BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

			_	_			_			
1.	RESIDENT NAME®									
		a. (First)		b. (Midd	e Initial))	c. (Last)	d. (J	Jr/Sr)
2.	GENDER®	1. Male		2.Fe	male					
3.	BIRTHDATE [®]									
		L L	n the				l L ear			
4.	RACE/⊛	Mo		Day Alaskan N	ativo	TE	4. His	nanic		
٦.	ETHNICITY		acific Islar		auve		5.Wh	ite, not		
				anic origin			His	spánic	origin	
5.	SOCIAL SECURITY®	a. Social S	Security N	umber						
	AND		-	-	-					
	MEDICARE	b. Medica	re numbei	r (or compa	 arable ra	ailroad i	nsurano	e num	ber)	
	NUMBERS® [C in 1st box if			Ì					ń	
	non med. no.]									
6.	FACILITY	a. State N	0.							
	PROVIDER NO.®									
										ㅡ
		b. Federa	No.							
7.	MEDICAID			•		•		_	•	
	NO. ["+" if									— I
	pending, "N" if not a									
	Medicaid									_
	recipient] &									
8.	REASONS FOR	[Note—Ot		•		is form]				
	ASSESS-			or assessn sessment		d by da	v 14\			
	MENT	2 Ann	ual asses	sment	` '	,	,			
				ange in sta						
		4. Sigi 5. Qua	nncant con arterly revie	rrection of ew assess	prior tuii ment	assess	sment			
		10. Sigr	nificant cor	rection of		arterly a	assessn	nent		
			NE OF AE							
				s sments r ay assessr		for Me	dicare	PPS o	r the State	,
				ay assessi day assess						
		3. Med	dicare 60 d	dáv assess	ment					
		4. Med 5. Med	aicare 90 d dicare read	dáy assess dmission/r	iment eturn as	sessme	ent			
		6. Oth	er state re	quired ass	essmer		•			
				day assess re required		sment				
		U. Olli	oi ivicuita	i o required	4 433633	Ji i ICI IL				

 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 w	
	ENTRY	closed at time of temporary discharge to hospital, etc. In such cases, us admission date	se 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	0. No	
	ALONE (PRIOR TO	1. Yes	
L	`ENTRY)	2. In other facility	
4.	ZIP CODE OF 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		
	occupations]		
7.	EDUCATION (Highest	1. No schooling 5. Technical or trade school 2. 8th grade/less 6. Some college	
	Level	3. 9-11 grades 7. Bachelor's degree	
8.	Completed)	4. High school 8. Graduate degree (Code for correct response)	
		a. Primary Language	
		0. English 1. Spanish 2. French 3. Other	
		b. If other, specify	
9.	MENTAL	Does resident's RECORD indicate any history of mental retardation,	
	HEALTH HISTORY	mental illness, or developmental disability problem? 0. No 1. Yes	
10.	CONDITIONS	(Check all conditions that are related to MR/DD status that were	
	RELATED TO MR/DD	manifested before age 22, and are likely to continue indefinitely)	
	STATUS	Not applicable—no MR/DD (Skip to AB11)	a.
		MR/DD with organic condition	
		Down's syndrome	b.
		Autism	c.
		Epilepsy	d.
		Other organic condition related to MR/DD	e.
		MR/DD with no organic condition	f.
11.	DATE BACK-		
	GROUND		
	INFORMA- TION	Month Day Year	
1	COMPLETED		

SECTION AC CUSTOMARY ROUTINE

_		C. CUSTOWART ROUTINE	
•	CUSTOMARY ROUTINE	(Check all that apply. If all information UNKNOWN, check last box onl	ly.)
	(In year prior	CYCLE OF DAILY EVENTS	
	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	e.
	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	o.
		Showers for bathing	р.
		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	y.
_			

		Daily animal companion/present	e	ļ	v.
		Involved in group activities			w.
		NONE OF ABOVE			x.
		UNKNOWN—Resident/family u	nable to provide information		y.
		D. FACE SHEET SIGN			
SI	GNATURES O	F PERSONS COMPLETING F	ACE SHEET:		
a. S	ignature of RN	Assessment Coordinator			Date
infordate applibasi from pation ness subs	mation for this so specified. To ilicable Medicar so for ensuring to federal funds, on in the governs of this informatian criminal fry that I am au	companying information accurat resident and that I collected or co the best of my knowledge, this i e and Medicaid requirements. I hat residents receive appropriate I further understand that paymer ment-funded health care progran tion, and that I may be personally , civil, and/or administrative pen thorized to submit this informatio	ordinated collection of this information was collected in inderstand that this information was collected in and quality care, and as a to f such federal funds and is is conditioned on the according to make the condition of the	information accordance ation is used basis for pa continued puracy and tr my organiza onformation.	on the ce with d as a syment particitathfulation to I also
S	ignature and Ti	tle	Sections		Date
b.					
C.					
d.					
e.					
f.					
g.					
es			MDS 2.0	Septembe	r, 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)

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re recalled ew situations supervision ons ote assessment have direct know from resident's u intion; gets RENESS OF meone not ses night and on, speech is a subject to or picking at skin,
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PERSONAL HYGIENE

SECTION D. VISION PATTERNS

		7.0.0.1.7.1.1.2.1.1.0	
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 D. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects 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	

		flashes of light; sees "curtains" over eyes				
		NONE OF ABOVE				
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes				
	AI I LIAITOLO	0.100				
SE	CTION E. M	OOD AND BEHAVIOR PATTERNS				
1.	INDICATORS	(Code for indicators observed in last 30 days, irrespective of the assumed cause)				
	OF DEPRES-	Indicator not exhibited in last 30 days Indicator of this type exhibited up to five days a week				
	SION, ANXIETY,	Indicator of this type exhibited daily or almost daily (6, 7 days a week	:)			
	SAD MOOD	VERBAL EXPRESSIONS OF DISTRESS h. Repetitive health complaints—e.g.,				
		a. Resident made negative persistently seeks medical attention, obsessive concern				
		statements—e.g., "Nothing matters; Would rather be				
		dead; What's the use; i. Repetitive anxious				
		Regrets having lived so complaints/concerns (non-long; Let me die" health related) e.g.,				
		persistently seeks attention/				
		"Where do I go; What do I schedules, meals, laundry,				
		c. Repetitive verbalizations— sleep-cycle issues				
		e.g., calling out for help, ("God help me") j. Unpleasant mood in morning				
		d. Persistent anger with self or others—e.g., easily				
		annoyed, anger at SAD, APATHETIC, ANXIOUS placement in nursing home; SAD, APATHETIC, ANXIOUS APPEARANCE				
		anger at care received I. Sad, pained, worried facial				
		e. Self deprecation—e.g., "I am nothing: I am of no use brows expressions—e.g., furrowed brows				
		to anyone" m. Crying, tearfulness				
		f. Expressions of what appear to be unrealistic farm on far of being movements—e.g., pacing,				
		abandoned left alone hand wringing, restlessness,				
		being with others LOSS OF INTEREST				
		g. Recurrent statements that something terrible is about o. Withdrawal from activities of				
		to happen—e.g., believes interest—e.g., no interest in				
		he or she is about to die, have a heart attack long standing activities or being with family/friends				
		p. Reduced social interaction				
2.	MOOD PERSIS-	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure				
	TENCE	the resident over last 7 days				
		0. No mood 1. Indicators present, 2. Indicators present, indicators easily altered not easily altered				
3.	CHANGE IN MOOD	Resident's mood status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days)				
	IN WOOD	0. No change 1. Improved 2. Deteriorated				
4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequency in last 7 days 0. Behavior not exhibited in last 7 days				
	01111111101110	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. 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)				
		e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)				

5.	CHANGE IN	Resident's behavio	or status has changed as	compared to status of 90	
			e last assessment if less	than 90 days)	
	SYMPTOMS	No change	 Improved 	Deteriorated	

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF	At ease interacting with others	T
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- SHIPS	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. c.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

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1.	(A) ADL SELF SHIFTS d	F-PERFORMANCE—(<i>Code f</i> or resident's PERFORMANCE OVER A luring last 7 days—Not including setup)	4 <i>LL</i>			
	INDEPEN during last	IDENT—No help or oversight —OR— Help/oversight provided only 1 .7 days	or 2 ti	mes		
	SUPERVISION—Oversight, encouragement or cueing provided 3 or more time last7 days —OR— Supervision (3 or more times) plus physical assistance pro 1 or 2 times during last 7 days					
	LIMITED ASSISTANCE—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times — OR—More help provided only 1 or 2 times during last 7 days					
	3. 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					
		EPENDENCE—Full staff performance of activity during entire 7 days				
		DID NOT OCCUR during entire 7 days				
	(B) ADL SUPF	PORT PROVIDED—(Code for MOST SUPPORT PROVIDED	(A)	(B)		
		L SHIFTS during last 7 days; code regardless of resident's self- ce classification)	r	(-,		
	 Setup help One perso 	or physical help from staff only n physical assist 8. ADL activity itself did not ons physical assist occur during entire 7 days	SELF-PERF	SUPPORT		
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				
				_		

How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)

	BATHING	transfers in/out of tub/shower (DE washing of back and hair.)		
		Code for most dependent in	self-peri	formance and support.	(A)	В)
		(A) BATHING SELF-PERFOR		E codes appear below		\dashv
		 Independent—No help pro Supervision—Oversight he 				
		Physical help limited to train		hv		
		Physical help in part of bat		•		
		Total dependence	i iii ig aci	avity		
		Activity itself did not occur	durina a	ontiro 7 dave		
		(Bathing support codes are as				
3.	TEST FOR	(Code for ability during test in t	he last i	7 days)		
	BALANCE	Maintained position as requi				
	(see training	 Unsteady, but able to rebala Partial physical support duri 		without physical support		
	manual)	or stands (sits) but does not	follow d			
		Not able to attempt test with Balance while standing	out pnys	sicai neip		_
		b. Balance while sitting—positi	on trun	k control		_
4	FUNCTIONAL			s that interfered with daily function	ns or	\dashv
	LIMITATION	placed resident at risk of injury		ŕ		
	IN RANGE OF MOTION	(A) RANGE OF MOTION 0. No limitation		(B) VOLUNTARY MOVEMEN 0. No loss	T	
		 Limitation on one side 		 Partial loss 	,	(D)
	(see training manual)	Limitation on both sides		2. Full loss	(A) ((B)
	manaay	a. Neck	albau		_	_
		b. Arm—Including shoulder orc. Hand—Including wrist or fing		-	+	\dashv
		d. Leg—Including hip or knee	_J C13	-	+	\dashv
		e. Foot—Including ankle or toe	s	-	+	\dashv
		f. Other limitation or loss	-	-	+	\dashv
5.	MODES OF	(Check all that apply during la	ast 7 da	vs)		
٠.	LOCOMO-	Cane/walker/crutch	a.	Wheelchair primary mode of		
	TION	Wheeled self	b.	locomotion	d.	
		Other person wheeled	С.	NONE OF ABOVE	e.	
6.	MODES OF	(Check all that apply during la		vs)		
	TRANSFER	Bedfast all or most of time		Lifted mechanically		
		Bed rails used for bed mobility	a.	Transfer aid (e.g., slide board,	d.	
		or transfer	b.	trapeze, cane, walker, brace)	e.	
		Lifted manually	c.	NONE OF ABOVE	f.	
_	TASK	Some or all of ADL activities w				
7.						
۲.	SEGMENTA- TION	days so that resident could pe 0. No 1. Yes		em		
8.	TION ADL	0. No 1. Ýes Resident believes he/she is ca	;	em increased independence in at		
	TION ADL FUNCTIONAL	0. No 1. Yes	;		a.	
	TION ADL FUNCTIONAL REHABILITA- TION	No 1. Yes Resident believes he/she is caleast some ADLs Direct care staff believe resider	pable of			
	TION ADL FUNCTIONAL REHABILITA-	No 1. Yes Resident believes he/she is caleast some ADLs Direct care staff believe resider in at least some ADLs	pable of	increased independence in at able of increased independence	b.	
	TION ADL FUNCTIONAL REHABILITA- TION	No 1. Yes Resident believes he/she is caleast some ADLs Direct care staff believe resider in at least some ADLs Resident able to perform tasks	pable of nt is cap /activity	increased independence in at able of increased independence but is very slow	ackslash	
	TION ADL FUNCTIONAL REHABILITA- TION	O. No	pable of nt is cap /activity	increased independence in at able of increased independence but is very slow	b.	
	TION ADL FUNCTIONAL REHABILITA- TION	O. No	pable of nt is cap /activity	increased independence in at able of increased independence but is very slow	b. c. d.	
8.	TION ADL FUNCTIONAL REHABILITA- TION POTENTIAL	O. No	pable of nt is cap /activity nance or	increased independence in at able of increased independence but is very slow ADL Support, comparing	b. c.	
8.	TION ADL FUNCTIONAL REHABILITA- TION POTENTIAL CHANGE IN ADL	O. No	pable of nt is cap /activity nance or	increased independence in at able of increased independence but is very slow ADL Support, comparing	b. c. d.	
8.	TION ADL FUNCTIONAL REHABILITA- TION POTENTIAL	O. No	pable of nt is cap /activity nance or nce statu	increased independence in at able of increased independence but is very slow ADL Support, comparing as has changed as compared assessment if less than 90	b. c. d.	
8.	TION ADL FUNCTIONAL REHABILITA- TION POTENTIAL CHANGE IN ADL	O. No	pable of nt is cap /activity nance or	increased independence in at able of increased independence but is very slow ADL Support, comparing	b. c. d.	
9.	TION ADL FUNCTIONAL REHABILITA- TION POTENTIAL CHANGE IN ADL FUNCTION	O. No	pable of pable of the state of	able of increased independence in at able of increased independence but is very slow ADL Support, comparing us has changed as compared assessment if less than 90 2. Deteriorated	b. c. d.	
9.	TION ADL FUNCTIONAL REHABILITA- TION POTENTIAL CHANGE IN ADL FUNCTION CTION H. CO	O. No	pable of ont is cap vactivity nance or once statunce last proved	increased independence in at able of increased independence but is very slow ADL Support, comparing us has changed as compared assessment if less than 90 2. Deteriorated	b. c. d.	
9.	TION ADL FUNCTIONAL REHABILITA- TION POTENTIAL CHANGE IN ADL FUNCTION CTION H. CO	O. No	pable of ont is cap vactivity nance or once statunce last proved	increased independence in at able of increased independence but is very slow ADL Support, comparing us has changed as compared assessment if less than 90 2. Deteriorated	b. c. d.	
9.	TION ADL FUNCTIONAL REHABILITA- TION POTENTIAL CHANGE IN ADL FUNCTION CTION H. Co CONTINENCE (Code for resi	0. No 1. Yes Resident believes he/she is ca 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 sidays) 0. No change 1. Imp ONTINENCE IN LAST 1 E SELF-CONTROL CATEGOR dent's PERFORMANCE OVE	pable of the pable	increased independence in at able of increased independence but is very slow ADL Support, comparing us has changed as compared assessment if less than 90 2. Deteriorated	b. c. d.	
9.	TION ADL FUNCTIONAL REHABILITA- TION POTENTIAL CHANGE IN ADL FUNCTION CTION H. Co CONTINENCE (Code for resi	O. No	pable of the pable	increased independence in at able of increased independence but is very slow ADL Support, comparing as has changed as compared assessment if less than 90 2. Deteriorated	b. c. d.	
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3.		Any scheduled toileting plan	a.	Did not use toilet room/	Γ
	AND PROGRAMS	Bladder retraining program		commode/urinal	f.
		External (condom) catheter	b.	Pads/briefs used	g.
		, ,	c.	Enemas/irrigation	h.
		Indwelling catheter	d.	Ostomy present	i.
		Intermittent catheter	e.	NONE OF ABOVE	j.
4.	CHANGE IN URINARY CONTI-	Resident's urinary continence 90 days ago (or since last ass	has cha essmer	anged as compared to status of nt if less than 90 days)	
	NENCE	0. No change 1. Im	proved	2. Deteriorated	
100	od and behavior ctive diagnoses)	status, medical treatments, nui	rsing mo	current ADL status, cognitive state onitoring, or risk of death. (Do not FABOVE box)	
١.	DISEASES		0,12 0,	Hemiplegia/Hemiparesis	
		ENDOCRINE/METABOLIC/ NUTRITIONAL		Multiple sclerosis	٧.
		Diabetes mellitus	_	Paraplegia	w.
		Hyperthyroidism	a. b.	Parkinson's disease	у.
		Hypothyroidism	С.	Quadriplegia	z.
		HEART/CIRCULATION	C.	Seizure disorder	aa.
		Arteriosclerotic heart disease		Transient ischemic attack (TIA)	bb
		(ASHD)	d.	Traumatic brain injury	CC
		Cardiac dysrhythmias	e.	PSYCHIATRIC/MOOD	CC
		Congestive heart failure	f.	Anxiety disorder	.1.1
		Deep vein thrombosis	g.	Depression	dd
		Hypertension	h.	Manic depression (bipolar	ee.
		Hypotension	i.	disease)	ff.
		Peripheral vascular disease	j.	Schizophrenia	gg
		Other cardiovascular disease	k.	PULMONARY	
		MUSCULOSKELETAL		Asthma	hh
		Arthritis	l.	Emphysema/COPD	ii.
		Hip fracture	m.	SENSORY	
		Missing limb (e.g., amputation)	n.	Cataracts	jj.
		Osteoporosis	о.	Diabetic retinopathy	kk.
		Pathological bone fracture	p.	Glaucoma	II.
		NEUROLOGICAL		Macular degeneration	mn
		Alzheimer's disease	q.	OTHER	
		Aphasia	r.	Allergies	nn
				l	
		Cerebral palsy	s.	Anemia	00
		Cerebral palsy Cerebrovascular accident (stroke)	s.	Anemia Cancer	oo pp

NONE OF ABOVE

Sexually transmitted diseases

Urinary tract infection in last 30

Septicemia

Tuberculosis

Viral hepatitis

Wound infection

NONE OF ABOVE

days

SECTION J. HEALTH CONDITIONS

OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9

CODES

3.

Dementia other than Alzheimer's disease

2. INFECTIONS (If none apply, CHECK the NONE OF ABOVE box)

Antibiotic resistant infection (e.g., Methicillin resistant staph)

Clostridium difficile (c. diff.)

Conjunctivitis

HIV infection

Pneumonia

Respiratory infection

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 period	_	Hallucinations	i.		
			a.	Internal bleeding	i		
		Inability to lie flat due to shortness of breath		Recurrent lung aspirations in	J.		
		snortness of breath	b.	last 90 days	k.		
		Dehydrated; output exceeds input		Shortness of breath	I.		
		'	C.	Syncope (fainting)	m.		
		Insufficient fluid; did NOT consume all/almost all liquids		Unsteady gait	n.		
		provided during last 3 days	d.	Vomiting	о.		
		OTHER		NONE OF ABOVE	p.		
		Delusions	e.				

_							
2.	PAIN	(Code the highest level of pain present in the last 7 days)					
	SYMPTOMS	a. FREQUENCY with which resident complains or shows evidence of pain		b. INTENSITY of pain1. Mild pain2. Moderate pain			
		O. No pain (<i>skip to J4</i>) 1. Pain less than daily 2. Pain daily		Times when pain is horrible or excruciating			
3.	PAIN SITE	(If pain present, check all site	s that ap	oply 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	Conditions/diseases make respatterns unstable—(fluctuating		ognitive, ADL, mood or behavior ious, or deteriorating)	a.		
	CONDITIONS	Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem			b.		
		End-stage disease, 6 or fewer	months	to live	c.		
		NONE OF ABOVE			d.		

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL	Chewing problem					a.	
	PROBLEMS	Swallowing problem					b.	
		Mouth pain					c.	
		NONE OF ABOVE					d.	
2.	HEIGHT AND WEIGHT	recent measure in last 30 day	Record (a.) height in inches and (b.) weight in pounds. Base weight or recent measure in last 30 days; measure weight consistently in accord w standard facility practice—e.g., in a.m. after voiding, before meal, with sho					
_		a. Weight loss—5 % or more		T (in.)	or 100	b. WT (lb.)	ot	
3.	WEIGHT CHANGE	180 days 0. No 1. Yes		u uays	, OI 10 :	% OF MOTE III Id	ISI PER	
		b.Weight gain—5 % or more		0 dave	or 10 º	6 or more in la	ct	
		180 days	iii iast J	o uays	, 01 10 /	o or more in ia	31	
		0. No 1. Yes	;					
4.	NUTRI- TIONAL PROBLEMS	Complains about the taste of many foods	a.			or more of food ost meals	C.	
		Regular or repetitive complaints of hunger	b.	NON	E OF AL	BOVE	d.	
5.	NUTRI-		(Check all that apply in last 7 days)					
	TIONAL APPROACH-	Parenteral/IV	a.	Dietai		ement betweer		
	ES	Feeding tube	b.				f.	
		Mechanically altered diet	c.	Plate utens		tabilized built-u	g.	
		Syringe (oral feeding)	d.	Ona	planned	weight change		
		Therapeutic diet	e.	progra	am		h.	
				NON	E OF AL	BOVE	i.	
	PARENTERAL	(Skip to Section L if neither !	a nor 5	b is ch	ecked)			
	OR ENTERAL INTAKE	Code the proportion of total parenteral or tube feedings i 0. None	n the las	st 7 day		eceived throug	ıh	
		1. 1% to 25% 2. 26% to 50%			to 100%	•		
		b. Code the average fluid inta					s	
		0. None 1. 1 to 500 cc/day			to 1500 to 2000			

SECTION L. ORAL/DENTAL STATUS

1	STATUS AND	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.

Numeric Identifier _____

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.	ă
		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.	
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 OR LESIONS	Abrasions, bruises	a.
	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- MENTS	Pressure relieving device(s) for chair	a.
	MILITIO	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)	J.
6.	PROBLEMS AND CARE	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	a.
		Open lesions on the foot	b.
		Nails/calluses trimmed during last 90 days	C.
		Received preventative or protective foot care (e.g., used special shoes,	d.
		inserts, pads, toe separators)	e.
		Application of dressings (with or without topical medications) NONE OF ABOVE	f.

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	AWAKE	Resident awake all or most of time (i.e., naps no more than one hour						
	70000	per time period) in the: Morning	a.	Evening	c.			
		Afternoon	b.	NONE OF ABOVE	d.			
(If resident is comatose, skip to Section O)								
2.	AVERAGE TIME	(When awake and not	receivi	ng treatments or ADL care)				
	ACTIVITIES	0. Most—more than 2/3 1. Some—from 1/3 to 2	$\frac{1}{3}$ of tim	e 3. None				
3.		(Check all settings in	which a	ctivities are preferred)				
	ACTIVITY	Own room	a.	Outside facility				
	SETTINGS	Day/activity room	b.	Outside lacility	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	0.000.000	b.	Watching TV				
	resident's current	Exercise/sports	c.	Gardening or plants				
	abilities)	Music	d.	• .	j.			
		Reading/writing	e.	Talking or conversing	k.			
		Spiritual/religious		Helping others	I.			
		activities	f.	NONE OF ABOVE	m.			

5.	PREFERS	Code for resident p	references in daily routines				
-	CHANGE IN	0. No change	 Slight change 	Major change			
	DAILY ROUTINE	a. Type of activities in which resident is currently involved					
		b. Extent of resider	nt involvement in activities				
SEC	CTION O. M	EDICATIONS					

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 nast 90 days) 0. No 1. Yes	medications that were initiated during the			
3.	INJECTIONS	(Record the number of DAYS the last 7 days; enter "0" if nor	(S injections of any type received during one used)			
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	used. Note—enter "1" for long- a. Antipsychotic	(S during last 7 days; enter "0" if not g-acting meds used less than weekly) d. Hypnotic e. Diuretic			

SECTION P SPECIAL TREATMENTS AND PROCEDURES

1.	CDECIAL	a. SPECIAL CARE—Check to	AND F	to or programs rossiu	od di	rina		
1.	SPECIAL TREAT- MENTS,	the last 14 days	eaunen	is or programs receiv	ea au	iririg		
	PROCE-	TREATMENTS		Ventilator or respira	tor			
	DURES, AND PROGRAMS	Chemotherapy	a.	PROGRAMS			l.	
		Dialysis	b.	Alcohol/drug treatm	ent			
		IV medication	c.	program	0110		m.	
		Intake/output	d.	Alzheimer's/demen	tia spe	ecial		
		Monitoring acute medical	<u> </u>	care unit			n.	
		condition	e.	Hospice care			o. p.	
		Ostomy care	f.	Pediatric unit Respite care			q.	
		Oxygen therapy	g.	Training in skills req	uirod	to	q.	
		Radiation	h.	return to the comm	unity (e.g.,		
		Suctioning	i.	taking medications, work, shopping, trar			r.	
		Tracheostomy care	j.	ADLs)	эроп	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. dail. [Note—count only post admission therapies] (A) = # of days administered for 15 minutes or more DAYS MIN						
		(B) = total # of minutes pro			(A)	(B)	
		a. Speech - language patholo	gy and	audiology services	•		\Box	П
		b. Occupational therapy					\Box	
		c. Physical therapy					\top	
		d. Respiratory therapy					\vdash	
		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	Special behavior symptom eva	aluation	program				
	FOR MOOD, BEHAVIOR.	Evaluation by a licensed ment	al health	n specialist in last 90	days		a.	
	COGNITIVÉ	Group therapy		•	-		b.	
	LOSS	Resident-specific deliberate ch	nanges	in the environment to	addre	ess	c.	
		mood/behavior patterns—e.g.	, providi	ng bureau in which to	rumr	nage	d.	
		Reorientation—e.g., cueing					e.	
		NONE OF ABOVE					f.	
3.	NURSING REHABILITA-	Record the NUMBER OF DA restorative techniques or pra	YS eac	th of the following re	habili	tation	or or	
	TION/	more than or equal to 15 m	inutes	per day in the last	7 day	/S	<i>.</i>	
	RESTOR- ATIVE CARE	(Enter 0 if none or less than a. Range of motion (passive)	15 min.				_	
	ALIVE OAKE	b. Range of motion (active)		f. Walking				
		c. Splint or brace assistance		g. Dressing or groor	•		_	_
		TRAINING AND SKILL		h. Eating or swallow	•		<u></u>	
		PRACTICE IN:		i. Amputation/prost	hesis	care		
		d. Bed mobility		j. Communication				
		e. Transfer		k. Other				

4.	DEVICES	(Use the following codes for last 7 days:)			
	AND	Ò. Not used			
	RESTRAINTS	Used less than daily Used daily			
		2. Osed daily Bed rails			
		264 14.10			
		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)			
6.		Record number of times resident visited ER without an overnight stay			
	ROOM (ER) VISIT(S)	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? <i>Do not include order</i>			
		renewals without change. (Enter 0 if none)			
9.		Has the resident had any abnormal lab values during the last 90 days			
	LAB VALUES	(or since admission)?			
		0. No 1. Yes			
		1.100			

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

_			_		
1.	DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community			
		0. No	1. Yes		
				s positive towards discharge	
		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) O. No 2. Within 31-90 days			
			days 3. Discharge st		
2.	OVERALL CHANGE IN	compared to s	erall self sufficiency has chatatus of 90 days ago (or s	nanged significantly as since last assessment if less	
	CARE NEEDS	than 90 days)			
		0. No change	 Improved—receives fe supports, needs less restrictive level of care 		

SECTION R. ASSESSMENT INFORMATION 1. PARTICIPA- a. Resident: 0. No 1. Yes

	ASSESS-	b. Family:	0. No	1. Yes	No family	
	MENT	c. Significant other:	0. No	1. Yes	2. None	
2.	SIGNATURE	OF PERSON COO	RDINATIN	GTHE ASSES	SMENT:	
a. Signature of RN Assessment Coordinator (sign on above line)						
		ment Coordinator				7
si	gned as comple	ete		— [] .		
			Month	Dav	Year	

	es		

Numeric Identifier		
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SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

_		•	
1.	SPECIAL TREAT- MENTS AND PROCE-	a. RECREATIONTHERAPY—Enter number of days and total minutes recreation therapy administered (for at least 15 minutes a day) in the last 7 days (Enter 0 if none) DAYS MIN DAYS MIN	
	DURES	(A) the fide up administrated for 15 minutes or more (A) (B)	
		(A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in last 7 days	
		Skip unless this is a Medicare 5 day or Medicare readmission/ return assessment.	
		b. ORDERED THERAPIES—Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical	
		therapy, occupational therapy, or speech pathology service? 0. No 1. Yes	
		If not ordered, skip to item 2	
		Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.	
		d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?	
2.	WALKING WHEN MOST SELF	Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0,1,2, or 3 AND at least one of the following are present:	
	SUFFICIENT	 Resident received physical therapy involving gait training (P.1.b.c) Physical therapy was ordered for the resident involving gait training (T.1.b) 	
		Resident received nursing rehabilitation for walking (P.3.f) Physical therapy involving walking has been discontinued within the past 180 days	
		Skip to item 3 if resident did not walk in last 7 days	
		(FOR FOLLOWING FIVE ITEMS, BASE CODING ONTHE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)	
		a. Furthest distance walked without sitting down during this episode.	
		0. 150+ feet 3. 10-25 feet 1. 51-149 feet 4. Less than 10 feet 2. 26-50 feet	
		b. Time walked without sitting down during this episode.	
		0.1-2 minutes 3.11-15 minutes 1.3-4 minutes 4.16-30 minutes 2.5-10 minutes 5.31+ minutes	
		c. Self-Performance in walking during this episode.	
		INDEPENDENT—No help or oversight SUPERVISION—Oversight, encouragement or cueing	
		provided 2. LIMITED ASSISTANCE—Resident highly involved in walking;	
		received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3. EXTENSIVE ASSISTANCE—Resident received weight	
		bearing assistance while walking	
		d. Walking support provided associated with this episode (code regardless of resident's self-performance classification).	
		No setup or physical help from staff Setup help only One person physical assist	
		Two+ persons physical assist Parallel bars used by resident in association with this episode.	
		0. No 1. Yes	
3.	CASE MIX GROUP	Medicare State	
	<u> </u>		_

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 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) Yes (If Yes, go to item W3) b. 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) 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. FEEDING TUBES 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 2. Month Day Year

3. Signature of Person Completing Care Planning Decision

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0) T (Minay moninonos and monthly Calledor) = One item required to trigger 2= Two items required to trigger | 40,400 militarion 17,300-4 @ | 40/1/8411891818 | 40/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/80818 | 30/1/8088 | 30/1/8088 | 30/1/8088 | 30/1/8088 | 30/1/8088 | 30/1/8088 | 30/1/8088 | 30/1/8088 | 30/1/8 Osmoraion Puio Maintenance ★ = One of these three items, plus at least one other item required to trigger @=When both ADL triggers present, maintenance takes Coming Lossonmia Ayahanoic Dug Use precedence Benedical Smalons Physical Restains Acivilies Tigger A | Numicoal States - Pressure Urers 1 Adimies Tigger F | Communication Footing Tibes Proceed to RAP Review once triggered MDS ITEM CODE B2a Short term memory B2a Long term memor Decision making Indicators of delirium JeA Behavioral symptoms Charge in behavioral symptoms Change in behavioral symptoms Establishes over gods/ Unsettled relationships Strong pt. rass / okes Lost roles ADL self-performance Balance Bedfast Glaucoma 1111 Denydration diagnosis Lung aspirations

ET Lines, Incomingon and Inchesing Callesia. 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, 1/4 minorance niger 8 @ A Dervotation Fluio Wainenance required to trigger @=When both ADL triggers present, maintenance takes A Coming Lossonmia A Psychologic Dug Uso precedence A Before Smoons 1. 400 miss 11906. 4 3 Trigger B " Pestraints 1 Numinal Saus A Pessule Users J Communication A Fooding Titles Proceed to RAP Review once triggered Aoiviies 7 MDS ITEM CODE Swallowing problem Previous pressure ulc Awake morning Involved in activities Antipsychotics Artianxiety/// Antidepressants

MDS QUARTERLY ASSESSMENT FORM

IVIL	JO QUAN	ERLY ASSESSIVIENT FORIVI			
A1.	RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)			
A2.	ROOM	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)			
	NUMBER				
A3.	ASSESS- MENT	a. Last day of MDS observation period			
	REFERENCE DATE				
		Month Day Year			
\4a	DATE OF	b. Original (0) or corrected copy of form (enter number of correction) Date of reentry from most recent temporary discharge to a hospital in			
	REENTRY	last 90 days (or since last assessment or admission if less than 90 days)			
		Month Day Year			
A6.	MEDICAL RECORD				
B1.	NO. COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (Skip to Section G)			
B2.	MEMORY	(Recall of what was learned or known)			
		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			
B4.	COGNITIVE	Memory OK 1. Memory problem (Made decisions regarding tasks of daily life)			
J-4.	SKILLS FOR DAILY	INDEPENDENT—decisions consistent/reasonable			
	DECISION- MAKING	1. MODIFIED INDEPENDENCE—some difficulty in new situations only			
		MÓDERATELY IMPAIRED—decisions poor; cues/supervision required			
B5.	INDICATORS	3. SEVERELY IMPAIRED—never/rarely made decisions (Code for behavior in the last 7 days.) [Note: Accurate assessment			
	OF DELIRIUM—	equires conversations with staff and family who have direct knowledge of resident's behavior over this time].			
	PERIODIC DISOR-	Behavior not present			
	DERED THINKING/	Behavior present, not of recent onset Behavior present, over last 7 days appears different from resident's usual			
	AWARENESS	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)			
		MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)			
C4.	MAKING	(Expressing information content—however able)			
	SELF UNDER-	UNDERSTOOD USUALLY UNDERSTOOD—difficulty finding words or finishing			
	STOOD	thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete			
		requests 3. RARELY/NEVER UNDERSTOOD			
C6.	ABILITYTO UNDER-	(Understanding verbal information content—however able)			
	STAND OTHERS	UNDERSTANDS UNDERSTANDS—may miss some part/intent of			
		message 2. SOMETIMES UNDERSTANDS—responds adequately to simple,			
		direct communication 3. RARELY/NEVER UNDERSTANDS ((Code for indicators observed in last 30 days, irrespective of the			
E1.	INDICATORS OF_	assumed cause)			
	DEPRES- SION,	Indicator not exhibited in last 30 days 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)			
	ANXIETY, SAD MOOD	2. Indicator of this type exhibited daily or almost daily (6, 7 days a week) VERBAL EXPRESSIONS c. Repetitive verbalizations—			
		OF DISTRESS e.g., calling out for help, ("God help me")			
		a. Resident made negative statements—e.g., "Nothing attemption by the statement anger with self or ethers, and applied the statement anger with self or ethers, and applied the statement and th			
		matters; Would rather be dead; What's the use; anger at placement in			
		Regrets having lived so nursing home; anger at care long; Let me die received			
		b. Repetitive questions—e.g., "Where do I go; What do I do?" e. Self deprecation—e.g., "I am nothing; I am of no use to anvone"			

E1.	INDICATORS OF	VERBAL EXPRESSIONS OF DISTRESS SLEEP-CYCLE ISSUES j. Unpleasant mood in morning			
	DEPRES- SION,	f. Expressions of what k. Insomnia/change in usual			
	SAD MOOD	appear to be unrealistic fears—e.g., fear of being abandoned, left alone,			
	(cont.)	being with others APPEARANCE			
		g. Recurrent statements that something terrible is about I. Sad, pained, worried facial expressions—e.g., furrowed			
		to happen—e.g., believes he or she is about to die, m. Crying, tearfulness			
		nave a neart attack n. Repetitive physical			
		complaints—e.g., hand wringing, restlessness,			
		attention, obsessive concern with body fidgeting, picking			
		functions o. Withdrawal from activities of			
		complaints/concerns (non-			
		p. Reduced social interaction			
		reassurance regarding schedules, meals, laundry, clothing, relationship issues			
E2.	MOOD	One or more indicators of depressed, sad or anxious mood were			
	PERSIS- TENCE	not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days			
		0. No mood 1. Indicators present, 2. Indicators present, indicators easily altered 2. Indicators present, not easily altered			
E4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequency in last 7 days 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 Behavioral symptom alterability in last 7 days			
		D. Behavior not present OR behavior was easily altered Behavior was not easily altered (A)	(B)		
		WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	Ť		
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)	╈		
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)	T		
		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)			
04	(A) ADI CELE	RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating) RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating) RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating) RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating) RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating) RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating) RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating) RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating) RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)			
G1.		F-PERFORMANCE—(<i>Code</i> for resident's PERFORMANCE OVER AL i luring last 7 days—Not including setup)	L		
	INDEPEN during last	<i>IDENT</i> —No help or oversight —OR— Help/oversight provided only 1 or: t7 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 es during last 7 days	uring d only		
	2. LIMITED ASSISTANCE—Resident highly involved in activity; received physical help in				
		aneuvering of limbs or other nonweight bearing assistance 3 or more time e help provided only 1 or 2 times during last 7 days	es—		
	period, he	VE ASSISTANCE—While resident performed part of activity, over last 7- lp of following type(s) provided 3 or more times:	day		
	— Weight- — Full sta	bearing support ff performance during part (but not all) of last 7 days			
		EPENDENCE—Full staff performance of activity during entire 7 days	/ A\		
а.	8. ACTIVITY	/ DID NOT OCCUR during entire 7 days How resident moves to and from lying position, turns side to side, and	(A)		
	MOBILITY TRANSFER	positions body while in bed How resident moves between surfaces—to/from: bed, chair,			
b.		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	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			
	OFF UNIT	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 ro transfer on/off toilet, cleanses, catheter, adjusts clothes					
j.	PERSONAL HYGIENE	brushing teeth, shaving, applyi	How resident maintains personal hygiene, including combing hair, orushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)				
G2.	BATHING	transfers in/out of tub/shower (Code for most dependent in	low resident takes full-body bath/shower, sponge bath, and ansfers in/out of tub/shower (EXCLUDE washing of back and hair.) Code for most dependent in self-performance. NEATHING SELE DEPENDENT NESS appear below.				
		[` '					(A)
		Physical help in part of ba		•			
		Total dependence	u iii iy ac	uvity			
		Activity itself did not occur	during	entire 7 days			
G/	FUNCTIONAL	(Code for limitations during las			with daily funct	ions i	or
	LIMITATION	placed residents at risk of injul			•		"
	IN RANGE OF MOTION	(A) RANGE OF MOTION 0. No limitation		(B) VOLUNTAI	RY MOVEME	NT	
		Limitation on one side		 Partial loss 	3	(4)	(D)
		Limitation on both sides Neck		2. Full loss		(A)	(B)
		b. Arm—Including shoulder or	olbow				
		c. Hand—Including wrist or fin					
		d. Leg—Including hip or knee	gois				
		e. Foot—Including ankle or too	es.				
		f. Other limitation or loss					
G6.	MODES OF	(Check all that apply during I	ast 7 da	ivs)			
	TRANSFER	Bedfast all or most of time		NONE OF ABO	OVE		
		Bed rails used for bed mobility	a.	-		f.	
		or transfer	b.				
H1.		E SELF-CONTROL CATEGOR Ident's PERFORMANCE OVE		SHIFTS)			
	,	IT—Complete control [includes		,	, aathatar ar aa	tom	,
	device that of	does not leak urine or stool]	use or n	naweiling annary	callielei oi oa	ютту	
		CONTINENT—BLADDER, inco	ntinent	episodes once a	week or less;		
	2. OCCASION BOWEL, on	IALLY INCONTINENT—BLAD ce a week	DER, 2	or more times a v	week but not d	aily;	
		TLY INCONTINENT—BLADDE ent (e.g., on day shift); BOWEL			ent daily, but s	ome	
		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 appl	iance or bowel co	ontinence		
b.	BLADDER CONTI- NENCE	Control of urinary bladder fund soak through underpants), wit programs, if employed	tion (if o	dribbles, volume i Inces (e.g., foley)	nsufficient to or continence		
H2.	BOWEL ELIMINATION PATTERN	Fecal impaction	d.	NONE OF ABO	OVE	e.	
Н3.	APPLIANCES	Any scheduled toileting plan	a.	Indwelling cathe	eter	d.	
	AND PROGRAMS	Bladder retraining program		Ostomy present	t		
			b.	NONE OF ABO		i.	
		External (condom) catheter	c.	NONE OF ABO		j.	
12.	INFECTIONS	Urinary tract infection in last 30 days	j.	NONE OF ABO	JVE	m	
13.	OTHER	(Include only those diseases relationship to current ADL s					
	CURRENT	medical treatments, nursing m				л за	ius,
	AND ICD-9			Г			
	CODES	a				•	
		b.				•	Щ
J1.	PROBLEM CONDITIONS	(Check all problems present	t in last	- /		_	
	CONDITIONS	Dehydrated; output exceeds input	c.	Hallucinations		i.	
-	F	•		NONE OF ABC		p.	
J2.	PAIN SYMPTOMS	(Code the highest level of pa	ııı prese		- /		
		a. FREQUENCY with which resident complains or		b. INTENSITY	ot pain		
		shows evidence of pain		Mild pain Moderate pair	n		
		0. No pain (<i>skip to J4</i>)		2. Moderate pair			
		1. Pain less than daily		Times when p or excrutiating			
		2. Pain daily		•	-		
J4.	ACCIDENTS	(Check all that apply)		Hip fracture in I	-	c.	
		Fell in past 30 days	a.	Other fracture in			
		Fell in past 31-180 days	b.	NONE OF ABO	JVE	e.	

J5.	STABILITY OF	Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating)			
	CONDITIONS	,	• .		a.
		chronic problem	an acute episo	de or a flare-up of a recurrent or	b.
		End-stage disease, 6 c	or fewer months	to live	c.
		NONE OF ABOVE			d.
K3.	WEIGHT	_	or more in last 3	0 days; or 10 % or more in last	
	CHANGE	180 days 0. No	1. Yes		
				30 days; or 10 % or more in last	
		180 days		,	
		0. No	1. Yes		
K5.	NUTRI- TIONAL	Feeding tube			b.
	APPROACH-	On a planned weight ch	hange program		h.
	ES	NONE OF ABOVE	fulgora at apah	ulcer stage—regardless of	i. ∟o
M1.	ULCERS	cause If none present	at a stage reco	ord "0" (zero). Code all that apply	nbe tag
	(Due to any cause)	during last 7 days . Cod	de 9 = 9 or mor	e.) [Requires full body exam.]	Number at Stage
	(duse)			edness (without a break in the	- 10
		·		ear when pressure is relieved.	
		b. Stage 2. A partial th clinically as	nickness loss of s an abrasion, t	skin layers that presents lister, or shallow crater.	
		tissues - pr	ness of skin is le resents as a de ng adjacent tiss	ost, exposing the subcutaneous ep crater with or without	
			0 ,	d subcutaneous tissue is lost,	
		exposing n	nuscle or bone.	·	
M2.	TYPE OF ULCER	(For each type of ulcer, scale in item M1—i.e.,		nighest stage in the last 7 days	using
	ULCER			by pressure resulting in damage	
		of underlying tissue			
		 b. Stasis ulcer—open I extremities 	lesion caused b	y poor circulation in the lower	
N1.	TIME	(Check appropriate ti	ime periods ov	ver last 7 days)	
	AWAKE	Resident awake all or r per time period) in the:	nost of time (i.e	., naps no more than one hour	
		Morning	a. Ever	ing	c.
		Afternoon		IE OF ABOVE	d.
<u>`</u>		matose, skip to Se			
N2.	AVERAGE TIME	(When awake and not	t receiving tre	atments or ADL care)	
	INVOLVED IN ACTIVITIES	0. Most—more than 2/3 1. Some—from 1/3 to 2		2. Little—less than 1/3 of time 3. None	
01.				o. None edications used in the last 7 days ,	
	MEDICA-	enter "0" if none used)		•	
04.	TIONS	(Record the number	of DAYS during	g last 7 days; enter "0" if not	
04.	RECEIVED			meds used less than weekly)	
	THE	a. Antipsychotic		d. Hypnotic	
	MEDICATION	b. Antianxiety		e. Diuretic	
		c. Antidepressant		C. Diarctic	
P4.	DEVICES	Use the following cod			
			es for last / d	ays:	
	AND RESTRAINTS	Not used Used less than dail		ays:	
		Not used Used less than dail Used daily		ays:	
		Not used Used less than dail Used daily Bed rails	у		
		O. Not used Used less than dail Used daily Bed rails a. — Full bed rails on	y all open sides	of bed	
		Not used Used less than dail Used daily Bed rails	y all open sides	of bed	
		O. Not used Used less than dail Used less than dail Used daily Bed rails a. — Full bed rails on Used by Used Tails on Used Tails on Used Tails on Used Tails on	y all open sides	of bed	
		O. Not used Sused less than dail Lised less than dail Lised daily Bed rails a. — Full bed rails on b. — Other types of s C. Trunk restraint d. Limb restraint e. Chair prevents rising	y all open sides side rails used (of bed e.g., half rail, one side)	
Q2.	RESTRAINTS	O. Not used 1. Used less than dail 2. Used daily Bed rails a. — Full bed rails on b. — Other types of s c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level	y all open sides ide rails used (of bed e.g., half rail, one side)	
Q2.	RESTRAINTS	O. Not used 1. Used less than dail 2. Used less than dail 3. Used daily Bed rails a. — Full bed rails on b. — Other types of s c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level compared to status of than 90 days)	y all open sides side rails used (d of self sufficier 90 days ago (c	of bed e.g., half rail, one side) acy has changed significantly as r since last assessment if less	
Q2.	RESTRAINTS OVERALL CHANGE IN	O. Not used 1. Used less than dail 2. Used daily Bed rails a. — Full bed rails on b. — Other types of s c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level compared to status of s than 90 days) O. No change 1. Impro	y all open sides side rails used (d of self sufficier 90 days ago (c	of bed e.g., half rail, one side) icy has changed significantly as ir since last assessment if less fewer 2. Deteriorated—receives	
	OVERALL CHANGE IN CARE NEEDS	O. Not used 1. Used less than dail 2. Used daily Bed rails a. — Full bed rails on b. — Other types of s c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level compared to status of than 90 days) O. No change 1. Improsupprestrii	y all open sides side rails used (of self sufficier so days ago (conved—receives orts, needs less ctive level of ca	of bed e.g., half rail, one side) cy has changed significantly as r since last assessment if less fewer 2. Deteriorated—receives more support	
	OVERALL CHANGE IN CARE NEEDS	O. Not used 1. Used less than dail 2. Used daily Bed rails a. — Full bed rails on b. — Other types of s c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level compared to status of s than 90 days) O. No change 1. Impro	y all open sides side rails used (of self sufficier so days ago (conved—receives orts, needs less ctive level of ca	of bed e.g., half rail, one side) cy has changed significantly as r since last assessment if less fewer 2. Deteriorated—receives more support	
R2.	OVERALL CHANGE IN CARE NEEDS	O. Not used 1. Used less than dail 2. Used daily Bed rails a. — Full bed rails on b. — Other types of s c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level compared to status of st	y all open sides side rails used (in a self sufficier self sufficier self sufficier self sufficier self sufficier self sufficier self self self self self self self self	of bed e.g., half rail, one side) icy has changed significantly as r since last assessment if less fewer 2. Deteriorated—receives more support re ASSESSMENT:	
R2.	OVERALL CHANGE IN CARE NEEDS SIGNATURE	O. Not used 1. Used less than dail 2. Used daily Bed rails a. — Full bed rails on b. — Other types of s c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level compared to status of sthan 90 days) O. No change OF PERSON COORD Assessment Coordinate	y all open sides side rails used (in a self sufficier self sufficier self sufficier self sufficier self sufficier self sufficier self self self self self self self self	of bed e.g., half rail, one side) icy has changed significantly as r since last assessment if less fewer 2. Deteriorated—receives more support re ASSESSMENT:	
R2. a. S b. D	OVERALL CHANGE IN CARE NEEDS SIGNATURE	O. Not used 1. Used less than dail 2. Used daily Bed rails a. — Full bed rails on b. — Other types of s c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level compared to status of St	y all open sides side rails used (in a self sufficier self sufficier self sufficier self sufficier self sufficier self sufficier self self self self self self self self	of bed e.g., half rail, one side) icy has changed significantly as r since last assessment if less fewer 2. Deteriorated—receives more support re ASSESSMENT:	
R2. a. S b. D	OVERALL CHANGE IN CARE NEEDS SIGNATURE	O. Not used 1. Used less than dail 2. Used daily Bed rails a. — Full bed rails on b. — Other types of s c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level compared to status of St	y all open sides side rails used (in graph of self sufficier source) of self sufficier source and conved—receives orts, needs less ctive level of cation of self sufficier (sign on above graph of self self self self self self self sel	of bed e.g., half rail, one side) icy has changed significantly as r since last assessment if less fewer 2. Deteriorated—receives more support re ASSESSMENT:	
R2. a. S b. D	OVERALL CHANGE IN CARE NEEDS SIGNATURE	O. Not used 1. Used less than dail 2. Used daily Bed rails a. — Full bed rails on b. — Other types of s c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level compared to status of St	y all open sides side rails used (in graph of self sufficier source) of self sufficier source and conved—receives orts, needs less ctive level of cation of self sufficier (sign on above graph of self self self self self self self sel	of bed e.g., half rail, one side) icy has changed significantly as r since last assessment if less fewer 2. Deteriorated—receives more support re ASSESSMENT:	
R2. a. S b. D	OVERALL CHANGE IN CARE NEEDS SIGNATURE	O. Not used 1. Used less than dail 2. Used daily Bed rails a. — Full bed rails on b. — Other types of s c. Trunk restraint d. Limb restraint e. Chair prevents rising Resident's overall level compared to status of St	y all open sides side rails used (in graph of self sufficier source) of self sufficier source and conved—receives orts, needs less ctive level of cation of self sufficier (sign on above graph of self self self self self self self sel	of bed e.g., half rail, one side) icy has changed significantly as r since last assessment if less fewer 2. Deteriorated—receives more support re ASSESSMENT:	

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 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) Yes (If Yes, go to item W3) b. 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) 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)

A1.	RESIDENT	IONAL VERSION FOR ROG-III)	_
ļ	NAME		_
A2.	ROOM	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
AZ.	NUMBER		
А3.	ASSESS- MENT	a. Last day of MDS observation period	
	REFERENCE DATE		
	DAIL	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 day	
			, -
		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 0. Memory OK 1. Memory problem	
		b. Long-term memory OK—seems/appears to recall long past	
B3.	MEMORY/	0. Memory OK 1. Memory problem (Check all that resident was normally able to recall during	
Б3.	RECALL	last 7 days)	
	ABILITY	Current season Location of own room That he/she is in a nursing home d.	
		Staff names/faces c. NONE OF ABOVE are recalled e.	
B4.	COGNITIVE SKILLS FOR	(Made decisions regarding tasks of daily life)	
	DAILY DECISION-	O. INDEPENDENT—decisions consistent/reasonable A MODIFIED INDEPENDENCE—access difficulty in payable to the pa	
	MAKING	1. MODIFIED INDEPENDENCE—some difficulty in new situations only	
		 MODERATELY IMPAIRED—decisions poor; cues/supervision required 	
DE.	INDICATORS	3. SEVERELY IMPAIRED—never/rarely made decisions (Code for behavior in the last 7 days.) [Note: Accurate assessment	
БЭ.	OF DELIRIUM—	requires conversations with staff and family who have direct knowledge of resident's behavior over this time].	је
	PERIODIC	Behavior not present	
	DISOR- DERED	Behavior present, not of recent onset Behavior present, over last 7 days appears different from resident's usual	
	THINKING/ AWARENESS	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	0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing	
	0.002	thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete	
		requests 3. RARELY/NEVER UNDERSTOOD	
C6.	ABILITYTO UNDER-	(Understanding verbal information content—however able)	
	STAND OTHERS	UNDERSTANDS USUALLY UNDERSTANDS—may miss some part/intent of	
	JIHERS	message 2. SOMETIMES UNDERSTANDS—responds adequately to simple,	
		direct communication 3. RARELY/NEVER UNDERSTANDS	
E1.	INDICATORS	(Code for indicators observed in last 30 days, irrespective of the	
	OF DEPRES-	assumed cause) 0. Indicator not exhibited in last 30 days	
	SION, ANXIETY,	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)	
	SAD MOOD		

	Numeric Ident	mer	
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 g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack p. Rec One or more indicators of depressed, sad of the sad the state of the person of the pressed, sad of the person of the	ying, tearfulness petitive physical vements—e.g., pacing, nd wringing, restlessness, peting, picking B OF INTEREST hdrawal from activities of prest—e.g., no interest in g standing activities or ng with family/friends duced social interaction or anxious mood were
E2.	MOOD PERSIS-	One or more indicators of depressed, sad on not easily altered by attempts to "cheer up	or anxious mood were o", console, or reassure
	TENCE	the resident over last 7 days 0. No mood 1. Indicators present, 2. I	dicators present,
F	BEHAVIORAL	indicators easily altered no	ot easily altered
		Behavior of this type occurred 1 to 3 day Behavior of this type occurred 4 to 6 day Behavior of this type occurred 4 to 6 day Behavior of this type occurred daily Behavior of this type occurred daily Behavior not present OR behavior was east. Behavior was not easily altered WANDERING (moved with no rational pure oblivious to needs or safety) B. VERBALLY ABUSIVE BEHAVIORAL SYMER were threatened, screamed at, cursed at) C. PHYSICALLY ABUSIVE BEHAVIORAL SYMER were hit, shoved, scratched, sexually abused. SOCIALLY INAPPROPRIATE/DISRUPTIVE SYMPTOMS (made disruptive sounds, no self-abusive acts, sexual behavior or disrot smeared/threw food/feces, hoarding, rumn belongings) e. RESISTS CARE (resisted taking medication assistance, or eating)	7 days easily altered (A) (B) pose, seemingly MPTOMS (others ed) VE BEHAVIORAL isiness, screaming, oing in public, naged through others'
G1.	(A) ADL SELF	F-PERFORMANCE—(<i>Code</i> for resident's <i>PE</i>	RFORMANCE OVER ALL
	INDEPEN during last SUPERVIS last7 days	uring last 7 days—Nòt including setup) DENT—No help or oversight —OR— Help/ov 7 days SION—Oversight, encouragement or cueing p —OR— Supervision (3 or more times) plus pl s during last 7 days	provided 3 or more times during
	guided ma	ASSISTANCE—Resident highly involved in ac ineuvering of limbs or other nonweight bearing a help provided only 1 or 2 times during last 7 o	assistance 3 or more times —
	period, hel —Weight-	VE ASSISTANCE—While resident performed p of following type(s) provided 3 or more times bearing support ff performance during part (but not all) of last 7	s:
	4. TOTAL DE	PENDENCE—Full staff performance of activi 'DID NOT OCCUR during entire 7 days	'
	OVER ALL	PORT PROVIDED—(<i>Code for MOST SUPPO</i> L <i>SHIFTS during last 7 days; code regardles</i> ce classification)	ss of resident's self- (A) (B)
	 Setup help One persor 	n physical assist 8. ADL a	activity itself did not during entire 7 days
a.	BED MOBILITY	How resident moves to and from lying position and positions body while in bed	n, turns side to side,
b.	TRANSFER	How resident moves between surfaces—to/fr wheelchair, standing position (EXCLUDE to/f	rom bath/toilet)
			MDS 2.0 September, 2000

G1.					(A)	(B)				
c.	WALK IN ROOM	How resident walks between lo	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 locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair							
f.	LOCOMO- TION OFF UNIT	areas set aside for dining, activ only one floor, how resident n	low resident moves to and returns from off unit locations (e.g., reas set aside for dining, activities, or treatments). If facility has nly one floor, how resident moves to and from distant areas on he 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 (nourishment by other means (nutrition)								
i.	TOILET USE	How resident uses the toilet roc transfer on/off toilet, cleanses, catheter, adjusts clothes								
j.	PERSONAL HYGIENE	How resident maintains persor brushing teeth, shaving, applyi hands, and perineum (EXCLU	ng make	eup, washing/drying face,						
G2.	BATHING	How resident takes full-body by transfers in/out of tub/shower (I Code for most dependent in (A) BATHING SELF PERFOR	EXCLU self-per	DE washing of back and hair.) formance.		(A)				
		 Independent—No help pro Supervision—Oversight he 				-				
		2. Physical help limited to trai	nsfer on	•						
		3. Physical help in part of bat4. Total dependence	thing act	ivity						
		8. Activity itself did not occur	during e	entire 7 days						
G3.	TEST FOR BALANCE	(Code for ability during test in t	he last	7 days)						
	(see training manual)	Maintained position as requi Unsteady, but able to rebala Partial physical support duri or stands (sits) but does not	nce self ng test;	without physical support						
		Not able to attempt test with Balance while standing				_				
		b. Balance while sitting—positi	ion, trun	k control		\dashv				
G4.	FUNCTIONAL	(Code for limitations during las	t 7 days		ions	or				
	LIMITATION IN RANGE OF	placed residents at risk of injur (A) RANGE OF MOTION	<i>y</i>)	(B) VOLUNTARY MOVEMEN	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			\vdash				
		c. Hand—Including wrist or fine	gers							
		d. Leg—Including hip or knee								
		e. Foot—Including ankle or toef. Other limitation or loss	S							
G6.	MODES OF	(Check all that apply during la	ast 7 da	vs)						
00.	TRANSFER	Bedfast all or most of time		NONE OF ABOVE						
		Bed rails used for bed mobility or transfer	a.		f.					
G7.	TASK SEGMENTA-	Some or all of ADL activities w								
H1.	TION	0. No 1. Yes	3							
	(Code for resi	ident's PERFORMANCE OVE	R ALL S	,	stomy	,				
	device that of	does not leak urine or stool] CONTINENT—BLADDER, inco			,					
		s than weekly <i>IALLY INCONTINENT</i> —BLADI ce a week	DER, 2	or more times a week but not d	aily;					
	3. FREQUENT	TLY INCONTINENT—BLADDE ent (e.g., on day shift); BOWEL,			ome					
	4. INCONTINE 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	rith appli	ance or bowel continence						
b.	BLADDER CONTI- NENCE	Control of urinary bladder functions soak through underpants), with programs, if employed								
H2.	BOWEL	Diarrhea	c.	NONE OF ABOVE	e.					
	ELIMINATION PATTERN	Fecal impaction	d.							

uэ	ADDITANCE				
пэ.	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.
				current ADL status, cognitive state	
	od and benavior tive diagnoses)	status, medical treatments, nu	irsing mo	onitoring, or risk of death. (Do not	list
I1 .	DISEASES	(If none apply, CHECK the N	IONE O	F ABOVE box)	
		MUSCULOSKELETAL		Multiple sclerosis	w.
		Hip fracture	m.	Quadriplegia	z.
		NEUROLOGICAL		PSYCHIATRIC/MOOD	
		Aphasia	r.	Depression	ee.
		Cerebral palsy Cerebrovascular accident	s.	Manic depressive (bipolar disease)	ff.
		(stroke)	t.	OTHER	
		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	I.
		Respiratory infection	f.	NONE OF ABOVE	m.
13.	OTHER CURRENT			osed in the last 90 days that have ognitive status, mood or behavior	
	DIAGNOSES	medical treatments, nursing n			,
	AND ICD-9 CODES				
		a		•	
J1.	PROBLEM	b. (Check all problems presen	t in last	$oxed{ }$	
J1.	CONDITIONS	indicated)	· · · · · · · · ·		
		INDICATORS OF FLUID		OTHER	
		STATUS		Delusions Edema	e.
		Weight gain or loss of 3 or more pounds within a 7 day		Fever	g. h.
		period	a.	Hallucinations	i.
		Inability to lie flat due to shortness of breath		Internal bleeding	j.
		Dehydrated; output exceeds	b.	Recurrent lung aspirations in	
		input	c.	last 90 days Shortness of breath	k. I.
		Insufficient fluid; did NOT		Unsteady gait	n.
		consume all/almost all liquids provided during last 3 days	d.	Vomiting	0.
				NONE OF ABOVE	p.
J2.	PAIN SYMPTOMS	(Code the highest level of pa	ain prese	ent in the last 7 days)	
	31WF IOWS	a. FREQUENCY with which resident complains or		b. INTENSITY of pain	
		shows evidence of pain		1. Mild pain	
		0. No pain (<i>skip to J4</i>)		Moderate pain Times when pain is begrible	
		1. Pain less than daily		Times when pain is horrible or excrutiating	
		2. Pain daily (Check all that apply)			
J4.	ACCIDENTS	Fell in past 30 days	a.	Hip fracture in last 180 days Other fracture in last 180 days	C.
		Fell in past 31-180 days	b.	NONE OF ABOVE	d. e.
J5.	STABILITY		sident's c	cognitive, ADL, mood or behavior	С.
	OF CONDITIONS	status unstable—(fluctuating,			a.
		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.
		NONE OF ABOVE			d.
K1.	ORAL	Chewing problem			a.
	PROBLEMS	Swallowing problem NONE OF ABOVE			b. d.
K2.	HEIGHT		and (b.)	weight in pounds. Base weight	
	AND	recent measure in last 30 day	/s ; meás	ure weight consistently in accord after voiding, before meal, with si	with
	WEIGHT	off, and in nightclothes	., 111 a.111.	and voluling, belone mean, with si	1003
				HT (in.) b. WT (lb.)	
K3.	WEIGHT CHANGE	a.Weight loss—5 % or more 180 days	in last 3	0 days; or 10 % or more in last	
	CHANGE	0. No 1. Yes	S		
			in last 3	0 days; or 10 % or more in last	
		180 days 0. No 1. Yes	2		
1	i	1.163	,		1

K5.	NUTRI-	(Check all	that apply	in last	7 days	5)			
	TIONAL APPROACH-	Parenteral/I\	/		a.	On a planned weight change			
	ES	Feeding tub	е		b.	program NONE OF ABOVE	h.		
M1.	ULCERS (Due to any	cause. If nor	ne present a	at a stag	ge, reco	ulcer stage—regardless of rd "0" (zero). Code all that apply e.) [Requires full body exam.]	nber tage		
	cause)	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.								
				esents a	as a dee	est, exposing the subcutaneous ep crater with or without ue.			
			A full thickn exposing m			subcutaneous tissue is lost,			
M2.	TYPE OF ULCER	using sca	(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)						
		of underly	ing tissue			by pressure resulting in damage			
		extremitie	s			y poor circulation in the lower			
M4.	OTHER SKIN PROBLEMS	(Check all t		luring la	ast 7 da	ys)			
	OR LESIONS	Abrasions, b Burns (seco		learee)			a. b.		
	PRESENT	,		,		s, cuts (e.g., cancer lesions)	c.		
						rash, heat rash, herpes zoster	d.		
		Skin desens	itized to pai	n or pre	essure		e.		
		Skin tears of	•	than s	urgery)		f.		
		Surgical wo					g.		
	01/01	NONE OF A		durina l	lact 7 d	ave)	h.		
M5.	SKIN TREAT-	Pressure re		•		ays)	a.		
	MENTS	Pressure re	•	. ,			b.		
		Turning/rep	ū	. ,			c.		
		Nutrition or I	hydration in	terventi	ion to m	anage skin problems	d.		
		Ulcer care					e.		
		Surgical wo	und care				f.		
		Application to feet	of dressings	s (with o	or withou	ut topical medications) other tha	n g.		
					,	other than to feet)	h.		
				otective	e skin ca	are (other than to feet)	i.		
M6.	FOOT	NONE OF		durina l	last 7 da	avs)	j.		
IVIO.	FOOT PROBLEMS	l `		•		ns—e.g., corns, callouses,			
	AND CARE	bunions, ha	mmer toes,	overlap	ping to	es, pain, structural problems	a.		
					ılitis, pur	rulent drainage	b.		
		Open lesion Nails/callus			loct OO	dovo	c.		
						•	d.		
		inserts, pad			cuve ioc	ot care (e.g., used special shoes	e.		
		Application	of dressings	s (with o	or withou	ut topical medications)	f.		
		NONE OF	<i>ABOVE</i>				g.		
N1.	TIME	(Check app	ropriate tir	ne peri	iods ov	er last 7 days)			
	AWAKE	Resident aw per time per		ost of t	,	, naps no more than one hour			
		Morning	' г	a.	Eveni	9	c.		
		Afternoon		b.		E OF ABOVE	d.		
`	esident is co		•		•	1			
N2.	AVERAGE TIME	(When awa	ke and not	receiv	ing trea	tments or ADL care)			
	INVOLVED IN					2. Little—less than 1/3 of time			
01.	ACTIVITIES NUMBER OF	1. Some—fr				3. None dications used in the last 7 days	5:		
O	MEDICA- TIONS	enter "0" if n			CIR mo	andanone adda iir ane l ada ii daya	,		
О3.	INJECTIONS	the last 7 da	ays ; enter "(0" if nor	ne úsed)				
04.	DAYS RECEIVED THE	used. Note-	enter "1" f	of DAYS or long-	3 during acting r	l last 7 days ; enter "0" if not meds used less than weekly)			
	FOLLOWING	a. Antipsych				d. Hypnotic			
	MEDICATION	b. Antianxie	•			e. Diuretic			

P1.	TREAT-	a. SPECIAL CARE—Check to the last 14 days	reatmen	ts or programs receiv	red du	ring		
	MENTS, PROCE-	TREATMENTS Ventilator or respirator						
	DURES, AND PROGRAMS	Chemotherapy	_	PROGRAMS	ilOi		l.	
	PROGRAMS	1,7	a.					
		Dialysis IV medication	b.	Alcohol/drug treatm program	nent			
		Intake/output	C.	Alzheimer's/demen	itia ene	rial	m.	_
		•	d.	care unit	ilia opc	olai	n.	
		Monitoring acute medical condition	e.	Hospice care			o.	
		Ostomy care	f.	Pediatric unit			p.	
		Oxygen therapy	g.	Respite care			q.	
		Radiation	h.	Training in skills req				
				return to the comm taking medications,			_	
		Suctioning	i.	work, shopping, trai			r.	
		Tracheostomy care	j.	ADLs)				
		Transfusions	k.	NONE OF ABOVE			s.	
		b.THERAPIES - Record the the following therapies wa in the last 7 calendar day [Note—count only post: (A) = # of days administere (B) = total # of minutes pro	as admin ys (Ente admiss d for 15	nistered (for at least er 0 if none or less th ion therapies] minutes or more	15 mi	nutes 5 min N	a d	ay,
		` '			(A)		(B) 	_
		a. Speech - language patholo	ogy and	audiology services	$\vdash \vdash$	_	_	1
		b. Occupational therapy						L
		c. Physical therapy			I			
		d. Respiratory therapy						
		e. Psychological therapy (by a health professional)	any lice	nsed mental				
P3.	NURSING REHABILITA- TION/ RESTOR- ATIVE CARE	Record the NUMBER OF DA restorative techniques or pra more than or equal to 15 m (Enter 0 if none or less than a. Range of motion (passive)	ictices v inutes	vas provided to the per day in the las t	e resid	lent f		
		b. Range of motion (active)		Ĭ	mina		\vdash	
		c. Splint or brace assistance		g. Dressing or groom	•			
		TRAINING AND SKILL		h. Eating or swallow	ving			
		PRACTICE IN:		i. Amputation/prost	thesis	care		
		d. Bed mobility		j. Communication				
		e. Transfer		k. Other				
94.	DEVICES AND RESTRAINTS	Use the following codes for Io O. Not used D. Used less than daily D. Used daily Bed rails a. — Full bed rails on all ope b. — Other types of side rails C. Trunk restraint O. Limb restraint O. Chair prevents rising	n sides (of bed	e)			
7.	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		
28.	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>	sistan			
	OVERALL CHANGE IN CARE NEEDS	Resident's overall level of self scompared to status of 90 days than 90 days)	ago (o	r since last assessme	ent if le	SS		
		supports, ne restrictive lev	eds less ⁄el of car	more suppo re		ceives	8	
R2 . a . Si b . D	OVERALL CHANGE IN CARE NEEDS SIGNATURE	practitioner) changed the resic renewals without change. (En Resident's overall level of self's compared to status of 90 days than 90 days) 0. No change 1. Improved—restrictive level of PERSON COORDINATION Assessment Coordinator (sign of ment Coordinator	dent's onter 0 if no sufficients ago (o eceives eds less rel of car	ders? Do not include one) cy has changed sign r since last assessme fewer 2. Deteriorate more suppore	order ificantlent if le	y as		

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 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) Yes (If Yes, go to item W3) b. 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) 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	.0,			J. 1	J. ()		• •••	. • •	•	- 10 -		,
A1.	RESIDENT NAME												
		a. (Fire	st)		b. (Midd	lle Initia	al)		С.	(Last)	d	I. (Jr/Sr)
A2.	ROOM NUMBER												
А3.	ASSESS-	a. Last o	day of	MDS ob	servatio	n perio	d						
	MENT REFERENCE			$\neg -$		_							
	DATE	_	Mont	th	Day			Ye	ar		J		
		b. Origin	nal (0)	or corre	cted cop	y of for	m (en	iter ni	umbe	er of c	correc	ction)	
A4a.	DATE OF REENTRY				most re e last as								oital in 90 days
		_	_			1 [
		l L	Marada]-[<u> </u>					
A6.	MEDICAL		Month		Day	_	1	Yea	r	_		1	
	RECORD NO.												
B1.	COMATOSE	Ò. No			state/no 1. Yes		(Skip						
B2.	MEMORY	Ι'			arned or OK—se		,	rs to	recal	lafte	r 5 mi	nutes	
			mory			mory p			ooui	uno		iidioo	
			-term		OK—se 1.Me	ems/a mory p			ecall	long	past		
В3.	MEMORY/ RECALL	(Check last 7 d		at reside	nt was n	ormali	y ablo	e to r	ecall	duri	ing		
	ABILITY	Current			a.	That	he/sł	ne is i	inan	ursin	ıq hor	ne	d.
		Staff na		vn room aces	b. c.	NON	IE OF	-AB	OVE	are re	ecalle	ed	e.
B4.	COGNITIVE SKILLS FOR	(Made	decisio	ons rega	rding tas	ks of a	aily lit	fe)					
	DAILY DECISION-				decisions ENDEN						eitı ıat	ions	
	MAKING	only			PAIRED-								
		requi	red		? R <i>ED</i> —ne					•			
B5.	INDICATORS	(Code fo	or beh	avior in t	he last 7	days.) [Na	te: A	ccur	ate a			nt owledge
	OF DELIRIUM— PERIODIC				r over ti			ııııy	WIIO	iiavc	unc	CI KIK	wieuge
	DISOR- DERED			ot preser resent, n	nt ot of rec	ent ons	et						
	THINKING/ AWARENESS				ver last 7 w onset				fferer	nt from	m res	ident's	s usual
	AWARENEOU		LY DIS		ED—(e	g., diffi	culty	payin	g atte	entio	n; get	S	
		SUR	ROUN	IDINGS	ERED P —(e.g., ı	noves	lips o	r talks	s to s	ome	one n	ot	
		prese day)	ent; be	lieves he	e/she is s	omew	here (else;	confu	ises i	night	and	
		incoh	nerent,	nonsen	SORGAN sical, irre of though	elevant							
		clothi	ing, na	apkins, e	TLESSI tc; freque								
		e.PERI	IODS		ig out) HARGY- tle body			gishn	ess;	starir	ng into	o spac	ce;
					N VARI		,	HE C	OUR	SE (OF TH	ΗE	
		some	etimes	present	mes bett , sometir	nes no	t)			beha	viors		
C4.	MAKING SELF	0. UND	U		on conte	nt—ho	weve	rable)				
	UNDER- STOOD		ALLY (STOOD-	-diffict	ulty fir	nding	word	ls or	finish	ing	
			ĬETIMI	ES UND	ERSTO	OD—a	bility i	is limi	ted to	o mal	king o	concre	ete
C6.	ABILITYTO	3. RAR	ELY/N		INDERS I informa			h0	weve	r ahle	5)		
J.	UNDER- STAND	0. UND	ERST	ANDS							•		
	OTHERS	mess	age		STANDS	•			•				
		direct	t comn	nunicatio				nds a	aaeq	uatel	y to si	mple,	
E1.	INDICATORS	(Code	for inc	licators	JNDERS observe			day	s, irre	espe	ctive	of the	,
	OF DEPRES-		ator no	ot exhibit	ted in las			do:	0.4	ol:			
	SION, ANXIETY, SAD MOOD				e exhibite e exhibite						days	s a we	ek)
	SUD INIOOD	I											

E1.	INDICATORS	VERBAL EXPRESSIONS h. Repetitive health		
	OF DEPRES-	OF DISTRESS complaints—e.g., persistently seeks medica	al	
	SION, ANXIETY, SAD MOOD	a. Resident made negative statements—e.g., "Nothing matters: Would rather be		
	SAD WOOD	dead; What's the use; Regrets having lived so i. Repetitive anxious complaints/concerns (nor	1 -	
		long; Let me die" health related) e.g., persistently seeks attention		
		b. Repetitive questions—e.g., "Where do I go; What do I do?" b. Repetitive questions—e.g., reassurance regarding schedules, meals, laundr clothing, relationship issue		
		c. Repetitive verbalizations— SLEEP-CYCLE ISSUES		
		e.g., calling out for help, ("God help me") j. Unpleasant mood in more	٦L	
		d. Persistent anger with self or others—e.g., easily annoyed, anger at k. Insomnia/change in usua sleep pattern SAD, APATHETIC, ANXIO	_	
		placement in nursing home; anger at care received APPEARANCE I. Sad, pained, worried facia		
		e. Self deprecation—e.g., "I expressions—e.g., furrow brows to anyone"		
		f. Expressions of what		
		fears—e.g., fear of being abandoned, left alone, federing abandoned, left alone,		
		g. Recurrent statements that		
		something terrible is about to happen—e.g., believes o. Withdrawal from activities interest—e.g., no interest	in	
		have a heart attack being with family/friends	F	
E2 .	MOOD	p. Reduced social interactio One or more indicators of depressed, sad or anxious mood were		
	PERSIS- TENCE	not easily altered by attempts to "cheer up", console, or reassuthe resident over last 7 days		
		0. No mood indicators or spresent, indicators easily altered 2. Indicators present, not easily altered		
E4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequency in last 7 days 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 1. Behavior was not easily altered	(A)	(E
		WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)		
		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)		
		belongings) e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)		f
31.		F-PERFORMANCE—(Code for resident's PERFORMANCE OVER	ALL	_
		u ring last 7 days —Not including setup) DENT—No help or oversight —OR— Help/oversight provided only 7 7 days	1 or 2	time
	SUPERVIS last7 days	SION—Oversight, encouragement or cueing provided 3 or more tim —OR— Supervision (3 or more times) plus physical assistance pro		
	2. LIMITED A	s during last 7 days ASSISTANCE—Resident highly involved in activity; received physica neuvering of limbs or other nonweight bearing assistance 3 or more		
	3. EXTENSI period, hel	e help provided only 1 or 2 times during last 7 days /E ASSISTANCE—While resident performed part of activity, over la: p of following type(s) provided 3 or more times:	st 7-d	ay
	— Full stat	bearing support f performance during part (but not all) of last 7 days FPENDENCE—Full staff performance of activity during entire 7 days		
		FUND NOT OCCUR during entire 7 days		_
	` OVER ALI	PORT PROVIDED—(Code for MOST SUPPORT PROVIDED SHIFTS during last 7 days; code regardless of resident's self-	(A)	(E
	0. No setup o	ce classification) r physical help from staff	ŽĘRF	
		only n physical assist 8. ADL activity itself did not occur during entire 7 days	SELF-PERF	
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed	3,	
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		t

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 floo once in chair								
f.	LOCOMO- TION OFF UNIT	How resident moves to and ret areas set aside for dining, activ only one floor , how resident n the floor. If in wheelchair, self-s	rities, or noves to	treatments). If facility has and from distant areas on						
g.	DRESSING		ow resident puts on, fastens, and takes off all items of street othing, including donning/removing prosthesis							
h.	EATING	How resident eats and drinks (nourishment by other means (nutrition)								
i.	TOILET USE	How resident uses the toilet root transfer on/off toilet, cleanses, catheter, adjusts clothes								
j.	PERSONAL HYGIENE	How resident maintains persor brushing teeth, shaving, applyi hands, and perineum (EXCLU	ng make	eup, washing/drying face,						
G2.	BATHING	How resident takes full-body by transfers in/out of tub/shower (I Code for most dependent in (A) BATHING SELF PERFOR 0. Independent—No help pro	EXCLUI self-peri MANCE ovided	DE washing of back and hair.) ormance.		(A)				
		 Supervision—Oversight he Physical help limited to train Physical help in part of bat Total dependence 	nsfer on	•						
		8. Activity itself did not occur								
G3.	TEST FOR BALANCE	(Code for ability during test in to 0. Maintained position as requi		• /						
	(see training manual)	Unsteady, but able to rebala Partial physical support durior stands (sits) but does not Not able to attempt test with Balance while standing	nce self ng test; follow d	without physical support irections for test						
		b. Balance while sitting—positi	on, trun	k control	F	=				
G4.	FUNCTIONAL	(Code for limitations during las		that interfered with daily funct	ions	or				
	LIMITATION IN RANGE OF		<i>y</i>)	(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 knee	_							
		e. Foot—Including ankle or toef. Other limitation or loss	S							
G6.	MODES OF	(Check all that apply during la	ast 7 da	<i>ys</i>)						
	TRANSFER	Bedfast all or most of time	a.	NONE OF ABOVE	f.					
		Bed rails used for bed mobility or transfer	b.		ï					
G7.	TASK SEGMENTA-	Some or all of ADL activities w days so that resident could pe	ere brok rform th							
H1.		0. No 1. Yes SELF-CONTROL CATEGOR	IES	2.455		$\overline{}$				
	0. CONTINEN	dent's PERFORMANCE OVE IT—Complete control [includes does not leak urine or stool]		,	stomy	,				
	1. USUALLY C	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	aily;					
	control pres	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 functions soak through underpants), with programs, if employed								
H2.	BOWEL ELIMINATION PATTERN	Diarrhea Fecal impaction	c. d.	NONE OF ABOVE	e.					
	INITERIN	1 1	u.	<u> </u>						

Н3.	APPLIANCES AND	Any scheduled toileting plan	a.	Indwelling catheter	d.
	PROGRAMS	Bladder retraining program	b.	Ostomy present	i.
		External (condom) catheter	_	NONE OF ABOVE	
				current ADL status, cognitive stat	
	id and benavior tive diagnoses)	status, medical treatments, nu	rsing mo	onitoring, or risk of death. (Do not	IIST
11.	DISEASES	(If none apply, CHECK the N	IONE O	,	
		ENDOCRINE/METABOLIC/ NUTRITIONAL		Hemiplegia/Hemiparesis	v.
		l	a.	Multiple sclerosis Quadriplegia	w. z.
		MUSCULOSKELETAL		PSYCHIATRIC/MOOD	Z.
		Hip fracture	m.	Depression	ee.
		NEUROLOGICAL Aphasia	_	Manic depressive (bipolar disease)	
		Cerebral palsy	r. s.	OTHER	ff.
		Cerebrovascular accident (stroke)		NONE OF ABOVE	rr.
12.	INFECTIONS	(If none apply, CHECK the N	t. 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 Respiratory infection	e. f.	Wound infection NONE OF ABOVE	l.
13.	OTHER	(Include only those diseases	diagno	sed in the last 90 days that hav	m. ve a
	CURRENT	relationship to current ADL s medical treatments, nursing m		ognitive status, mood or behavior g, or risk of death)	status,
	AND ICD-9 CODES				
	CODES	a			
J1.	PROBLEM	b. (Check all problems presen	t in last		<u> </u>
•	CONDITIONS	indicated)		TOTHER	
		INDICATORS OF FLUID STATUS		Delusions	e.
		Weight gain or loss of 3 or		Edema	g.
		more pounds within a 7 day period	a.	Fever Hallucinations	h.
		Inability to lie flat due to		Internal bleeding	i. j.
		shortness of breath Dehydrated; output exceeds	b.	Recurrent lung aspirations in	
		input	c.	last 90 days Shortness of breath	k. I.
		Insufficient fluid; did NOT consume all/almost all liquids		Unsteady gait	n.
		provided during last 3 days	d.	Vomiting	о.
10	PAIN	(Code the highest level of pa	oin proce	NONE OF ABOVE	p.
J2.	SYMPTOMS	a. FREQUENCY with which	m prese	b. INTENSITY of pain	
		resident complains or shows evidence of pain		1. Mild pain	
		0. No pain (skip to J4)		2. Moderate pain	
		1. Pain less than daily		Times when pain is horrible or excrutiating	
		2. Pain daily (Check all that apply)			
J4.	ACCIDENTS	Fell in past 30 days	a.	Hip fracture in last 180 days Other fracture in last 180 days	c. d.
		Fell in past 31-180 days	b.	NONE OF ABOVE	е.
J5.	STABILITY OF	Conditions/diseases make res status unstable—(fluctuating,		cognitive, ADL, mood or behavior us, or deteriorating)	a.
	CONDITIONS			de or a flare-up of a recurrent or	
		chronic problem		4- E	b.
		End-stage disease, 6 or fewer NONE OF ABOVE	months	to live	c. d.
K1.	ORAL	Chewing problem			a.
	PROBLEMS	Swallowing problem NONE OF ABOVE			b.
K2.	HEIGHT		and (b.)	weight in pounds. Base weight	d. on mos
	AND WEIGHT			sure weight consistently in accord after voiding, before meal, with s	
		off, and in nightclothes			
K3.	WEIGHT	a.Weight loss—5 % or more		1T (in.) b. WT (lb.) 0 days; or 10 % or more in last	
	CHANGE	180 days		, .,	
		0. No 1. Yes b. Weight gain—5 % or more		0 days; or 10 % or more in last	
		180 days		<u>.</u>	
		0. No 1. Yes	j .		1

K5.	NUTRI-	(Check all that apply in last 7 days)	
NO.	TIONAL		
	APPROACH-	program	h.
	ES	Feeding tube b. NONE OF ABOVE	i.
	PARENTERAL	(Skip to Section M if neither 5a nor 5b is checked)	
	OR ENTERAL INTAKE	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	
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
	(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	2 10
		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	
M4.	OTHER SKIN	At	a.
	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)	f.
	uuyo,	Surgical wounds NONE OF ABOVE	g.
	01/01	Pressure relieving device(s) for chair	h.
M5.	SKIN	Fressure relieving device(s) for Grail	a.
	TREAT-	Pressure relieving device(s) for hed	
	TREAT- MENTS	Pressure relieving device(s) for bed Turning/repositioning program	b.
	MENTS (Check all	3 (7	
	MENTS (Check all that apply	Turning/repositioning program	b. c. d.
	MENTS (Check all	Turning/repositioning program Nutrition or hydration intervention to manage skin problems	b. c.
	MENTS (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than	b. c. d. e. f.
	MENTS (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet	b. c. d. e. f.
	MENTS (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet)	b. c. d. e. f. g. h.
	MENTS (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet	b. c. d. e. f.
	MENTS (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet)	b. c. d. e. f. g. h.
	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet 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	b. c. d. e. f. g. h. i. j. a.
	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet 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	b. c. d. e. f. g. h. i. j. a. b.
	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet 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	b. c. d. e. f. g. h. i. j. a. b. c.
	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet 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	b. c. d. e. f. g. h. i. j. a. b.
	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet 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	b. c. d. e. f. g. h. i. j. a. b. c. d. e.
	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet 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,	b. c. d. e. f. g. h. i. j. a. b. c. d.
	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet 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	b. c. d. e. f. g. h. i. j. a. b. c. d. e.
	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet 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)	b. c. d. e. f. s. b. c. d. e. f. f.
M6.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days)	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet 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:	b. c. d. g. h. i. j. a. b. c. d. e. f. g. g. g.
M6.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet 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	b. c. d. g. f. j. a. b. c. d. e. f. g. g. c. d. c. c. d.
M6.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet 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 Atternoon NONE OF ABOVE	b. c. d. g. h. i. j. a. b. c. d. e. f. g. g. g.
M6.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet 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	b. c. d. g. f. j. a. b. c. d. e. f. g. g. c. d. c. c. d.
M6.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is co	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet 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 Evening Afternoon NONE OF ABOVE Morning Afternoon NONE OF ABOVE Morning Afternoon NONE OF ABOVE	b. c. d. g. f. j. a. b. c. d. e. f. g. g. c. d. c. c. d.
M6.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is co	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet 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: Worning Afternoon Evening NONE OF ABOVE	b. c. d. g. h. i. j. a. b. c. d. g. f. g. d. c. d.
M6.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is co AVERAGE TIME INVOLVED IN	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet 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 The Morning Afternoon 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	b. c. d. g. h. i. j. a. b. c. d. g. f. g. d. c. d.
M6.	MENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is concept and average the concept and average the concept and average and average and average the concept and average the concept and average and	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet 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 a. NONE OF ABOVE (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)	b. c. d. g. h. i. j. a. b. c. d. g. f. g. d. c. d.
M6. (If ron N2.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is co AVERAGE TIME INVOLVED IN ACTIVITIES NUMBER OF MEDICA-	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet 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 Description NONE OF ABOVE Tevening NONE OF ABOVE Onatose, 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 2. Little—less than 1/3 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)	b. c. d. g. h. i. j. a. b. c. d. g. f. g. d. c. d.
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M6. N1. (If ron) N2. O1.	GENTS (Check all that apply during last 7 days) FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) TIME AWAKE esident is concave and a con	Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet 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 Dematose, 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	b. c. d. g. h. i. j. a. b. c. d. g. f. g. d. c. d.

ng	ed during	ts or programs receive	eatmen		a. SPECIAL CAR the last 14 day	SPECIAL TREAT- MENTS.	P1.
	tor	Ventilator or respirat		;	TREATMENTS	PROCE-	
l.	.0.	PROGRAMS	a.		Chemotherapy	DURES, AND PROGRAMS	
	ent	Alcohol/drug treatme	b.		Dialysis	TROOKAMO	
m.		program	c.		IV medication		
	tia special	Alzheimer's/dement	d.		Intake/output		
n. o.		care unit		te medical	Monitoring acute		
p.		Hospice care Pediatric unit	е.		condition		
q.		Respite care	f.		Ostomy care		
	uired to	Training in skills requ	g.	/	Oxygen therapy		
.g.,	unity (e.g.	return to the commi	h.		Radiation		
		taking medications, work, shopping, tran	i.		Suctioning		
1		ADLs)	j.	care	Tracheostomy ca		
s.		NONE OF ABOVE	k.		Transfusions		
nutes a da	15 minute nan 15 mi	minutes of more	s admir /s (Ente admiss d for 15	g therapies wa calendar day int only post a s administered	the following in the last 7 o [Note—cour		
	(1)			•	` '		
++-	-	audiology services	yy and				
++	\dashv	-			b. Occupationalc. Physical thera		
++	-				d. Respiratory th		
++-	\dashv	nsed mental	any lice	.,	e. Psychological		
		th of the following rel		sional)	health profess		P3.
ent for	resident 7 days	vas provided to the per day in the last :	ctices v inutes	hniques or pra equal to 15 m e or less than tion (passive) tion (active)	restorative technimore than or electric (Enter 0 if none a. Range of motion b. Range of motion)	NURSING REHABILITA- TION/ RESTOR- ATIVE CARE	. 0.
	ing	h. Eating or swallow			c. Splint or brace		
are	hesis care	i. Amputation/prostl			TRAINING AND PRACTICE IN:		
		j. Communication			d. Bed mobility		
		k. Other			e. Transfer		
		ays:	ast 7 da	•	Use the followin 0. Not used 1. Used less tha 2. Used daily Bed rails	DEVICES AND RESTRAINTS	P4.
		of bed	n sides (rails on all one	a. — Full bed ra		
	3)	e.g., half rail, one side		•			
	,	, 0110 0100	2000 (0		c. Trunk restraint		
					d. Limb restraint		
				ts rising	e. Chair prevents		
or		sion if less than 14 da ian (or authorized ass Enter 0 if none)	e physic	ny days`has th		PHYSICIAN VISITS	P7.
or	sistant or	sion if less than 14 da ian (or authorized ass ders? <i>Do not include</i> o one)	e physic lent's or	ny days has th anged the resid	facility) how man	PHYSICIAN ORDERS	P8.
		cy has changed signif				OVERALL	22.
	d—receiv	fewer 2. Deteriorated	eceives	1. Improved—r	than 90 days)	CHANGE IN CARE NEEDS	
	л l 			supports, ne restrictive lev			
					OF PERSON CO		
	ear	Day Ye		Month	ment Coordinator ete	ate RN Assess igned as comple	
	d—recort	cy has changed signif r since last assessme fewer 2. Deteriorated more suppore ASSESSMENT:	sufficients ago (or eceives eds less el of car GTHE A	all level of self satus of 90 days 1. Improved—r supports, ne restrictive lev OORDINATIN ordinator (sign or	Resident's overa compared to stat than 90 days) 0. No change 1. OF PERSON CO Assessment Coorment Coordinator	CHANGE IN CARE NEEDS SIGNATURE ignature of RN A pate RN Assess	R2 . a . Si b . D

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 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) Yes (If Yes, go to item W3) b. 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) 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 AB. DEMOGRAPHIC INFORMATION SECTION AA. IDENTIFICATION INFORMATION [Complete only for stays less than 14 days] (AA8a=8) RESIDENT Date the stay began. Note — Does not include readmission if record was DATE OF NAME® closed at time of temporary discharge to hospital, etc. In such cases, use prior **ENTRY** a. (First) d. (Jr/Sr) b. (Middle Initial) c. (Last) admission date GENDER® 1. Male 2. Female 3. BIRTHDATE Month Day Year 2. 1. Private home/apt. with no home health services 2. Private home/apt. with home health services **ADMITTED** Month Day Year FROM RACE/ 1. American Indian/Alaskan Native (AT ENTRY) Board and care/assisted living/group home 4. Hispanic ETHNICITY® 2. Asian/Pacific Islander Nursing home 5. White, not of 5. Acute care hospital Black, not of Hispanic origin Hispanic origin 6. Psychiatric hospital, MR/DD facility SOCIAL a. Social Security Number Rehabilitation hospital SECURITY 8. Other AND MEDICARE Medicare number (or comparable railroad insurance number) NUMBERS & SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION [C in 1st box if non med. no.] MEDICAL 6 **FACILITY** a. State No. RECORD PROVIDER NO.® SECTION R. ASSESSMENT/DISCHARGE INFORMATION b. Federal No. 3. DISCHARGE a. Code for resident disposition upon discharge MEDICAID NO. ["+" if pending, "N' STATUS 1. Private home/apartment with no home health services 2. Private home/apartment with home health services if not a Medicaio 3. Board and care/assisted living recipient] € 4. Another nursing facility Note—Other codes do not apply to this form] 8 REASONS 5. Acute care hospital FOR a. Primary reason for assessment 6. Psychiatric hopital, MR/DD facility ASSESS-MENT 7. Rehabilitation hospital 6. Discharged—return not anticipated7. Discharged—return anticipated 8. Deceased 8. Discharged prior to completing initial assessment 9. Other 9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or b. Optional State Code Tracking Form 4. DISCHARGE Date of death or discharge 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 DATE 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 Month Day Year 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

*	= Key i	items for	computerized	resident	tracking
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a. b.

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 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) Yes (If Yes, go to item W3) b. 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) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered 	

REENTRY TRACKING FORM

SE	CTION A	A. IDENTI	IFICATION INFO	RMATION	
1.	RESIDENT NAME €				
		a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)
2.	GENDER®	1. Male	2. Female		
3.	BIRTHDATE ®				
		Month			
4.	RACE/	1. American Ir	ndian/Alaskan Native	4. Hispanic	
	ETHNICITY®		ic Islander of Hispanic origin	5. White, not of Hispanic orig	nin
5.	SOCIAL	a. Social Secu		r noparno orig	,
	SECURITY®		$\Box = \Box \Box = \Box$		
	MEDICARE.	b . Medicare n	umber (or comparable railr	road insurance number)
	NUMBERS € [C in 1st box if				j l
	non med. no.]				
6.	FACILITY PROVIDER	a. State No.			
	NO.®				
					
		b. Federal No.			
7.	MEDICAID NO. ["+" if				
	pending, "N"				
	if not a Medicaid				
	recipient] €				
8.	REASONS FOR	Γ	codes do not apply to this	formj	
	ASSESS-	a. Primary rea	ason for assessment		
	MENT	9. Reentry			
	Signatures of Tracking Form		Completed a Portion of	the Accompanying A	ssessment or
-			nformation accurately refl	lects resident assessm	ent or tracking
info	rmation for this	resident and th	hat I collected or coordinat	ted collection of this info	ormation on the
			y knowledge, this informa id requirements. I underst		
			eceive appropriate and qurstand that payment of suc		
patio	on in the goverr	nment-funded h	health care prógrams is co	nditioned on the accura	acy and truthful-
			I may be personally subject administrative penalties for		
cert	ify that I am au	thorized to sub	omit this information by th	is facility on its behalf.	
5	Signature and T	ïtle		Sections	Date
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.	

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

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	72 i	O. No (If No, go to item W2b) Or (If Yes / go to item W3) D. If Influenza vaccine not received, state reason: Or (If Not in facility during this year's flu season) Or (If No item W2b) Or (If No, go to item W3) Or (If No, go to item W	
		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)	
V		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
 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.

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				FCT	

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.)

Priori AA1.	RESIDENT NAME				
		a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)
Priori AA2	GENDER	1. Male	2. Female		
Priori AA3.	BIRTHDATE	Month		Year	
Priori AA5.	SOCIAL SECURITY	a. Social Securi	•		
Priori	REASONS FOR ASSESSMENT	ASSESSMENT 1. Admissio 2. Annual as 3. Significar 4. Significar 5. Quarterly 10. Significar 0. NONE OI DISCHARGETI 6. Discharg 7. Discharg 8. DIscharg REENTRY TRA 9. Rentry b. Codes for as 1. Medicare 2. Medicare 3. Medicare 4. Medicare 5. Medicare 6. Other sta 7. Medicare 8. Other Me	at change in status asset to correction of prior full a review assessment correction of prior qual FABOVE RACKING (Complete Priced—return not anticipated ed prior ro completing inic CKING (Complete Prior Editor) of a day assessment a day assessment a 90 day assessment a eadmission/return asset are quired assessment at 14 day assessment asset required assessment adicare required assessment adicare required assessment adicare required assessment	by day 14) ssment assessment rterly assessment or Date item Prior R4 d tial assessment Date item Prior A4a C or Medicare PPS or to	DNLY)
	PRIOR DATE	5, 10, or 0. Complete Prior	A3a if Primary Reason (P R4 if Primary Reason (P R4 if Primary Reason (P	rior AA8a) equals 6,	7, or 8.
Priori A3.	ASSESSMENT REFERENCE DATE	a. Last day of Month	MDS observation period Day	Year	
Priori R4.	DISCHARGE DATE	Date of dischar		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

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.) INACTIVE record in error. (Do NOT submit an assessment or tracking form. Submit the correction request only. Skip to item AT4.)	

AT3.	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:	
AT4.	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	
		b. Event did not occur	
		c. Inadvertent submission of inappropriate record	
		d. Other reason requiring inactivation	
		If "Other" checked, please specify:	

		RNCOORDINATO	R ATTESTATION (OFCOMPLETION	
AT5.	ATTESTING INDIVIDUAL NAME				
	INAIVIE	a. (First)	b. (Last)	c. (Title)	
	SIGNATURE				
AT6.	ATTESTATION DATE				
		Month	Day	Year	
AT7.		N OF ACCURACY ASSESSMENT O		ES OF PERSONS WH FORMATION	O CORRECT A

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. 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	Attestation Date
a.	
b.	
c.	
d.	
e.	
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=inhalation2=sub lingual (SL)6=rectal (R)9=enteral tube3=intramuscular (IM)7=topical10=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.	ND	C (Coc	les		
										\coprod	
										Ш	
										\prod	
										\prod	

BASIC ASSESSMENT TRACKING FORM

SECTION AA IDENTIFICATION INFORMATION

	.00,			011111111111111111111111111111111111111				
1.	RESIDENT NAME®							
		a. (First)	b. (Middle Initia	il) c. (Las	t) d. (Jr/Sr)			
2.	GENDER®	1. Male	2. Female					
3.	BIRTHDATE®	Mont		Year				
4.	RACE/⊛	1 American	Indian/Alaskan Native	4. Hispan	ic			
	ETHNICITY	2. Asian/Pag	cific Islander t of Hispanic origin	5. White,				
5.	SOCIAL		curity Number	•	, i			
	SECURITY®							
	AND			-				
	MEDICARE NUMBERS®	b. Medicare	number (or comparable	railroad insurance n	umber)			
	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.	REASONS	[Note—Othe	er codes do not apply to t	his form]				
	FOR ASSESS-		eason for assessment ssion assessment (requi	red by day 14)				
	MENT	Annua	al assessment					
			icant change in status as					
			Significant correction of prior full assessment Overtexly regions assessment					
		10. Signifi	Quarterly review assessment Significant correction of prior quarterly assessment					
		0. NŎNE	NONE OF ABOVE					
			. Codes for assessments required for Medicare PPS or the State					
			care 5 day assessment					
			care 30 day assessment care 60 day assessment					
			care 90 day assessment					
		5. Medic	care readmission/return a					
			state required assessme care 14 day assessment	ent				
			Medicare required asses	ssment				
			,					

0	Signatures of Persons who Completed a Portion of the Accompanying Assessment of
9.	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- TIAL	(Check all settings resident lived in during 5 years prior to date of entry.)	
	HISTORY	a. Prior stay at this nursing home	
	5 YEARS PRIOR TO ENTRY	b. Stay in other nursing home c. Other residential facility—board and care home, assisted living,	
	ENIKI	group home	
		d. MH/psychiatric setting e. MR/DD setting	
		f. NONE OF ABOVE	
A1.	RESIDENT NAME		
	10 0112	a. (First) b. (Middle Initial) c. (Last) d. (Jr/S	Sr)
A2.	ROOM NUMBER		
	100700		
A3.	ASSESS- MENT	a. Last day of MDS observation period	
	REFERENCE DATE		
A4a	DATE OF	Month Day Year Date of reentry from most recent temporary discharge to a hospital i	in
лта	REENTRY	last 90 days (or since last assessment or admission if less than 90	
		days)	
A5.	MARITAL	Month Day Year 1. Never married 3. Widowed 5. Divorced	
A6.	STATUS MEDICAL	2. Married 4. Separated	
Αυ.	RECORD NO.		
A10.	ADVANCED	(For those items with supporting documentation in the medical	
AIU.	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)	
B2.	MEMORY	(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 b. Long-term memory OK—seems/appears to recall long past	
		0. Memory OK 1. Memory problem	
В3.	MEMORY/ RECALL	(Check all that resident was normally able to recall during last 7 days)	
	ABILITY	a. Current season d. That he/she is in a nursing home	
		b. 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	0. INDEPENDENT—decisions consistent/reasonable	
	DECISION- MAKING	MODIFIED INDEPENDENCE—some difficulty in new situations only	
	III/AIAIAO	2. MODERATELY IMPAIRED—decisions poor; cues/supervision	
		required 3. SEVERELY IMPAIRED—never/rarely made decisions	
B5.	INDICATORS	(Code for behavior in the last 7 days.) [Note: Accurate assessment	
	OF DELIRIUM—	requires conversations with staff and family who have direct knowle of resident's behavior over this time].	dge
	PERIODIC DISOR-	Behavior not present	
	DERED THINKING/	 Behavior present, not of recent onset Behavior present, over last 7 days appears different from resident's usu 	ıal
	AWARENESS		
		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)	

SELF UNDERSTOOD 1. USUALLY UNDERSTOOD—ability is limited to making concrete requests 2. SCMETIMES UNDERSTOOD (Understanding verbal information content—however able) 0. UNDERSTAND OTHERS 3. RARELY/NEVER UNDERSTANDS—may miss some part/intent of message 2. SCMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY/NEVER UNDERSTANDS D1. VISION (Ability to see in adequate light and with glasses if used) 0. ADEQUATE—sees fine detail, including regular print in newspapers/books 1. IMPAIRED—sees large print, but not regular print in newspapers/books 2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY MAPAIRED—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 E1. INDICATORS (Obde for indicators observed in last 30 days, irrespective of the assumed cause) 0. Indicator of this type exhibited daily or almost daily (6, 7 days a week) VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., which are be dead. What's the use; Regrets having lived so long: Let me die" b. Repetitive questions—e.g., "Whate 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 lears—e.g., lear of being abandwated, life alone, being with others g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to lie, have a heart attack be a heart attack be a heart attack be a heart attack be a control to the proper of the days and the proper of the proper of the proper of the period of the proper o	C4.	MAKING	(Expressing information conte	ent—however able)	
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p. Reduced social interaction					
				· ·	
E2. MOOD One or more indicators of depressed, sad or anxious mood were	E2	MOOD	One or more indicators of do	·	
PERSIS- not easily altered by attempts to "cheer up", console, or reassure	LZ.	PERSIS-	not easily altered by attempt	s to "cheer up", console, or reassure	
TENCE the resident over last 7 days		TENCE	the resident over last 7 days		
0. No mood 1. Indicators present, 2. Indicators present, indicators easily altered not easily altered]
	ш		,	-	

Numeric Identifier ___

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

Resident Identifier	Numeric Identifier
F4 REHAVIORAL (A) Rehavioral symptom frequency in last 7 days	G3 TEST FOR (Code for ability during test in the last 7 days)

E4.	BEHAVIORAL	(A) Behavioral symptom frequency in last 7 days			G3.		(Code for ability during test in the last 7 days)	
	SYMPTOMS	D. Behavior not exhibited in last 7 days	BALANCE 0. Maintained position as required in test			Maintained position as required in test		
		Behavior of this type occurred 1 to 3 days in last 7 days				(see training	Unsteady, but able to rebalance self without physical support Partial physical support during test;	
		2. Behavior of this type occurred 4 to 6 days, but less than daily				Illallual)	or stands (sits) but does not follow directions for test	
		Behavior of this type occurred daily					Not able to attempt test without physical help a. Balance while standing	
		(B) Behavioral symptom alterability in last 7 days					b. Balance while sitting—position, trunk control	
		Behavior not present OR behavior was easily altered			G4.	FUNCTIONAL	(Code for limitations during last 7 days that interfered with daily function	ns or
			(A)	(B)	1 1	LIMITATION I	placed residents at risk of injury) (A) RANGE OF MOTION (B) VOLUNTARY MOVEMENT	
		a. WANDERING (moved with no rational purpose, seemingly	T	`		MOTION	0. No limitation 0. No loss	
		oblivious to needs or safety)					1. Limitation on one side 1. Partial loss 2. Limitation on both sides 2. Full loss (A)) (B
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others					a. Neck	T
		were threatened, screamed at, cursed at)		_			b. Arm—Including shoulder or elbow	1
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)					c. Hand—Including wrist or fingers	
							d. Leg—Including hip or knee	
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming,					e. Foot—Including ankle or toes	\bot
		self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others'			G5.	MODES OF	f. Other limitation or loss (Check if applied during last 7 days)	
		belongings)			G5.	LOCOMO-	b. Wheeled self	
		e. RESISTS CARE (resisted taking medications/injections, ADL			Ш	TION	b. Wheeled Sell	
_		assistance, or eating)		_	G6.	MODES OF	(Check all that apply during last 7 days)	
31.		F-PERFORMANCE—(Code for resident's PERFORMANCE OVER A Juring last 7 days —Not including setup)	\LL			TRANSFER	a. Bedfast all or most of time	
	ı	IDENT—No help or oversight —OR— Help/oversight provided only 1	or 2				b. Bed rails used for bed	
		ng last 7 days	-		G7.	TASK	mobility or transfer Some or all of ADL activities were broken into subtasks during last 7	
	1. SUPERVI	SION—Oversight, encouragement or cueing provided 3 or more times	s dur	ing	"'	SEGMENTA-	days so that resident could perform them	
	last 7 days	s —OR— Supervision (3 or more times) plus physical assistance proves during last 7 days	/ided	only	114		0. No 1. Yes	
		ASSISTANCE—Resident highly involved in activity; received physical	help		H1.		E SELF-CONTROL CATEGORIES ent's PERFORMANCE OVER ALL SHIFTS)	
	in guided	maneuvering of limbs or other nonweight bearing assistance 3 or more	re tim	nes		`	,	2001/
		lore help provided only 1 or 2 times during last 7 days					NT—Complete control [includes use of indwelling urinary catheter or osto does not leak urine or stool]	IIIy
		VE ASSISTANCE—While resident performed part of activity, over last lp of following type(s) provided 3 or more times:	7-da	ay		1 1151141170	CONTINENT—BLADDER, incontinent episodes once a week or less;	
	— Weight	-bearing support					ss than weekly	
		ff performance during part (but not all) of last 7 days				2. OCCASION	NALLY INCONTINENT—BLADDER, 2 or more times a week but not dail	v:
	l	EPENDENCE—Full staff performance of activity during entire 7 days				BOWEL, on		,,
	8. ACTIVITY	/ DID NOT OCCUR during entire 7 days				3. FREQUEN	ITLY INCONTINENT—BLADDER, tended to be incontinent daily, but som	ne
		PORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL				control pres	sent (e.g., on day shift); BOWEL, 2-3 times a week	
	classificat	ring last 7 days; code regardless of resident's self-performance ion)	_	(B)			ENT—Had inadequate control BLADDER, multiple daily episodes;	
		or physical help from staff	ERI	Ā			(or almost all) of the time	
	Setup help One person	p only on physical assist 8. ADL activity itself did not	ᇤ	о ^с [a.	BOWEL CONTI-	Control of bowel movement, with appliance or bowel continence programs, if employed	
		sons physical assist occur during entire 7days	SELF-PERF	SUPPORT		NENCE		
a.	BED	How resident moves to and from lying position, turns side to side,			b.	BLADDER CONTI-	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence	
		and positions body while in bed				NENCE	programs, if employed	
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)			H2.	BOWEL ELIMINATION	c. Diarrhea	
c.	WALK IN	,			Ш	PATTERN	d. Fecal impaction	
	ROOM	How resident walks between locations in his/her room			H3.	APPLIANCES AND	a. Any scheduled toileting plan d. Indwelling catheter	
d.	WALK IN CORRIDOR	How resident walks in corridor on unit				DDOCDAME	b. Bladder retraining program c. External (condom) catheter	
e.		How resident moves between locations in his/her room and					,	
٠.	TION	adjacent corridor on same floor. If in wheelchair, self-sufficiency					eck only those diseases that have a relationship to current ADL status ood and behavior status, medical treatments, nursing monitoring, or risk o	
f.		once in chair How resident moves to and returns from off unit locations (e.g.,					nactive diagnoses)	- 1
١.	TION	areas set aside for dining, activities, or treatments). If facility has			11.	DISEASES	a. Diabetes melitus v. Hemiplegia/Hemiparesis	_
		only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair			'''	DIOLAGEG	d. Arteriosclerotic heart d. Arteriosclerotic heart w. Multiple sclerosis v. Hemiplegia/Hemiparesis w. Multiple sclerosis	
g.		How resident puts on, fastens, and takes off all items of clothing ,					disease (ASHD)	
_		including donning/removing prosthesis					f. Congestive heart failure x. Paraplegia z. Quadriplegia	
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 ee. Depression	
		nutrition)					disease ff. Manic depressive (bipolar	
i.		How resident uses the toilet room (or commode, bedpan, urinal);					m. Hip fracture disease)	
		transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes					r. Aphasia gg. Schizophrenia	
j.	PERSONAL						s. Cerebral palsy hh. Asthma	
,	HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, bend partieum (EVCL LDE between a believe to the combined of the combined between the combi					t. Cerebrovascular accident ii. Emphysema/COPD	
		hands, and perineum (EXCLUDE baths and showers) How resident takes full-body bath/shower, sponge bath, and				INICEOTICS	(stroke)	
G2.		transfers in/out of tub/shower (EXCLUDE washing of back and			12.	INFECTIONS	(If none apply, CHECK the NONE OF ABOVE box) a. Antibiotic resitant infection g. Septicemia	
		hair.) Code for most dependent in self-performance.					(e.g. Methicillin resistant h. Sexually transmitted	
	1 1	(A) BATHING SELF PERFORMANCE codes appear below	_((A)			stapn) diseasés	
		Independent—No help provided Supervision—Oversight help only]			b. Clostridium difficile (c. diff.) i. Tuberculosis	
	1 1	Physical help limited to transfer only					c. Conjunctivitis j. Urinary tract infection in last 30 days	
	1 1	Physical help in part of bathing activity					La Vinal la anatitia	
		4. Total dependence					L Wound infection	
		Activity itself did not occur during entire 7 days					f. Respiratory infection m. NONE OF ABOVE	

Resident Identifier ______ Numeric Identifier _____

13.	OTHER							
	CURRENT							
	DIAGNOSES AND ICD-9	a.		•				
	CODES	b.		•				
J1.	PROBLEM	(Check all problems present in last 7	days unless other time frame is					
	CONDITIONS	indicated)	OTHER					
		INDICATORS OF FLUID STATUS	e. Delusions					
			g. Edema					
		a. Weight gain or loss of 3 or more pounds within a 7-	h. Fever					
		day period	i. Hallucinations					
		b. Inability to lie flat due to	j. Internal bleeding					
		shortness of breath c. Dehydrated; output	k. Recurrent lung aspirations i	n				
		exceeds input	I. Shortness of breath					
		d. Insufficient fluid; did NOT consume all/almost all	n. Unsteady gait					
		liquids provided during last 3 days	o. Vomiting					
J2.	PAIN	(Code the highest level of pain pres	sent in the last 7 days)					
	SYMPTOMS	a. FREQUENCY with which	b. INTENSITY of pain					
		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 daily	3. Times when pain is hor	rible				
		2. Pain daily	or excruciating					
J4.	ACCIDENTS	(Check all that apply)	c. Hip fracture in last 180 days	T				
"		a. Fell in past 30 days	d. Other fracture in last 180					
		b. Fell in past 31-180 days	days					
		. , _	e. NONE OF ABOVE					
J5.	STABILITY OF	a. Conditions/diseases make resident	dent's cognitive, ADL, mood or uctuating, precarious, or deteriorating	4)				
	CONDITIONS	, ,	te episode or a flare-up of a recurren	"				
		or chronic problem	te episode of a flare-up of a recurren	`				
		c. End-stage disease, 6 or fewer	months to live					
		d. NONE OF ABOVE						
K1.	ORAL	a. Chewing problem						
$oxed{oxed}$	PROBLEMS	b. Swallowing problem						
K2.	HEIGHT AND	Record (a.) height in inches and (b.) weight in pounds. Base weight on most ecent measure in last 30 days; measure weight consistently in accord with						
	WEIGHT	tandard facility practice—e.g., in a.m. after voiding, before meal, with shoes						
		off, and in nightclothes						
			a. HT (in.) b. WT (lb.)	1 1 1				
K3.	WEIGHT CHANGE	a. Weight loss—5 % or more in	last 30 days; or 10 % or more in las					
		190 days	• '	t				
	ļ	180 days	• /	t				
		0. No 1. Yes						
		0. No 1. Yes	last 30 days; or 10 % or more in las					
		0. No 1. Yes b. Weight gain —5 % or more in						
K5.	NUTRI-	0. No 1. Yes b. Weight gain—5 % or more in 180 days	last 30 days; or 10 % or more in las					
K5.	TIONAL	0. No 1. Yes b. Weight gain—5 % or more in 180 days 0. No 1. Yes	last 30 days; or 10 % or more in last h. On a planned weight					
K5.		0. No 1. Yes b. Weight gain—5 % or more in 180 days 0. No 1. Yes (Check all that apply in last 7 days) a. Parenteral/IV	last 30 days; or 10 % or more in las					
	TIONAL APPROACH- ES	No 1.Yes Weight gain—5 % or more in 180 days 0. No 1.Yes (Check all that apply in last 7 days) a. Parenteral/IV b. Feeding tube	last 30 days; or 10 % or more in last h. On a planned weight change program					
	TIONAL APPROACH- ES PARENTERAL	0. No 1. Yes b. Weight gain—5 % or more in 180 days 0. No 1. Yes (Check all that apply in last 7 days) a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a nor 5b)	last 30 days; or 10 % or more in last h. On a planned weight change program	st				
	TIONAL APPROACH- ES	O. No 1. Yes b. Weight gain—5 % or more in 180 days O. No 1. Yes (Check all that apply in last 7 days) a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a nor 5b a. Code the proportion of total c.	last 30 days; or 10 % or more in last h. On a planned weight change program is checked) alories the resident received through	st				
	TIONAL APPROACH- ES PARENTERAL OR ENTERAL	0. No 1. Yes b. Weight gain—5 % or more in 180 days 0. No 1. Yes (Check all that apply in last 7 days) a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a nor 5b a. Code the proportion of total coparenteral or tube feedings in 0. None	h. On a planned weight change program is checked) alories the resident received through the last 7 days 3. 51% to 75%	st				
	TIONAL APPROACH- ES PARENTERAL OR ENTERAL	D. No D. Yes D. Weight gain—5 % or more in 180 days D. No D. No D. Yes Check all that apply in last 7 days D. Parenteral/IV D. Feeding tube (Skip to Section M if neither 5a nor 5b D. Code the proportion of total coparenteral or tube feedings in 10. None D. None D. None D. Weight gain—1. 1% to 25%	h. On a planned weight change program is checked) alories the resident received through the last 7 days	st				
	TIONAL APPROACH- ES PARENTERAL OR ENTERAL	D. No D. No D. No D. Weight gain—5 % or more in 180 days D. No D. No D. Yes Check all that apply in last 7 days D. Parenteral/IV D. Feeding tube (Skip to Section M if neither 5a nor 5b D. Code the proportion of total coparenteral or tube feedings in 10. None D. None D. None D. 1. 1% to 25% D. 26% to 50%	h. On a planned weight change program is checked) alories the resident received through the last 7 days 3. 51% to 75% 4. 76% to 100%	h				
	TIONAL APPROACH- ES PARENTERAL OR ENTERAL	D. No D. Feeding tube D. Section M if neither 5a nor 5b D. Code the proportion of total coparenteral or tube feedings in 10. None D. None D. None D. None D. Code the average fluid intaken	h. On a planned weight change program h. on a planned weight change program h is checked) alories the resident received through the last 7 days 3. 51% to 75% 4. 76% to 100% e per day by IV or tube in last 7 days	h				
	TIONAL APPROACH- ES PARENTERAL OR ENTERAL	0. No 1. Yes b. Weight gain—5 % or more in 180 days 0. No 1. Yes (Check all that apply in last 7 days) a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a nor 5b a. Code the proportion of total coparenteral or tube feedings in 0. None 1. 1% to 25% 2. 26% to 50% b. Code the average fluid intake 0. None 1. 1 to 500 cc/day	h. On a planned weight change program h. On a planned weight change program his checked) alories the resident received through the last 7 days 3. 51% to 75% 4. 76% to 100% be per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 4. 1501 to 2000 cc/day	h				
K6.	TIONAL APPROACH- ES PARENTERAL OR ENTERAL INTAKE	0. No 1. Yes b. Weight gain—5 % or more in 180 days 0. No 1. Yes (Check all that apply in last 7 days) a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a nor 5b a. Code the proportion of total control of the parenteral or tube feedings in 10. None 1. 1% to 25% 2. 26% to 50% b. Code the average fluid intakenon. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day	h. On a planned weight change program h. On a planned weight change program his checked) alories the resident received through the last 7 days 3. 51% to 75% 4. 76% to 100% be per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day	h h				
	TIONAL APPROACH- ES PARENTERAL OR ENTERAL	0. No 1. Yes b. Weight gain—5 % or more in 180 days 0. No 1. Yes (Check all that apply in last 7 days) a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a nor 5b a. Code the proportion of total caparenteral or tube feedings in 10. None 1. 1% to 25% 2. 26% to 50% b. Code the average fluid intake 0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day (Record the number of ulcers at 10.	h. On a planned weight change program h. On a planned weight change program h is checked) alories the resident received through the last 7 days 3. 51% to 75% 4. 76% to 100% per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 4. 2001 or more cc/day 5. 2001 or more cc/day each ulcer stage—regardless of	h h				
K6.	TIONAL APPROACH- ES PARENTERAL OR ENTERAL INTAKE ULCERS (Due to any	0. No 1. Yes b. Weight gain—5 % or more in 180 days 0. No 1. Yes (Check all that apply in last 7 days) a. Parenteral/IV b. Feeding tube (Skip to Section M if neither 5a nor 5b a. Code the proportion of total caparenteral or tube feedings in 10. None 1. 1% to 25% 2. 26% to 50% b. Code the average fluid intake 0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day (Record the number of ulcers at 10.	h. On a planned weight change program h. On a planned weight change program his checked) alories the resident received through the last 7 days 3. 51% to 75% 4. 76% to 100% be per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day	h h				
K6.	TIONAL APPROACH- ES PARENTERAL OR ENTERAL INTAKE ULCERS	D. No D. No D. Weight gain—5 % or more in 180 days D. No D. No D. Yes Check all that apply in last 7 days D. Parenteral/IV D. Feeding tube (Skip to Section M if neither 5a nor 5b D. Code the proportion of total caparenteral or tube feedings in 10. None D. Todo the average fluid intake D. None D. None D. None D. Todo the average fluid intake D. None D. None D. None D. Todo the average fluid intake D. None D. None D. Todo the average fluid intake D. None D. Todo the average fluid intake D. None D. None D. Todo the average fluid intake D. None D. None D. Todo the average fluid intake D. None D. None D. Todo the average fluid intake D. None D. None D. Todo the average fluid intake D. Todo the	h. On a planned weight change program h. On a planned weight change program h is checked) alories the resident received through the last 7 days 3. 51% to 75% 4. 76% to 100% per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 4. 2001 or more cc/day 5. 2001 or more cc/day each ulcer stage—regardless of	t en				
K6.	TIONAL APPROACH- ES PARENTERAL OR ENTERAL INTAKE ULCERS (Due to any	D. No D. Yes D. Weight gain—5 % or more in 180 days D. No D. Yes Check all that apply in last 7 days D. Feeding tube Cskip to Section M if neither 5a nor 5b D. Code the proportion of total coparenteral or tube feedings in 10. None D. None D. None D. None D. None D. Node the average fluid intake D. None D. None D. None D. None D. None D. Odday Crecord the number of ulcers at cause. If none present at a stage during last 7 days. Code 9 = 9 o D. Stage 1. A persistent area of	h. On a planned weight change program h. On a planned weight change program his checked) alories the resident received throughte last 7 days 3. 51% to 75% 4. 76% to 100% e per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day each ulcer stage—regardless of record "0" (zero). Code all that apply or more.) [Requires full body exam.	h h				
K6.	TIONAL APPROACH- ES PARENTERAL OR ENTERAL INTAKE ULCERS (Due to any	D. No D. Yes D. Weight gain—5 % or more in 180 days D. No D. Yes Check all that apply in last 7 days D. Feeding tube Cskip to Section M if neither 5a nor 5b D. Code the proportion of total coparenteral or tube feedings in 10. None D. None D. None D. None D. None D. Noole D. Code the average fluid intake D. None D. None D. None D. None D. Hoto 500 cc/day D. Sold to 1000 cc/day D. Sold	h. On a planned weight change program h. On a planned weight change program h is checked) alories the resident received through the last 7 days 3. 51% to 75% 4. 76% to 100% per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day each ulcer stage—regardless of precord "0" (zero). Code all that appler more.) [Requires full body exam. skin redness (without a break in the isappear when pressure is relieved.	h h				
K6.	TIONAL APPROACH- ES PARENTERAL OR ENTERAL INTAKE ULCERS (Due to any	D. No D. Yes D. Weight gain—5 % or more in 180 days D. No D. Yes Check all that apply in last 7 days a. Parenteral/IV D. Feeding tube (Skip to Section M if neither 5a nor 5b a. Code the proportion of total caparenteral or tube feedings in 0. None D. None D. None D. None D. Code the average fluid intake D. None D. None D. None D. None D. None D. Hoto 500 cc/day D. Sold to 1000 cc/day D. Wecord the number of ulcers at cause. If none present at a stage during last 7 days. Code 9 = 90 a. Stage 1. A persistent area of skin) that does not declinically as an abrasistance.	h. On a planned weight change program h. On a planned weight change program h. Sis checked) alories the resident received through the last 7 days 3. 51% to 75% 4. 76% to 100% per day by IV or tube in last 7 days 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day seach ulcer stage—regardless of precord "0" (zero). Code all that apply more.) [Requires full body exam. skin redness (without a break in the isappear when pressure is relieved. loss of skin layers that presents sion, blister, or shallow crater.	Number at Stage				
K6.	TIONAL APPROACH- ES PARENTERAL OR ENTERAL INTAKE ULCERS (Due to any	D. No D. No D. Yes D. Weight gain—5 % or more in 180 days D. No D. No D. Yes Check all that apply in last 7 days D. Parenteral/IV D. Feeding tube (Skip to Section M if neither 5a nor 5b D. Code the proportion of total concentrated or tube feedings in 10. None D. None D. 1 % to 25% D. Code the average fluid intake D. None D. 1 to 500 cc/day D. So1 to 1000 cc/day D. So1 to 1000 cc/day D. So2 to 1000 cc/day D. So3 to 1000 cc/day D. So4 to 1000 cc/day D. So4 to 1000 cc/day D. So5	h. On a planned weight change program h. On a planned we	Number at Stage				

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)					
		a. Pressure ulcer—any lesion damage of underlying tiss		d by pressure resulting in			
		b. Stasis ulcer—open lesion extremities	caused	by poor circulation in the lower			
M3.		Resident had an ulcer that wa	Resident had an ulcer that was resolved or cured in LAST 90 DAYS				
	RESOLVED ULCERS). No 1. Yes					
M4.	OTHER SKIN	a. Abrasions, bruises					
	PROBLEMS	b. Burns (second or third deg	gree)				
	OR LESIONS PRESENT	c. Open lesions other than ul	cers, ra	shes, cuts (e.g., cancer lesions)			
	(Chaple all that	d. Rashes—e.g., intertrigo, e	czema,	drug rash, heat rash, herpes			
	(Check all that apply during	zoster					
	last 7 days)	e. Skin desensitized to pain of	•				
		f. Skin tears or cuts (other that	an surge	ery)			
		g. Surgical wounds					
<u></u>	CIVIN	h. NONE OF ABOVE	`				
M5.	SKIN TREAT-	a. Pressure relieving device	,				
	MENTS	b. Pressure relieving device	,	ed			
	(Check all that	c. Turning/repositioning progd. Nutrition or hydration inter		to manago ekin probleme			
	àpply during	e. Ulcer care	VEHILIOH	to manage skin problems			
	last 7 days)	f. Surgical wound care					
			vith or v	vithout topical medications) other			
		than to feet					
		h. Application of ointments/m	nedication	ons (other than to feet)			
		i. Other preventative or prote	ective sl	kin care (other than to feet)			
		j. NONE OF ABOVE					
M6.	FOOT PROBLEMS			oblems—e.g., corns, callouses, ag toes, pain, structural problems			
	AND CARE	b. Infection of the foot—e.g.,		•			
	(Check all that	c. Open lesions on the foot	oonanac	s, paraiorit arainago			
	apply during last 7 days)	d. Nails/calluses trimmed du	ring las	t 90 days			
	ast / days)			ve foot care (e.g., used special			
		shoes, inserts, pads, toe s		•			
		f. Application of dressings (with or without topical medications)					
N1.	TIME	g. NONE OF ABOVE (Check appropriate time periods	over last	t 7 days)			
' ' '	AWAKE	Resident awake all or most of time (i.e., naps no more than one hour					
		per time period) in the: a. Morning c. Evening					
		b. Afternoon d. NONE OF ABOVE					
(lf ı	resident is co	matose, skip to Section	matose, skip to Section O)				
N2.	AVERAGE	(When awake and not receiving treatments or ADL care)					
	TIME INVOLVED IN ACTIVITIES	0. Most—more than 2/3 of tin 1. Some—from 1/3 to 2/3 of t		2. Little—less than 1/3 of time 3. None			
01.	NUMBER OF MEDICA-	(Record the number of different "0" if none used)	medica	tions used in the last 7 days; enter			
03.	TIONS	(Pecard the number of DAVS ini	octions	of any type received during the	\vdash		
		last 7 days; enter "0" if none u	sed)				
04.	DAYS RECEIVED	(Record the number of DAYS du Note—enter "1" for long-acti					
	THE FOLLOWING	a. Antipsychotic		d. Hypnotic			
	MEDICATION	b. Antianxiety		e. Diuretic			
		c. Antidepressant					
P1.	SPECIAL			ments or programs received			
	TREAT- MENTS,	during the last 14 days					
	PROCE-	TREATMENTS		PROGRAMS			
	DURES, AND PROGRAMS	a. Chemotherapy		m. Alcohol/drug treatment			
		b. Dialysis		program			
		c. IV medication		n. Alzheimer's/dementia special			
		d. Intake/output		care unit			
		e. Monitoring acute medical		o. Hospice care			
		condition		p. Pediatric unit			
		f. Ostomy care		 q. Respite care r. Training in skills required to 			
		g. Oxygen therapy h. Radiation		return to the community			
		i. Suctioning		(e.g., taking medications, house work, shopping,			
		j. Tracheostomy care		transportation, ADLs)			
		k. Transfusions		s. NONE OF THE ABOVE			
1		I Ventilator or respirator					

Resi	dent Identifier_			
P1.	SPECIAL	b. THERAPIES - Record the number of days and total m	inutes ea	ch of the
	TREAT-	following therapies was administered (for at least 15 m	inutes a i	dav) in the last 7
	MENTS,	calendar days (Enter 0 if none or less than 15 min. da		
	PROCE-	[Note — count only post admission therapies]	,	
	DURES, AND	(A) = # of days administered for 15 minutes or more	DAYS	MIN
	PROGRAMS	(B) = total # of minutes provided in last 7 days	(A)	(B)

TREAT- MENTS, PROCE- DURES, AND		DAYS MIN			
PROGRAMS	(B) = total # of minutes provided in last 7 days	(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				
	professional)				
NURSING REHABILITA-	Record the NUMBER OF DAYS each of the following restorative techniques or practices was provided to the				

	(A) = # or days administered for 15 minutes or more DA13			IVIIIV				
PROGRAMS	(B) = total # of minutes pro	vided in	last 7 days	(A)		([3)	
	a. Speech - language patho	logy and	audiology services					
	b. Occupational therapy							
	c. Physical therapy							
	d. Respiratory therapy							
	Psychological therapy (by professional)	any lice	ensed mental health					
TION/ RESTOR-	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							
ATIVE CARE	a. Range of motion (passive)		f. Walking					
	b. Range of motion (active)		g. Dressing	or groom	ning			
	c. Splint or brace assistance		h. Eating or	swallowi	ng			
	TRAINING AND SKILL PRACTICE IN:		i. Amputatio	on/prosth	esis ca	re		
	d. Bed mobility		j. Communio	cation				
	e. Transfer		k. Other					
DEVICES	Use the following codes fo	r last 7	days:					
	0. Not used							
	Used less than daily							
	2. Used daily							
	Bed rails							
	a. —Full bed rails on all o	pen side	es of bed					
	b. —Other types of side ra	ails use	d (e.g., half rail, one	side)				
	c. Trunk restraint							
	d. Limb restraint							
	e. Chair prevents rising							
PHYSICIAN VISITS	facility) how many days ha	as the p	hysician (or authorize			r		
	NURSING REHABILITATION/ RESTORATIVE CARE DEVICES AND RESTRAINTS	PROGRAMS (B) = total # of minutes pro a. Speech - language patholo b. Occupational therapy d. Respiratory therapy e. Psychological therapy (by professional) NURSING REHABILITATION/ RESTOR- ATIVE CARE RESTOR- ATIVE CARE RESTOR- ATIVE CARE DEVICES AND RESTRAINTS LUSE the following codes for the following codes fo	PROGRAMS (B) = total # of minutes provided in a. Speech - language pathology and b. Occupational therapy c. Physical therapy d. Respiratory therapy e. Psychological therapy (by any lice professional) NURSING REHABILITATION/ RESTOR-ATIVE CARE RESTOR-ATIVE CARE DEVICES AND RESTRAINTS RESTRAINTS DEVICES AND RESTRAINTS DEVICES AND C. Transfer Use the following codes for last 7 0. Not used 1. Used less than daily 2. Used daily Bed rails a. —Full bed rails on all open side b. —Other types of side rails used c. Trunk restraint e. Chair prevents rising PHYSICIAN VISITS PHYSICIAN IN CACHERAL OF CONTRAINED AND STAND PROPRIES AND PRESTRAINT (C. Trunk restraint e. Chair prevents rising PHYSICIAN VISITS	RESTRAINTS DEVICES AND RESTRAINTS RESTRAINTS DEVICES AND RESTRAINTS RESTRAINTS DEVICES AND RESTRAINTS RESTRAINTS DEVICES AND RESTRAINTS RESTRAINTS RESTRAINTS DEVICES AND RESTRAINTS RESTRA	READBILITATION/ RESTOR- ATIVE CARE DEVICES AND RESTRAINTS DEVICES AND RESTRAINTS DEVICES AND RESTRAINTS DEVICES AND RESTRAINTS RESTRAINTS RESTRAINTS (A) a. Speech - language pathology and audiology services b. Occupational therapy d. Respiratory therapy e. Psychological therapy (by any licensed mental health professional) Record the NUMBER OF DAYS each of the following rehabiling restorative techniques or practices was provided to the resignate than or equal to 15 minutes per day in the last 7 day (ENTER 0 if none or less than 15 min. daily.) a. Range of motion (passive) b. Range of motion (active) c. Splint or brace assistance TRAINING AND SKILL PRACTICE IN: d. Bed mobility e. Transfer Use the following codes for last 7 days: 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 PHYSICIAN VISITS (A) (A) (A) (A) (A) (A) (A) (A	REATIVE CARE DEVICES AND RESTRAINTS RESTRAINTS (B) = total # of minutes provided in last 7 days (A) a. Speech - language pathology and audiology services b. Occupational therapy c. Physical therapy d. Respiratory therapy e. Psychological therapy (by any licensed mental health professional) Record the NUMBER OF DAYS each of the following rehabilitation of restorative techniques or practices was provided to the residents in more than or equal to 15 minutes per day in the last 7 days (ENTER 0 if none or less than15 min. daily.) a. Range of motion (passive) b. Range of motion (active) c. Splint or brace assistance TRAINING AND SKILL PRACTICE IN: d. Bed mobility e. Transfer Use the following codes for last 7 days: 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 PHYSICIAN INSITS PHYSICIAN INSITS	READILITATION/ RESTOR- ATIVE CARE DEVICES AND RESTRAINTS RESTRAINTS (B) = total # of minutes provided in last 7 days (A) (B) (B) = total # of minutes provided in last 7 days (A) (B) (B) = total # of minutes provided in last 7 days (B) = total # of minutes provided in last 7 days (C) (C) (C) (C) (C) (C) (C) (C) (C) (C	RESTRAINTS (B) = total # of minutes provided in last 7 days a. Speech - language pathology and audiology services b. Occupational therapy c. Physical therapy d. Respiratory therapy e. Psychological therapy (by any licensed mental health professional) NURSING REHABILITA- TIONV RESTOR- ATIVE CARE ATIVE CARE 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 than15 min. daily.) a. Range of motion (passive) b. Range of motion (active) c. Splint or brace assistance TRAINING AND SKILL PRACTICE IN: d. Bed mobility e. Transfer Use the following codes for last 7 days: 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 d. Limb 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

		Numeric Identifier					
P8.		the LAST 14 DAYS (or since admission if less than 14 days in cility) how many days has the physician (or authorized assistant or ractitioner) changed the resident's orders? Do not include order enewals without change. (Enter 0 if none)					
Q1.	Q1. DISCHARGE POTENTIAL a. Resident expresses/indicates preference to return to the community						
		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 2. Deteriorated—receives fewer supports, needs less restrictive level of care					
R2.	SIGNATURE (DF PERSON COORDINATING THE ASSESSMENT:					
b. 🗅		Assessment Coordinator (sign on above line) ment Coordinator tee Month Day Year					
T1.	SPECIAL TREATMENTS	Skip unless this is a Medicare 5 day or Medicare readmission/return assessment					
	AND PROCE- DURES	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.					
		d. Through day15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered.					
	CASEMIY						
T3.	GROUP	Medicare State State					

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:	
		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)	
		b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	