repetitive physical						
		fears—e.g., fear of being	movements—e.g., pacing,						
		abandoned, left alone,	hand wringing, restlessness, fidgeting, picking						
		being with others	LOSS OF INTEREST						
		g. Recurrent statements that something terrible is about	o. Withdrawal from activities						
		to happen—e.g., believes	of interest—e.g., no interest						
		he or she is about to die, have a heart attack	in long standing activities or being with family/friends						
			p. Reduced social interaction						
E2.	MOOD	One or more indicators of de	epressed, sad or anxious mood were						
<u></u> .	PERSIS-	not easily altered by attempt	s to "cheer up", console, or reassure						
	TENCE	the resident over last 7 days							
		No mood 1. Indicators pro- indicators easily altered							
ш		and the second second second							

Numeric Identifier ____

OMB 0938-0739 expiration date 12/31/2002 MDS 2.0 PPS July 2002

Resident Identifier			Numeric Identifier
			· · · · · · · · · · · · · · · · · · ·
E4. BEHAVIORAL (A) Behavioral symptom frequency in last 7 days	G3.		(Code for ability during test in the last 7 days)
SYMPTOMS `	- 1	BALANCE	Maintained position on required in test

E4.	BEHAVIORAL	- (A) Behavioral symptom frequency in last 7 days			G3.		(Code for ability during test in t	ne last 7 day	rs)			
	SYMPTOMS	0. Behavior not exhibited in last 7 days				BALANCE	Maintained position as requi	red in test	thaut nhu	roigal ar magart		
		1. Behavior of this type occurred 1 to 3 days in last 7 days				(see training manual)	 Unsteady, but able to rebala Partial physical support during 	ng test;		• •		
		2. Behavior of this type occurred 4 to 6 days, but less than daily				ilialiuai)	or stands (sits) but does not 3. Not able to attempt test with	follow dired		test		
		3. Behavior of this type occurred daily					a. Balance while standing	out priysica	ıı neib		\top	
		(B) Behavioral symptom alterability in last 7 days					b. Balance while sitting—position	on, trunk c	ontrol			
		O. Behavior not present OR behavior was easily altered			G4.	FUNCTIONAL	(Code for limitations during las	t 7 days th		ered with daily fund	tions	or
			A)	(B)		LIMITATION IN BANGE OF	placed residents at risk of injur (A) RANGE OF MOTION		3) VOLLI	NTARY MOVEME	NT	
		a. WANDERING (moved with no rational purpose, seemingly				MOTION	No limitation	Ò.	. No los	S	., • ,	
		oblivious to needs or safety)					 Limitation on one side Limitation on both sides 		. Partial . Full los		(A)	(B
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others					a. Neck					_
		were threatened, screamed at, cursed at)	_	_			b. Arm—Including shoulder or	elbow		İ		Π
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)					c. Hand-Including wrist or fine	gers		[
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL					d. Leg-Including hip or knee			ļ		_
		SYMPTOMS (made disruptive sounds, noisiness, screaming,					e. Foot—Including ankle or toe	S				<u> </u>
		self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others'			G5.		f. Other limitation or loss (Check if applied during last 7 days	2)				
		belongings)			45.	LOCOMO-	b. Wheeled self	•)				
		e. RESISTS CARE (resisted taking medications/injections, ADL			Ш	TION						
24		assistance, or eating)			G6.	TDANCEED	(Check all that apply during last 7	days)		,		
G1.		F-PERFORMANCE—(Code for resident's PERFORMANCE OVER A Juring last 7 days —Not including setup)	LL			INANSFER	a. Bedfast all or most of time					
	l	IDENT—No help or oversight —OR— Help/oversight provided only 1 of	or 2				 b. Bed rails used for bed mobility or transfer]		
	times duri	ng last 7 days			G7.	TASK	Some or all of ADL activities w	ere broken	into sub	tasks during last 7	,	
	1. SUPERVI	ISION—Oversight, encouragement or cueing provided 3 or more times s—OR— Supervision (3 or more times) plus physical assistance prov	dur	ring	~"	SEGMENTA-	days so that resident could pe			January Hot I		
		s –OA– Supervision (3 or more times) plus physical assistance provi es during last 7 days	iaea	Office	H1.		0. No 1. Yes E SELF-CONTROL CATEGOR	IEC				_
	2. LIMITED	ASSISTANCE—Resident highly involved in activity; received physical h	nelp		'''		nt's PERFORMANCE OVER ALL SH					
	in guided	maneuvering of limbs or other nonweight bearing assistance 3 or mor	e tin	nes		0 CONTINEN	IT—Complete control [includes	use of ind	wellina u	rinary catheter or c	netom	21/
		lore help provided only 1 or 2 times during last 7 days	-			device that	does not leak urine or stool]	use of frid	welling an	mary carreter or c	00011	y
	period, he	IVE ASSISTANCE—While resident performed part of activity, over last lp of following type(s) provided 3 or more times: -bearing support	/-ua	ay			CONTINENT—BLADDER, inco	ntinent epi	sodes on	ice a week or less;	;	
		ff performance during part (but not all) of last 7 days					•	DED 0			4 - 9	
	4. TOTAL DE	EPENDENCE—Full staff performance of activity during entire 7 days				BOWEL, or	<i>NALLY INCONTINENT</i> —BLADI nce a week	JEH, 2 OF I	nore time	es a week but not (dally;	
	8. ACTIVITY	/ DID NOT OCCUR during entire 7 days					TLY INCONTINENT—BLADDE	D tondod	to bo inc	ontinent daily but	como	,
	(B) ADL SUP	PORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL					ent (e.g., on day shift); BOWEL			ortinent daily, but	301110	,
		ring last 7 days; code regardless of resident's self-performance	(A)	(B)		4 INCONTINI	ENT—Had inadequate control E	BI ADDER	multiple	daily enisodes:		
	l	or physical help from staff	ᇤ	l ≒ l	Ш		(or almost all) of the time					
	 Setup hel 	p only	4	G	a.	BOWEL CONTI-	Control of bowel movement, w	ith applian	ce or bov	vel continence		
	 One person Two+ person 	on physical assist 8. ADL activity itself did not sons physical assist occur during entire 7days	SELF-PERF	SUPPORT		NENCE	programs, if employed					
a.	BED	How resident moves to and from lying position, turns side to side,	()	0)	b.	BLADDER CONTI-	Control of urinary bladder functions soak through underpants), with	tion (if drib	bles, volu es (e.a. f	ume insufficient to pley) or continence	e	
	MOBILITY	and positions body while in bed			Ш	NENCE	programs, if employed		(3.,			
b.		How resident moves between surfaces—to/from: bed, chair,			H2.	BOWEL ELIMINATION	c. Diarrhea					
_	WALK IN	wheelchair, standing position (EXCLUDE to/from bath/toilet)				PATTERN	d. Fecal impaction					
С.	ROOM	How resident walks between locations in his/her room			Н3.		a. Any scheduled toileting plan			Indwelling cathete Ostomy present	r	
d.	WALK IN CORRIDOR	How resident walks in corridor on unit				DDOCDAMS	b. Bladder retraining programc. External (condom) catheter		1.	Ostorny present		
e.		How resident moves between locations in his/her room and			For	Section L · che	eck only those diseases that h	ave a rela	tionshir	to current ADI et	atus	
		adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair			cog	nitive status, mo	ood and behavior status, medica					
f.	LOCOMO-	How resident moves to and returns from off unit locations (e.g.,			dea	th. (Do not list ir	nactive diagnoses)					
	TION OFF UNIT	areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on			11.	DISEASES	a. Diabetes melitus		v. Hemir	olegia/Hemiparesis	; [_
		the floor. If in wheelchair, self-sufficiency once in chair					d. Arteriosclerotic heart	v	v. Multip	e sclerosis		_
g.		How resident puts on, fastens, and takes off all items of clothing ,					disease (ASHD)		x. Parapl	egia		_
ı.		including donning/removing prosthesis					f. Congestive heart failure		z. Quadr	iplegia		_
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral					j. Peripheral vascular	e	e. Depre	ssion		
		nutrition)					disease	1	f. Manic	depressive (bipola	ar	
i.		How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or					m. Hip fracture		diseas	se)		
		catheter, adjusts clothes					r. Aphasia	"	g. Schizo	•		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair,					s. Cerebral palsy	hl	h. Asthm	a		
	HYGIENE	brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)					 t. Cerebrovascular accident (stroke) 		i i. Emph	ysema/COPD		
G2.	BATHING	How resident takes full-body bath/shower, sponge bath, and	Ţ		12	INFECTIONS	(If none apply, CHECK the NONE O	FABOVE ho) (x)			
		transfers in/out of tub/shower (EXCLUDE washing of back and hair.) Code for most dependent in self-performance.			-	2.1.2.1.3	a. Antibiotic resitant infection		. Septice	emia		_
		(A) BATHING SELF PERFORMANCE codes appear below		(A)			(e.g. Methicillin resistant staph)	h		y transmitted		
		Independent—No help provided	_	\ ~)			b. Clostridium difficile (c. diff.)		disease		\vdash	
		Supervision—Oversight help only		_			c. Conjunctivitis		. Tubercu			
		Physical help limited to transfer only					d. HIV infection	—	last 30	tract infection in days		_
		Physical help in part of bathing activity					e. Pneumonia	k	. Viral he	epatitis		
		4. Total dependence Activity itself did not occur during entire 7 days.					f. Respiratory infection			infection	L	_
		Activity itself did not occur during entire 7 days				l l		m	NONE	OF ABOVE	- 1	

Resident Identifier _____

13.	OTHER				
	CURRENT	[_		1 1 1 1	1 1
	AND ICD-9	a		•	
	CODES	b.		<u> </u>	
J1.	PROBLEM CONDITIONS	(Check all problems present in la indicated)		ne frame is	
		INDICATORS OF FLUID STATUS	OTHER e. Delusions		
			g. Edema		
		a. Weight gain or loss of 3 or more pounds within a 7-	h. Fever		
		day period	i. Hallucinatio	ons	
		b. Inability to lie flat due to	j. Internal ble	eding	
		shortness of breath c. Dehydrated; output	k. Recurrent l	ung aspirations in	
		exceeds input	I. Shortness		
		d. Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days	n. Unsteady g o. Vomiting	ait	
J2.	PAIN	(Code the highest level of pain p	present in the last 7 days	<u> </u>	
JZ.	SYMPTOMS	a. FREQUENCY with which		SITY of pain	
		resident complains or	1. Mild pa	•	
		shows evidence of pain	2. Modera		
		0. No pain (<i>skip to J4</i>)		when pain is horri	ble
		Pain less than daily Pain daily		uciating	
J4.	ACCIDENTS	(Check all that apply)	c. Hip fracture	in last 180 days	
		a. Fell in past 30 days	d. Other fractu	=	
		b. Fell in past 31-180 days	days		
			e. NONE OF A		
J5.	STABILITY OF	 Conditions/diseases make in behavior patterns unstable- 			
	CONDITIONS	b. Resident experiencing an a	acute episode or a flare	-up of a recurrent	
		or chronic problem	•		
		c. End-stage disease, 6 or fev	ver months to live		
144	ODAL	d. NONE OF ABOVE			
K1.	ORAL PROBLEMS	a. Chewing problem b. Swallowing problem			
K2.	HEIGHT	Record (a.) height in inches and	(b.) weight in pounds	. Base weight on	most
	AND	recent méasure in last 30 da	ys, measure weight cor	nsistently in accor	d with
	WEIGHT	standard facility practice—e.g off, and in nightclothes	ı., ırı a.rrı. aner volulrig, i	Delore meal, Willi	snoes
			a. HT (in.)	b. WT (lb.)	
K3.	WEIGHT	a. Weight loss-5 % or more	in last 30 days; or 10	% or more in last	
	CHANGE	180 days			
		0. No 1. Ye			
		b. Weight gain—5 % or more 180 days	e in last 30 days ; or 10	% or more in last	
		0. No 1. Ye	S		
K5.	NUTRI-	(Check all that apply in last 7 d	ays)		
	TIONAL APPROACH-	a. Parenteral/IV	h. On a pla	anned weight	
	ES	b. Feeding tube	change	program	
			or file in other 1. A		
K6.	PARENTERAL OR ENTERAL	(Skip to Section M if neither 5a no	•		
	INTAKE	 Code the proportion of total parenteral or tube feedings 		received through	
		0. None	3. 51% to 75%		
		1. 1% to 25% 2. 26% to 50%	4. 76% to 100%	,	
		b. Code the average fluid int	ake ner day by IV or tul	ne in last 7 days	
		0. None	3. 1001 to 1500	-	
		1. 1 to 500 cc/day 2. 501 to 1000 cc/day	4. 1501 to 2000 5. 2001 or more	cc/day	
M1.	ULCERS	(Record the number of ulcers			<u> </u>
.vi 1 .		cause. If none present at a sta during last 7 days . Code 9 =	age, record "0" (zero). C	ode all that apply	mbe
	(Due to any cause)	auring last 7 days. Code 9 =	9 or more.) [Requires	тин body exam.]	Number at Stage
		a. Stage 1. A persistent area skin) that does no	of skin redness (withou ot disappear when pres		
		b. Stage 2. A partial thicknes clinically as an at	s loss of skin layers tha orasion, blister, or shallo		
			s as a deep crater with		
		undermining adja d. Stage 4. A full thickness o	f skin and subcutaneou	s tissue is lost,	
		exposing muscle	or bone.		

		١	Numeric Ide	ntifier					
M2.	TYPE OF ULCER	scale in item M1—i.e.,	0=none; st	,					
		Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue							
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities							
M3.	HISTORY OF RESOLVED ULCERS		t was resol . Yes	ved or cured in LAST 90 DAYS					
M4.	OTHER SKIN PROBLEMS	a. Abrasions, bruises							
	OR LESIONS	b. Burns (second or third	0 /	ahaa auta (a.a. aanaar laajana)					
	PRESENT	c. Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) 1. Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes							
	(Check all that apply during	zoster							
	last 7 days)	e. Skin desensitized to paf. Skin tears or cuts (other	•						
		g. Surgical wounds	than oarg	5. y)					
		h. NONE OF ABOVE							
M5.	SKIN TREAT-	a. Pressure relieving devi	. ,						
	MENTS	b. Pressure relieving devi		ed	\vdash				
	(Check all that	c. Turning/repositioning p	•	to manage skin problems	$\vdash\vdash\vdash$				
	apply during last 7 days)	e. Ulcer care		to manage our prosionio					
		f. Surgical wound care							
		g. Application of dressing than to feet	s (with or v	vithout topical medications) other					
		h. Application of ointment		,					
		i. Other preventative or pj. NONE OF ABOVE	rotective si	kin care (other than to feet)					
M6.	FOOT	<u>-</u>	ore foot pro	oblems—e.g., corns, callouses,					
	PROBLEMS AND CARE	bunions, hammer toes	, overlappir	ig toes, pain, structural problems					
		b. Infection of the foot—e		s, purulent drainage					
	(Check all that apply during	c. Open lesions on the fod. Nails/calluses trimmed		t 90 days					
	last 7 days)		•	•					
		shoes, inserts, pads, to	Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)						
		f. Application of dressings (with or without topical medications) g. NONE OF ABOVE							
N1.	TIME	(Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour							
	AWAKE	Resident awake all or mo per time period) in the:	st of time (i	.e., naps no more than one hour					
		a. Morning							
(lf ı	resident is co	b. Afternoon d. NONE OF ABOVE matose, skip to Section O)							
N2.	AVERAGE	(When awake and not re		eatments or ADL care)					
	TIME INVOLVED IN ACTIVITIES		of time	2. Little—less than 1/3 of time 3. None					
01.	NUMBER OF MEDICA- TIONS	(Record the number of differ "0" if none used)	ent medica	tions used in the last 7 days; enter					
О3.	INJECTIONS	(Record the number of DAYS last 7 days; enter "0" if north		of any type received during the					
O4.	DAYS RECEIVED			7 days; enter "0" if not used.					
	THE	Note—enter "1" for long- a. Antipsychotic	acui iy Me0	d. Hypnotic					
	FOLLOWING MEDICATION	b. Antianxiety		e. Diuretic					
		c. Antidepressant							
P1.	SPECIAL TREAT- MENTS,	a. SPECIAL CARE—CI during the last 14 da		ments or programs received					
	PROCE- DURES, AND	TREATMENTS		PROGRAMS					
	PROGRAMS	a. Chemotherapy		m. Alcohol/drug treatment					
		b. Dialysis		program					
		c. IV medication		 n. Alzheimer's/dementia special care unit 					
		d. Intake/output	al	o. Hospice care	\blacksquare				
		 e. Monitoring acute medic condition 	a1	p. Pediatric unit	$\vdash \vdash$				
		f. Ostomy care		q. Respite care					
		g. Oxygen therapy		 r. Training in skills required to return to the community 					
		h. Radiation		(e.g., taking medications, house work, shopping,					
		i. Suctioning		transportation, ADLs)					
		j. Tracheostomy carek. Transfusions		s. NONE OF THE ABOVE					
		Ventilator or respirator							

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SPECIAL b. THERAPIES - Record the number of days and total minutes each of the TREAT-MENTS, following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily) [Note — count only post admission therapies]
(A) = # of days administered for 15 minutes or more
(B) = total # of minutes provided in last 7 days PROCE-DURES, AND DAYS MIN **PROGRAMS** (A) (B) a. Speech - language pathology and audiology services b. Occupational therapy c. Physical therapy d. Respiratory therapy e. Psychological therapy (by any licensed mental health Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the residents for more than or equal to 15 minutes per day in the last 7 days (ENTER 0 if none or less than 15 min. daily.) P3. NURSING REHABILITA TION/ RESTOR-ATIVE CARE a. Range of motion (passive) f. Walking b. Range of motion (active) g. Dressing or grooming c. Splint or brace assistance h. Eating or swallowing TRAINING AND SKILL i. Amputation/prosthesis care PRACTICE IN: j. Communication d. Bed mobility e. Transfer k. Other P4. DEVICES Use the following codes for last 7 days: AND RESTRAINTS 0. Not used 1. Used less than daily 2. Used daily Bed rails a. -Full bed rails on all open sides of bed b. —Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint e. Chair prevents rising In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter 0 if none) PHYSICIAN

		Numeric Identifier
P8.		In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter 0 if none)
Q1.	DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0. No 1. Yes
		c. Stay projected to be of a short duration—discharge projected within 90 days (do not include expected discharge due to death) 0. No 2. Within 31-90 days 1. Within 30 days 3. Discharge status uncertain
Q2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 1. Improved—receives more support more support
R2.	SIGNATURE (OF PERSON COORDINATING THE ASSESSMENT:
b. D		Assessment Coordinator (sign on above line) ment Coordinator te Month Day Year
T1.	SPECIAL TREATMENTS AND PROCE- DURES	Skip unless this is a Medicare 5 day or Medicare readmission/return assessment b. ORDERED THERAPIES—Has physician ordered any of the following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service? 0. No 1. Yes
		c. Through day15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.
T3.	CASE MIX	at least 1 therapy service can be expected to have been delivered. d. Through day15, provide an estimate of the number of therapy minutes (across the therapies) that can be

VISITS

Resident	Numeric Identifier

1.	National Provider ID	Enter for all assessments and tracking forms, if available.	
		his assessment or the discharge date of this discharge s between July 1 and September 30, skip to W3.	
2.	Influenza Vaccine	 a. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3) b. If Influenza vaccine not received, state reason: 1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine 	
3.	Pneumo- coccal Vaccine	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	