

the code in the column labeled (A). If the resident has an amputation on one side of the body, use Code "1", Limitation on one side of the body. If there are bilateral amputations, use code "2", Limitation on both sides of the body.

- 0. **No limitation** — Resident has full function range of motion on the right and left side.
- 1. **Limitation on one side of the body (either right or left side).**
- 2. **Limitation on both sides of the body.**

**Example of Coding for  
(A) Limitation in Range of Motion**

Mr. O was admitted to the nursing home for rehabilitation following right knee surgery. His right leg is in an immobilizer. With the exception of his right leg, Mr. O has full active range of motion in all other areas.

Coding (A)	
Neck	0
Arm	0
Hand	0
Leg	1
Foot	0
Other	0

**(B) Loss of voluntary movement.**

**Definition:** Loss of voluntary movement — Impairment in purposeful (intentional) functional movement. This category refers to a range of impairments exhibited when a resident tries to perform a task and includes deficits such as incoordination, tremors, spasms, muscular rigidity, "freezing", choreiform movements (jerking) as well as lack of initiation of movement. Impairments in voluntary movement are often due to injury or disease of muscles, bones, nerves, spinal cord or the brain and can place a resident at risk for functional disability and injury.

**Process:** While performing the assessment of range of motion in item G4(A) above, observe the resident for impairment(s) in purposeful movement on each side of the resident's body.

**Coding:** For each body part, code the appropriate response for the resident's function during the past seven days. Enter the code in the column labelled (B). If the body part is missing on one side (e.g., left above knee amputation), code "1",

Partial loss of voluntary movement. If missing bilaterally, code "2", Full loss of voluntary movement.

- 0. No loss of voluntary movement — Resident moves body part to complete the required task. Movements are smooth and coordinated.
- 1. Partial loss of voluntary movement — Resident is able to initiate and complete the required task but movements are slow, spastic, uncoordinated, rigid, choreiform frozen, etc. on one or both sides.
- 2. Full loss of voluntary movement — Resident is not able to initiate the required task. There is no voluntary movement on either side.

**Example of Function Limitation**

Mrs. X is a diabetic who sustained a CVA 2 months ago. She can only turn her head slightly from side to side and tip her head towards each shoulder (limited neck range of motion). She can perform all arm, hand, and leg motions on the right side, with smooth coordinated movements. She is unable to move her left side (limited arm, hand, and leg motion) as she has a flaccid left hemiparesis. She is able to extend her legs flat on the bed. She has no feet. She has no other limitations.

	Coding	
	(A) Limitation in Range of Motion	(B) Loss of Voluntary Movement
a. Neck	2	0
b. Arm	1	1
c. Hand	1	1
d. Leg	1	1
e. Foot	2	2
f. Other	0	0

**5. Modes of Locomotion**

*Intent:* To record the type(s) of appliances, devices, or personal assistance the resident used for locomotion (on and off unit).

*Definition:* **Cane/walker/crutch** — Also check this item in those instances where the resident walks by pushing a wheelchair for support.

**Wheeled self** — Includes using a hand-propelled or motorized wheelchair, as long as the resident takes responsibility for self-mobility, even for part of the time.

**Other person wheeled** — Another person pushed the resident in a wheelchair.

**Wheelchair primary mode of locomotion** — Even if resident walks some of the time, he or she is primarily dependent on a wheelchair to get around. The wheelchair may be motorized, self-propelled, or pushed by another person.

**Coding:** Check all that apply during the last 7 days. If no appliances or assistive devices were used, check *NONE OF ABOVE*.

## 6. Modes of Transfer

**Intent:** To record the type(s) of appliances or assistive devices the resident used for transferring in and out of bed or chair, and for bed mobility.

**Definition:** **Bedfast all or most of the time** — Resident is in bed or in a recliner in own room for 22 hours or more per day. This definition also includes residents who are primarily bedfast but have bathroom privileges. For care planning purposes this information is useful for identifying residents who are at risk of developing physical and functional problems associated with restricted mobility, as well as cognitive, mood, and behavior impairment related to social isolation. Code this item when it was true on at least 4 of the last 7 days.

**Bed rail(s) used for bed mobility or transfer** — Refers to any type of side rail(s) attached to the bed USED by the resident as a means of support to facilitate turning and repositioning in bed, as well as for getting in and out of bed. Do not check this item if resident did not use rails for this purpose.

**Lifted manually** — The resident was completely lifted by one or more persons.

**Lifted mechanically** — The resident was lifted by a mechanical device (e.g., Hoyer lift). Does not include a bath lift.

**Transfer Aid** — Includes devices such as slide boards, trapezes, canes, walkers, braces and other assistive devices.

**Coding:** Check all that apply. If none of these items apply, check *NONE of ABOVE*.

## 7: Task Segmentation

**Intent:** To identify residents who are more involved and independent in personal care tasks (such as eating, bathing, grooming, dressing) because they have received help in breaking tasks down into smaller steps. Some residents become overwhelmed and anxious when there are expectations for greater independence and they are no longer able to perform the steps necessary to complete an ADL activity. Such residents are at great risk for becoming dependent on others unless activities are made easier for them to manage by task segmentation. These residents usually have some deficits in memory, thinking, or paying attention to the task consequent to problems such as dementia, head injury, CVA, or depression. Other residents receive task segmentation care because of body-control problems, poor stamina, or other physical difficulties that limit self-performance.

**Definition:** Task segmentation provides the resident with directions — such as verbal cues, physical cues, or verbal and physical cues — for performing each constituent step in an ADL activity.

Verbal cueing involves giving a verbal direction to complete the first step in a task, and once the step is accomplished, giving another verbal direction to complete the next step. Verbal encouragement, praise, and feedback for the resident's successful completion of the steps are usually given by the direct care staff person prior to providing the next verbal cue. For example, "That looks good. Now put on this skirt."

Physical cueing involves giving the resident an object as a reminder of what needs to be done — e.g., handing the resident some toilet paper as a cue to wipe self, or placing an item from a food tray in front of the resident and handing him or her a fork as a cue to eat the item.

Physical and verbal cueing involves use of objects and words to stimulate action — e.g., giving the resident one item of clothing at a time and saying "Put this shirt on," which is less confusing to a cognitively impaired resident than putting all clothing items before him or her and saying "Get dressed."

<b>Examples</b>	
<b>Task Segmentation</b>	<b>No Task Segmentation</b>
<ul style="list-style-type: none"> <li>• When handed a soapy face cloth and asked, "Would you please wash your face?", the resident washes her face.</li>   <li>• When a nurse assistant sets a mirror in front of the resident, and hands him a brush, the resident brushes his hair.</li>   <li>• When the nurse assistant hands the resident a sock and says "Put this sock on this foot" and upon completion of the step hands the resident another sock and says "Put this sock on this foot," the resident dons his socks.</li>   <li>• When single food items and only one utensil are presented to the resident in succession, the resident eats independently.</li>   <li>• When a nurse assistant gives verbal directions for each step in transferring from a wheelchair (e.g., "Lock the brakes... Hold onto the arms of the chair and push yourself up... Hold onto your walker with both hands like this [demonstrates]"), the resident succeeds in transferring himself from a seated to a standing position.</li> </ul>	<ul style="list-style-type: none"> <li>• When a wash basin, a face cloth, a towel, and various grooming supplies are placed before the resident, the resident becomes overwhelmed.</li>   <li>• When a nurse assistant places the resident's clothes for the day on the bed and says, "Get dressed," the resident becomes confused and is unable to dress self.</li>   <li>• When a tray containing an entire meal and several different utensils are placed before the resident on a table, the resident becomes confused and is unable to eat by herself.</li>   <li>• When a nurse assistant lifts a resident from a sitting to a standing position and does not involve the resident in the process of self-care in the activity, the resident becomes more physically dependent on the nurse assistant.</li> </ul>
<p>For all above examples, Code "1" for Yes.</p>	<p>For all above examples, Code "0" for No.</p>

**Process:** Ask the nurse assistant to think about how the resident completes activities of daily living, or ways the nurse assistant helped the resident complete an activity of daily living over the last seven days. Specifically: Did the nurse assistant break the ADL activity into subtasks (smaller steps) so that the resident could perform them? Did this occur in the last seven days?

**Coding:** Code "0" if task segmentation was not done. Code "1" if ADLs were broken into a series of subtasks so that resident could perform them.

## 8. ADL Functional Rehabilitation Potential

**Intent:** To describe beliefs and characteristics related to the resident's functional status that may indicate he or she has the capacity for greater independence and involvement in self-care in at least some ADL areas. Even if highly independent in an activity, the resident may believe he or she can do better (e.g., walk longer distances, shower independently).

**Process:** Ask if the resident thinks he or she could be more self-sufficient given more time. Listen to and record what the resident believes, even if it appears unrealistic. Also, as a clue to whether the resident might do better all the time, ask if his or her ability to perform ADLs varies from time to time, or if ADL function or joint range of motion has declined or improved in the last three months.

Ask direct care staff (e.g., nurse assistants on all shifts) who routinely care for the resident if they think he or she is capable of greater independence, or if the resident's performance in ADLs varies from time to time. Ask if ADL function or range of motion of joints declined or improved in the last three months. You may need to prompt staff to consider such factors as:

- Has self-performance in any ADL varied over the last week (e.g., the resident usually requires two-person assistance but on one day transferred out of bed with assistance of one person)?
- Has resident's performance varied during the day (e.g., more involved and independent in the afternoon than in the morning)?
- Was the resident so slow in performing some activities that staff members intervened and performed the task or activity? Is the resident capable of increased self-performance when given more time? - OR - Is the resident capable of increased self-performance when tasks are broken into manageable steps?

- Does the resident tire noticeably during most days?
- Does the resident avoid an ADL activity even though physically or cognitively capable (e.g., refuses to walk alone for fear of falling, demands that others attend to personal care because they do it better)?
- Has the resident's performance in any ADL improved?

**Coding:** Check all that apply. If none of these items apply check *NONE OF ABOVE*.

#### Examples

Mr. N, who is cognitively impaired, receives limited physical assistance in locomotion for safety purposes. However, he believes he is capable of walking alone and often gets up and walks by himself when staff aren't looking. Check "a" (Resident believes he/she capable of increased independence).

The nurse assistant who totally feeds Mrs. W has noticed in the past week that Mrs. W has made several attempts to pick up finger foods. She believes Mrs. W could become more independent in eating if she received close supervision (cueing) in a small group for restorative care in eating. Check "b" (Direct care staff believes resident is capable of increased independence).

Mrs. Y has demonstrated the ability to get dressed, but has missed breakfast on several occasions because she was slow getting organized. Therefore, every morning her nurse assistant physically helped her to dress so that she would be ready for breakfast. Check "c" (Resident able to perform task but is very slow).

Mrs. F remained continent during day shifts while receiving supervision in toileting. During the evening and night shifts she was incontinent because she was not helped out of bed to the toilet room. After incontinence episodes, direct-care staff provided total help in hygiene. Check "d" (Difference in ADL self-performance or ADL support, comparing mornings to evenings).

Mr. K has hemiplegia secondary to a CVA. He receives extensive assistance in bed mobility transfer, dressing, toilet use, personal hygiene and eating. He is totally dependent in locomotion (wheelchair). Whenever he has tried to do more for himself he has experienced chest pain and shortness of breath. Both Mr. K and direct care staff believe that he is involved in self-care as much as he is physically able. Check "e" (*NONE OF ABOVE*).

## 9. Change in ADL Function

- Intent:** To document any changes occurring in the resident's overall ADL self-performance, as compared to status of 90 days ago (or since last assessment if less than 90 days ago). These include, but are not limited to, changes in the resident's level of involvement in ADL activities as well as the amount and the type of support received by staff. If the resident is a new admission to the facility, this item includes changes during the period prior to admission.
- Process:** Review the record for indications of a change. Consult with the resident and direct care staff. Review Section G from the last assessment and compare these findings with current findings. For new residents, consult with the primary family caregiver.
- Coding:** Code "0" if there has been no change. Code "1" if the resident's ADL function has improved. Code "2" if the resident's function has deteriorated. You may find that some ADLs have improved, some deteriorated, and others remain unchanged. You must weigh all of the information and make an overall clinical judgment (e.g., in general, the resident's ADL function has...).

### Examples

Dr. B had been highly involved in self-care in most ADL activities. Seven weeks ago he slipped, fell, and bruised his right wrist. For several weeks he received more extensive assistance with dressing, grooming, and eating. However, in the last three weeks he is functioning at the same level of involvement in ADLs as before the fall. Code "0" for No change.

Ms. A participated in a structured feeding group during the past six weeks. With lots of encouragement and supervision from the group leader, she has progressed from requiring extensive assistance to feeding herself under staff supervision. Her performance in other ADLs remains unchanged. Code "1" for Improved.

Since fracturing her left hip three weeks ago, Mrs. Z receives more weight bearing help with transfers, locomotion, dressing, toileting, personal hygiene, and bathing. However, she has made strides in OT and PT. Her improvement in self-care has been steady although she still has a long way to go to reach her Self-Performance level of 90 days ago. Code "2" for Deteriorated.

(continued on next page)

**Examples  
(continued)**

Mr. L's favorite nurse (Miss McC) transferred to another unit 30 days ago. Although he says he's happy for her, he has become more passive and withdrawn. He no longer dresses himself in a suit and tie. His personal hygiene habits have deteriorated and he now must be frequently coaxed to shave and wash himself and comb his hair. Because he now wears stained clothing, staff have started to select and set out his clothes each day. Despite these losses, Mr. L is now somewhat more self-sufficient in locomotion, making twice-a-week trips to see Miss McC on her new unit. Code "2" for Deteriorated. The *rationale* for the coding decision is that although some improvement is noted in one ADL activity (locomotion) it only occurs twice weekly. In general, Mr. L has deteriorated in his self-care performance in two ADL activities (dressing and personal hygiene) that require multiple daily tasks.

During a Significant Change assessment for severe mood distress, Mrs. M was found to be more dependent on others for physical assistance in personal hygiene, dressing and toileting. She also received more coaxing and encouragement to eat. These changes represented less involvement in self-care since the last assessment two months ago. Code "2" for Deteriorated.

## SECTION H. CONTINENCE IN LAST 14 DAYS

### 1. Continenence Self-Control Categories

**Note:** This section differs from the other ADL assessment items in that the time period for review has been extended to 14 days. Research has shown that 14 days are the minimum required to obtain an accurate picture of bowel continence patterns. For the sake of consistency, both bowel continence and bladder continence are evaluated over 14 days.

**Intent:** To determine and record the resident's pattern of bladder and bowel continence (control) over the last 14 days.

**Definition:** **Bladder and Bowel Continence** — Refers to control of urinary bladder function and/or bowel movement. This item describes the resident's bowel and bladder continence pattern even with scheduled toileting plans, continence training programs, or appliances. It does not refer to the resident's ability to toilet self — e.g., a resident can receive extensive assistance in toileting and yet

4. **Incontinent** — Has inadequate control. Bladder incontinent episodes occur multiple times daily; Bowel incontinent is all (or almost all) of the time.

**Coding:** Choose one response to code level of bladder continence and one response to code level of bowel continence for the resident over the last 14 days.

Code for the resident's actual bladder and bowel continence pattern — i.e., the frequency with which the resident is wet and dry during the 14 day assessment period. Do not record the level of control that the resident might have achieved under optimal circumstances.

For bladder incontinence, the difference between a code of "3" (Frequently Incontinent) and "4" (Incontinent) is determined by the presence ("3") or absence ("4") of any bladder control.

**Examples of Bladder Continence Coding**

Mr. Q was taken to the toilet after every meal, before bed, and once during the night. He was never found wet and is considered continent. Code "0" for "Continent" — Bladder.

Mr. R had an indwelling catheter in place during the entire 14 day assessment period. He was never found wet and is considered continent. Code "0" for "Continent" — Bladder.

Although she is generally continent of urine, every once in a while (about once in 2 weeks) Mrs. T doesn't make it to the bathroom to urinate in time after receiving her daily diuretic pill. Code "1" for "Usually Continent" — Bladder.

Mrs. A has less than daily episodes of urinary incontinence, particularly late in the day when she is tired. Code "2" for "Occasionally Incontinent" — Bladder.

Mr. S is comatose. He wears an external (condom) catheter to protect his skin from contact with urine. This catheter has been difficult for staff to manage as it keeps slipping off. They have tried several different brands without success. During the last 14 days Mr. S has been found wet at least twice daily on the day shift. Code "3" for "Frequently Incontinent" — Bladder.

Mrs. U is terminally ill with end-stage Alzheimer's disease. She is very frail and has stiff, painful contractures of all extremities. She is primarily bedfast on a special water mattress, and is turned and re-positioned hourly for comfort. She is not toileted and is incontinent of urine for all episodes. Code "4" for "Incontinent" — Bladder.

## 2. Bowel Elimination Pattern

**Intent:** To record the effectiveness of resident's bowel function.

**Definition:** **Bowel elimination pattern regular** — Resident has at least one movement every three days.

**Constipation** — Resident passes two or fewer bowel movements per week, or strains more than one out of four times when having a bowel movement.

**Diarrhea** — Frequent elimination of watery stools from any etiology (e.g., diet, viral or bacterial infection).

**Fecal impaction** — The presence of hard stool upon digital rectal exam. Fecal impaction may also be present if stool is seen on abdominal x-ray in the sigmoid colon or higher, even with a negative digital exam or documentation in the clinical record of daily bowel movement.

**Process:** Ask the resident. Examine, if necessary. Review the clinical record, particularly any documentation flow sheets of bowel elimination patterns. Ask direct care staff (e.g., nurse assistants from all shifts).

**Coding:** Check all that apply in the last 14 days. If no items apply, check *NONE OF ABOVE*.

## 3. Appliances and Programs

**Definition:** **Any scheduled toileting plan** — A plan whereby staff members at scheduled times each day either take the resident to the toilet room, or give the resident a urinal, or remind the resident to go to the toilet. Includes habit training and/or prompted voiding.

**Bladder retraining program** — A retraining program where the resident is taught to consciously delay urinating (voiding) or resist the urgency to void. Residents are encouraged to void on a schedule rather than according to their urge to void. This form of training is used to manage urinary incontinence due to bladder instability.

**External (condom) catheter** — A urinary collection appliance worn over the penis.

**Indwelling catheter** — A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. Includes catheters inserted through the urethra or by supra-pubic incision.

**Intermittent catheter** — A catheter that is used periodically for draining urine from the bladder. This type of catheter is usually removed immediately after the bladder has been emptied. Includes intermittent catheterization whether performed by a licensed professional or by the resident. Catheterization may occur as a one-time event (e.g., to obtain a sterile specimen) or as part of a bladder emptying program (e.g., every shift in a resident with an underactive or acontractile bladder muscle).

**Did not use toilet room/commode/urinal** — Resident never used any of these items during the last 14 days, nor used a bed pan.

**Pads/brief used** — Any type of absorbent, disposable or reusable undergarment or item, whether worn by the resident (e.g., diaper, adult brief) or placed on the bed or chair for protection from incontinence. Does not include the routine use of pads on beds when a resident is never or rarely incontinent.

**Enemas/irrigation** — Any type of enema or bowel irrigation, including ostomy irrigations.

**Ostomy present** — Any type of ostomy of the gastrointestinal or genitourinary tract.

**Process:** Check the clinical record. Consult with nurse assistant and the resident. Be sure to ask about any items that are usually hidden from view because they are worn under street clothing (e.g., pads or briefs).

**Coding:** Check all that apply. If none of the items apply, check *NONE OF ABOVE*.

#### 4. Change in Urinary Continence

**Intent:** To document changes in the resident's urinary continence status as compared to 90 days ago (or since last assessment if less than 90 days ago), including any changes in self-control categories, appliances, or programs. If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

**Process:** Review the resident's clinical record and Bladder Continence patterns as recorded in the last assessment (if available). Validate findings with the

resident and direct care staff on all shifts. For new residents, consult with the primary family caregiver.

**Coding:** Code "0" for No change, "1" for Improvement, or "2" for Deteriorated. A resident who was incontinent 90 days ago who is now continent by virtue of a catheter should be coded as "1", Improved. See fourth example in the box below.

#### Examples of Change in Urinary Continence

During an outbreak of gastroenteritis at the nursing home six weeks ago, Mrs. L, who is usually continent, became totally incontinent of bladder and bowel. This problem lasted only two weeks and she has been continent for the last month. Code "0" for No change.

Dr. R had prostate surgery three months ago. Prior to surgery, he was frequently incontinent. Upon returning from the hospital, his indwelling catheter was discontinued. Although he initially experienced incontinence, he now remains dry with only occasional incontinence. He sings the praises of surgery to his peers. Code "1" for Improved.

Mrs. B is a new admission. Both she and her daughter report that she has never been incontinent of urine. By her third day of residency, her urinary incontinence became evident, especially at night. Code "2" for Deteriorated.

Two weeks ago Mr. K returned from the hospital following plastic surgery for a pressure ulcer. Prior to hospital admission, Mr. K was totally incontinent of urine. He is now continent with an indwelling catheter in place. Code "1" for Improved. *Rationale:* Although one could perceive that Mr. K had "deteriorated" because he now has a catheter for bladder control, remember that the MDS definition for bladder continence states "Control of bladder function with appliances (e.g., foley) or continence programs, if employed."

## SECTION I. DISEASE DIAGNOSES

**Intent:** To document the presence of diseases that have a relationship to the resident's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death. In general, these are conditions that drive the current care plan. Do not include conditions that have been resolved or no longer affect the resident's functioning or care plan. In many facilities, clinical staff and physicians neglect to update the list of

resident's "active" diagnoses. There may also be a tendency to continue old diagnoses that are either resolved or no longer relevant to the resident's plan of care. One of the important functions of the MDS assessment is to generate an updated, accurate picture of the resident's health status.

**Definition:** **Nursing monitoring** — Includes clinical monitoring by a licensed nurse (e.g., serial blood pressure evaluations, medication management, etc.)

## 1. Diseases

**Definition:** **Diabetes mellitus** — Includes insulin-dependent diabetes mellitus (IDDM) and diet-controlled diabetes mellitus (NIDDM or AODM).

**Cardiac dysrhythmias** — Disorder of heart rate or heart rhythm.

**Peripheral vascular disease** — Vascular disease of the lower extremities that can be of venous and/or arterial origin.

**Arthritis** — Includes degenerative joint disease (DJD), osteoarthritis (OA), and rheumatoid arthritis (RA). Record more specific forms of arthritis (e.g., Sjogren's syndrome; gouty arthritis) in Item I3 (with ICD-9-CM code).

**Hip fracture** — Includes any hip fracture that occurred at any time that continues to have a relationship to current status, treatments, monitoring, etc. Hip fracture diagnoses also include femoral neck fractures, fractures of the trochanter, subcapital fractures.

**Missing limb (e.g., amputation)** — Includes loss of any part of any upper or lower extremity.

**Pathological bone fracture** — Fracture of any bone due to weakening of the bone, usually as a result of a cancerous process.

**Aphasia** — A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (i.e., speaking, writing), or understanding spoken or written language.

**Cerebral palsy** — Paralysis related to developmental brain defects or birth trauma.

**Cerebrovascular accident (CVA/Stroke)** — A vascular insult to the brain that may be caused by intracranial bleeding, cerebral thromboses, infarcts, emboli.

**Dementia other than Alzheimer's** — Includes diagnoses of organic brain syndrome (OBS) or chronic brain syndrome (CBS), senility, senile dementia, multi-infarct dementia, and dementia related to neurologic diseases other than Alzheimer's (e.g., Picks, Creutzfeld-Jacob, Huntington's disease, etc.).

**Hemiplegia/hemiparesis** — Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor. There must be a diagnosis of hemiplegia or hemiparesis in the resident's record.

**Paraplegia** — Paralysis (temporary or permanent impairment of sensation, function, motion) of the lower part of the body, including both legs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury. There must be a diagnosis of paraplegia in the resident's record.

**Quadriplegia** — Paralysis (temporary or permanent impairment of sensation, function, motion) of all four limbs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury. There must be a diagnosis of quadriplegia in the resident's record.

**Transient ischemia attack** — A sudden, temporary, inadequate supply of blood to a localized area of the brain. Often recurrent.

**Traumatic brain injury** — Damage to the brain as a result of physical injury to the head.

**Manic depressive (bipolar disease)** — Includes documentation of clinical diagnoses of either manic depression or bipolar disorder. "Bipolar disorder" is the current term for manic depressive illness.

**Emphysema/COPD** — Includes COPD (chronic obstructive pulmonary disease) or COLD (chronic obstructive lung disease), chronic restrictive lung diseases such as asbestosis, and chronic bronchitis.

**Allergies** — Any hypersensitivity caused by exposure to a particular allergen. Includes agents (natural and artificial) to which the resident is susceptible for an allergic reaction, not only those to which he or she currently reacted to in the last seven days. This item includes allergies to drugs (e.g., aspirin, antibiotics), foods (e.g., eggs, wheat, strawberries, shellfish, milk), environmental substances (e.g., dust, pollen), animals (e.g., dogs, birds, cats), and cleaning products (e.g., soap, laundry detergent), etc. Hypersensitivity reactions include but are not limited to, itchy eyes, runny nose, sneezing, contact dermatitis, etc.

Anemia — Includes anemia of any etiology.

**Process:** Consult transfer documentation and medical record (including current physician treatment orders and nursing care plans). If the resident was admitted from an acute care or rehabilitation hospital, the discharge forms often list diagnoses and corresponding ICD-9-CM codes that were current during the hospital stay. If these diagnoses are still active, record them on the MDS form. Also, accept statements by the resident that seem to have clinical validity. Consult with physician for confirmation and initiate necessary physician documentation.

Physician involvement in this part of the assessment process is crucial. The physician should be asked to review the items in Section I at the time of visit closest to the scheduled MDS assessment. Use this scheduled visit as an opportunity to ensure that active diagnoses are noted and "inactive" diagnoses are designated as resolved. This is also an important opportunity to share the entire MDS assessment with the physician. In many nursing facilities physicians are not brought into the MDS review and assessment process. It is the responsibility of facility staff to aggressively solicit physician input. Inaccurate or missed diagnoses can be a serious impediment to care planning. Thus, you should share this section of the MDS with the physician and ask for his or her input. Physicians completing a portion of the MDS assessment should sign in Item R2 (Signatures of Those Completing the Assessment).

Full physician review of the most recent MDS assessment or ongoing input into the assessment currently being completed can be very useful. For the physician, the MDS assessment completed by facility staff can provide insights that would have otherwise not been possible. For staff, the informed comments of the physician may suggest new avenues of inquiry, or help to confirm existing observations, or suggest the need for additional follow-up.

Check a disease item only if the disease has a relationship to current ADL status, cognitive status, behavior status, medical treatment, nursing monitoring, or risk of death. For example, it is not necessary to check "hypertension" if one episode occurred several years ago unless the hypertension is either currently being controlled with medications, diet, biofeedback, etc., or is being regularly monitored to prevent a recurrence.

**Coding:** Do not record any conditions that have been resolved and no longer affect the resident's functional status or care plan.

Check all that apply. If none of the conditions apply, check *NONE OF ABOVE*. If you have more detailed information available in the clinical record for a more definitive diagnosis than is provided in the list in Section II, check the more general diagnosis in II and then enter the more detailed diagnosis (with ICD-9-CM code) under I3.

**For example:** If the record reveals that the resident has "osteoarthritis" you check item I11 (Arthritis) and record "Osteoarthritis" with ICD-9-CM Code 715.00 in Section I3.

Consult the resident's transfer documentation (in the case of new admissions or re-admissions) and current medical record including current nursing care plans. There will be times when a particular diagnosis will not be documented in the medical record. If that is the case, as indicated above, accept statements by the resident that seem to have clinical validity, consult with the physician for confirmation, and initiate necessary physician documentation.

**For example:** If a new resident says he or she had a severe depression and was seeing a private psychiatrist in the community, this information may have been missed if the information was not carried forward in records accompanying the resident from an acute care hospital to the nursing home.

The following chart of ICD-9-CM codes for diseases listed in Item I1 is intended to clarify the level of specificity represented when the disease item is checked. This is also the list to use in computer applications of the MDS.

<b>ICD-9-CM Codes for Diseases Listed in Section I1</b>	
<b>ICD-9-CM Code</b>	<b>Disease Condition</b>
<b>ENDOCRINE/METABOLIC/NUTRITIONAL</b>	
250.00	Diabetes mellitus
242.9[0 or1]	Hyperthyroidism
244.9	Hypothyroidism
<b>HEART/CIRCULATION</b>	
414.00 through 414.03	Arteriosclerotic heart disease (ASHD)
427.9	Cardiac dysrhythmia
428.0	Congestive heart failure
453.8	Deep vein thrombosis
401.9	Hypertension (unspecified)
458.9	Hypotension (unspecified)
443.9	Peripheral vascular disease (unspecified)
429.2	Other cardiovascular disease
<b>MUSCULOSKELETAL</b>	
716.90	Arthritis (unspecified site)
820.9	Hip fracture (unspecified site or NOS [not otherwise specified])
736.89	Missing limb (e.g., amputation)
733.00	Osteoporosis (unspecified)
733.10.	Pathological bone fracture (unspecified sites)

*(Continued on next page)*

**ICD-9-CM Codes for Diseases Listed in Section II**  
(Continued)

ICD-9-CM Code	Disease Condition
<b>NEUROLOGICAL</b>	
331.0	Alzheimer's disease
784.3	Aphasia
343.90	Cerebral palsy (unspecified)
436	Cerebrovascular accident (stroke) (NOS acute)
290.0	Dementia other than Alzheimer's (Senile Dementia, NOS)
342.90 through 342.92	Hemiplegia/Hemiparesis
340	Multiple sclerosis (NOS)
344.1	Paraplegia
332.0	Parkinson's disease
344.00 through 344.09	Quadriplegia
780.3	Seizure disorder
435.9	Transient ischemic attack (TIA) (unspecified)
854.00	Traumatic brain injury (unspecified)
<b>PSYCHIATRIC/MOOD</b>	
300.00	Anxiety disorder (unspecified)
311	Depression
296.8	Manic depression (bipolar disease)
295.90	Schizophrenia (unspecified)
<b>PULMONARY</b>	
493.90	Asthma (unspecified)
492.8	Emphysema
496	COPD
<b>SENSORY</b>	
366.9	Cataracts (unspecified)
362.01, 362.02 and 250.50 through 250.53	Diabetic retinopathy
365.9	Glaucoma (unspecified)
362.50	Macular degeneration (unspecified)
<b>OTHER</b>	
995.3	Allergies (unspecified)
285.9	Anemia
199.1	Cancer (unspecified as to site or stage)
586	Renal failure (unspecified)

*ICD-9-CM: The International Classification of Diseases - 9th Revision - Clinical Modification.* Ann Arbor, Michigan: Edward Brothers, Inc., October, 1989.

## 2. Infections

**Definition:** **Antibiotic resistant infection** (e.g., Methicillin resistant staph) — An infection in which bacteria have developed a resistance to the effective actions of an antibiotic. Check this item only if there is supporting documentation in the clinical record (including transmittal records of new admissions and recent transfers from other institutions).

**Clostridium difficile (C.diff)** — Diarrheal infection caused by the Clostridium difficile bacteria. Check this item only if there is supporting documentation in the clinical record of new admissions and recent transfers (e.g., hospital referral or discharge summary, laboratory report).

**Conjunctivitis** — Inflammation of the mucous membranes lining the eyelids. May be of bacterial, viral, allergic, or traumatic origin.

**HIV infection** — Check this item only if there is supporting documentation or the resident (or surrogate decision-maker) informs you of the presence of a positive blood test result for the Human Immunodeficiency Virus or diagnosis of AIDS.

**Pneumonia** — Inflammation of the lungs; most commonly of bacterial or viral origin.

**Respiratory infection** — Any upper or lower (e.g., bronchitis) respiratory infection other than pneumonia.

**Septicemia** — Morbid condition associated with bacterial growth in the blood.

**Sexually transmitted diseases** — Check this item only if there is supporting documentation of a current diagnosis of gonorrhea, or syphilis. DO NOT include HIV in this category.

**Tuberculosis** — Includes residents with active tuberculosis or those who have converted to PPD positive tuberculin status and are currently receiving drug treatment (e.g., isoniazid (INH), ethambutol, rifampin, cycloserine) for tuberculosis.

**Urinary tract infection** — Includes chronic and acute symptomatic infection(s) in the last 30 days. Check this item only if there is current supporting documentation and significant laboratory findings in the clinical record.

**Viral hepatitis** — Inflammation of the liver of viral origin. This category includes diagnoses of hepatitis A, hepatitis B, hepatitis non-A non-B, and hepatitis C.

**Wound infection** — Infection of any type of wound (e.g., surgical; traumatic; pressure) on any part of the body.

**Process:** Consult transfer documentation and the resident's clinical record (including current physician treatment orders and nursing care plans). Accept statements by the resident that seem to have clinical validity. Consult with physician for confirmation and initiate necessary physician documentation.

Physician involvement in this part of the assessment process is crucial.

**Coding:** Check an item only if the infection has a relationship to current ADL status, cognitive status, mood and behavior status, medical treatment, nursing monitoring, or risk of death. Do not record any conditions that have been resolved and no longer affect the resident's functional status or care plan. For example, do not check "tuberculosis" if the resident had TB several years ago unless the TB is either currently being controlled with medications or is being regularly monitored to detect a recurrence.

Check all that apply. If none of the conditions apply, check *NONE OF ABOVE*. If you have more detailed information available in the clinical record for a more definitive diagnosis than is provided in the list in Section I2 check the appropriate box in I2 and enter the more detailed information (with ICD-9-CM code) under I3.

**ICD-9-CM Codes for Diseases Listed in Section I2**

ICD-9-CM Code	Disease Condition
<b>INFECTION</b>	
041.9 or 041.11 or 041.19	Antibiotic resistant infection (e.g., methicillin resistant staph)
040.0	Clostridium difficile (C.diff)
372.30	Conjunctivitis
042	HIV infection
486	Pneumonia (organism unspecified)
038.9	Septicemia (not otherwise specified)
099.9	Sexually transmitted diseases (Venereal diseases) (unspecified)
011.90	Tuberculosis (pulmonary unspecified)
599.0	Urinary tract infection (site not specified)
070.9	Viral hepatitis (unspecified, without mention of hepatic coma)
958.3 or 998.5	Wound infection

*ICD-9-CM: The International Classification of Diseases - 9th Revision - Clinical Modification. Ann Arbor, Michigan: Edward Brothers, Inc., October, 1989.*

**3. Other Current Diagnoses and ICD-9-CM Codes**

**Intent:** To identify conditions not listed in Item I1 and I2 that affect the resident's current ADL status, mood and behavioral status, medical treatments, nursing monitoring, or risk of death. Also, to record more specific designations for general disease categories listed under I1 and I2.

**Coding:** Enter the description of the diagnoses on the lines provided. For each diagnosis, an ICD-9-CM code must be entered in the boxes to the right of the line. If this information is not available in the medical records, consult the most recent version of the full set of volumes of ICD-9-CM codes.

The person assigned to enter these codes should be trained in the ICD-9-CM assignment system. The task is best completed by a member of the medical record staff or the facility's medical record consultant. The person entering the ICD-9-CM codes must also enter his or her signature under MDS item R2, indicating that these codes were entered. The most recently updated version of the International Classification of Diseases - 9th Revision - Clinical Modification (ICD-9-CM) must be used. Volumes 1 and 2 of ICD-9-CM can be ordered from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Specify order number S/N 9176-014-000000-1. Facilities do not need to order Volume 3, which classifies surgical, diagnostic, and nonsurgical procedures.

## SECTION J. HEALTH CONDITIONS

### 1. Problem Conditions

To record specific problems or symptoms that affect or could affect the resident's health or functional status, and to identify risk factors for illness, accident, and functional decline.

**INDICATORS OF FLUID STATUS** — It is often difficult to recognize when a frail, chronically ill elder is experiencing fluid overload that could precipitate congestive heart failure, or alternatively dehydration. Ways to monitor the problem, particularly in residents who are unable to recognize or report the common symptoms of fluid variation, are as follows:

**Definition:** **Weight gain or loss of 3 or more pounds within a 7-day period** — This can only be determined in residents who are weighed in the same manner at least weekly. However, the majority of residents will not require weekly or more frequent weights, and for these residents you will be unable to determine whether there has been a 3 or more pound gain or loss. When this is the case, leave this item blank.

**Inability to lie flat due to shortness of breath** — resident is uncomfortable lying supine. Resident requires more than one pillow or having the head of the bed mechanically raised in order to get enough air. This symptom often occurs with fluid overload. If the resident has shortness of breath when not lying flat, also check item J11 "Shortness of breath." If the resident does not have shortness of breath when upright (e.g., O.K. when using two pillows or sitting up) do not check item J11.

**Dehydrated; output exceeds intake** — check this item if the resident has 2 or more of the following indicators.

- Resident usually takes in less than the recommended 2500 ml of fluids daily (water or liquids in beverages, and water in food).
- Resident has clinical signs of dehydration.
- Resident's fluid loss exceeds the amount of fluids he or she takes in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).

**Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days** — Liquids can include water, juices, coffee, gelatins, and soups.

**OTHER**

**Delusions** — Fixed, false beliefs not shared by others that the resident holds even when there is obvious proof or evidence to the contrary (e.g., belief he or she is terminally ill; belief that spouse is having an affair; belief that food served by the facility is poisoned).

**Dizziness/vertigo** — The resident experiences the sensation of unsteadiness, that he or she is turning, or that the surroundings are whirling around.

**Edema** — Excessive accumulation of fluid in tissues, either localized or systemic (generalized). Includes all types of edema (e.g., dependent, pulmonary, pitting).

**Fever** — Rectal temperatures above 100°Fahrenheit (38°Celsius) are considered significant in an elderly nursing home population. Many frail elders have normally low rectal baseline temperatures (e.g., 96° to 99°F). A fever is present when the resident's temperature (°F) is 2.4 degrees greater than the baseline temperature.

**Hallucinations** — False perceptions that occur in the absence of any real stimuli. A hallucination may be auditory (e.g., hearing voices), visual (e.g., seeing people, animals), tactile (e.g., feeling bugs crawling over skin), olfactory (e.g., smelling poisonous fumes), or gustatory (e.g., having strange tastes).

**Internal bleeding** — Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting "coffee grounds", hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed).

**Recurrent lung aspirations in last 90 days** — Note the extended time frame. Often occurs in residents with swallowing difficulties or who receive tube feedings (ie. esophageal reflux of stomach contents). Clinical indicators include productive cough, shortness of breath, wheezing. It is not necessary that there be X-ray evidence of lung aspiration for this item to be checked.

**Shortness of breath** — Difficulty breathing (dyspnea) occurring at rest, with activity, or in response to illness or anxiety. If the resident has shortness of breath while lying flat, also check item J1b ("Inability to lie flat due to shortness of breath. ").

**Syncope (fainting)** — Transient loss of consciousness, characterized by unresponsiveness and loss of postural tone with spontaneous recovery.

**Unsteady gait** — A gait that places the resident at risk of falling. Unsteady gaits take many forms. The resident may appear unbalanced or walk with a sway. Other gaits may have uncoordinated or jerking movements. Examples of unsteady gaits may include fast gaits with large, careless movements; abnormally slow gaits with small shuffling steps; or wide-based gaits with halting, tentative steps:

**Vomiting** — Regurgitation of stomach contents; may be caused by any etiology (e.g., drug toxicity; influenza; psychogenic).

**Process:** Ask the resident if he or she has experienced any of the listed symptoms in the last seven days. Review the clinical records (including current nursing care plan) and consult with facility staff members and the resident's family if the resident is unable to respond. A resident may not complain to staff members or others, attributing such symptoms to "old age." Therefore, it is important to ask and observe the resident, directly if possible, since the health problems being experienced by the resident can often be remedied.

**Coding:** Check all conditions that occurred within the past seven days unless otherwise indicated (i.e. lung aspirations in the last 90 days). If no conditions apply, check *NONE OF ABOVE*.

## 2. Pain Symptoms

**Intent:** To record the frequency and intensity of signs and symptoms of pain. For care planning purposes this item can be used to identify indicators of pain as well as to monitor the resident's response to pain management interventions.

**Definition:** **Pain** — For MDS assessment purposes, pain refers to any type of physical pain or discomfort in any part of the body. Pain may be localized to one area, or may be more generalized. It may be acute or chronic, continuous or intermittent (comes and goes), or occur at rest or with movement. The pain experience is very subjective; pain is whatever the resident says it is.

**Shows evidence of pain** — depends on the observation of others (i.e., cues), either because the resident does not verbally complain, or is unable to verbalize.

**Process:** Ask the resident if he or she has experienced any pain in the last seven days. Ask him/her to describe the pain. If the resident states he or she has pain, take his or her word for it. Pain is a subjective experience. Also observe the resident for indicators of pain. Indicators include moaning, crying, and other vocalizations; wincing or frowning and other facial expressions; or body

posture such as guarding/protecting an area of the body, or lying very still; or decrease in usual activities.

In some residents, the pain experience can be very hard to discern. For example, in residents who have dementia and cannot verbalize that they are feeling pain, symptoms of pain can be manifested by particular behaviors such as calling out for help, pained facial expressions, refusing to eat, or striking out at a nurse assistant who tries to move them or touch a body part. Although such behaviors may not be solely indicative of pain, but rather may be indicative of multiple problems, code for the frequency and intensity of symptoms if in your clinical judgement it is possible that the behavior could be caused by the resident experiencing pain.

Ask nurse assistants and therapists who work with the resident if the resident had complaints or indicators of pain the last week.

**Coding:** Code for the highest level of pain present in the last seven days. If the resident has no pain, code "0", (No pain) and then Skip to item J4.

a. Frequency — How often the resident complains or shows evidence of pain.

- Codes: 0. No pain (Skip to item J4)  
1. Pain less than daily  
2. Pain daily

b. Intensity — The severity of pain as described or manifested by the resident.

- Codes: 1. Mild pain — Although the resident experiences some ("a little") pain he or she is usually able to carry on with daily routines, socialization, or sleep.
2. Moderate pain — Resident experiences "a medium" amount of pain.
3. Times when pain is horrible or excruciating — Worst possible pain. Pain of this type usually interferes with daily routines, socialization, sleep.

Use your best clinical judgement when coding. If you have difficulty determining the exact frequency or intensity of pain, code for the more severe level of pain. *Rationale:* Residents having pain will usually require further evaluation to determine the cause and to find interventions that promote comfort. You never want to miss an opportunity to relieve pain.

Pain control often enables rehabilitation, greater socialization and activity involvement.

Examples	Pain Frequency	Pain Intensity
<p>Mrs. G, a resident with poor short-and-long term memory and moderately impaired cognitive function asked the charge nurse for "a pill to make my aches and pains go away" once a day during the last 7 days. The medication record shows that she received Tylenol every evening. The charge nurse states that Mrs. G usually rubs her left hip when she asks for a pill. However, when you ask her about pain, Mrs. G tells you that she is fine and never has pain. <i>Rationale for coding:</i> It appears that Mrs. G has forgotten that she has reported having pain during the last 7 days. Best clinical judgement calls for coding that reflects that Mrs. G has mild, daily pain.</p>	2	1
<p>Mr. T is cognitively intact. He is up and about and involved in self-care, social and recreational activities. During the last week he has been cheerful, engaging and active. When checked by staff at night, he appears to be sleeping. However, when you ask him how he's doing, he tells you that he has been having horrible cramps in his legs every night. He's only been resting, but feels tired upon arising. <i>Rationale for coding:</i> Although Mr. T may look comfortable to staff, he reports to you that he has terrible cramps. Best clinical judgement for coding this "screening" item for pain would be to record codes that reflect what Mr. T tells you. It is highly likely that Mr. T warrants a further evaluation.</p>	2	3

### 3. Pain Site

*Intent:* To record the location of physical pain as described by the resident, or discerned from objective physical and laboratory tests. Sometimes is difficult to pinpoint the exact site of pain, particularly if the resident is unable to describe the quality and location of pain in detail. Likewise, it will be difficult to pinpoint the exact site if the resident has not had physical or laboratory tests to evaluate the pain. In order to begin to develop a responsive care plan for

promoting comfort, the intent of this item is to help residents and caregivers begin a pain evaluation by attempting to target the site of pain.

**Definition:** **Back pain** — Localized or generalized pain in any part of the neck or back.

**Bone pain** — Commonly occurs in metastatic disease. Pain is usually worse during movement but can be present at rest. May be localized and tender but may also be quite vague.

**Chest pain while doing usual activities** — The resident experiences any type of pain in the chest area, which may be described as burning, pressure, stabbing, vague discomfort, etc. "Usual activities" are those that the resident engages in normally. For example, the resident's usual activities may be limited to minor participation in dressing and grooming, short walks from chair to toilet room.

**Headache** — The resident regularly complains or shows evidence (clutching or rubbing the head) of headache.

**Hip pain** — Pain localized to the hip area. May occur at rest or with physical movement.

**Incisional pain** — The resident complains or shows evidence of pain at the site of a recent surgical incision.

**Joint pain (other than hip)** — The resident complains or shows evidence of discomfort in one or more joints either at rest or with physical movement.

**Soft tissue pain** — Superficial or deep pain in any muscle or non-bony tissue. Examples include abdominal cramping, rectal discomfort, calf pain, wound pain.

**Stomach Pain** — The resident complains or shows evidence of pain or discomfort in the left upper quadrant of the abdomen.

**Other** — Includes either localized or diffuse pain of any other part of the body. Examples include general "aches and pains," etc.

**Process:** Ask the resident and observe for signs of pain. Consult staff members. Review the clinical record. Use your best clinical judgement.

**Coding:** Check all that apply during the last 7 days. If the resident has mouth pain check item K1c in Section K, "Oral/Nutritional Status."

#### 4. Accidents

**Intent:** To determine the resident's risk of future falls or injuries. Falls are a common cause of morbidity and mortality among elderly nursing home residents. Residents who have sustained at least one fall are at risk of future falls. About half of all residents fall each year, with serious injury resulting from 6 to 10 percent of falls. Hip fractures account for approximately one-half of all serious injuries.

**Definition:** Fell — Note time frames (past 30 days and past 31-180 days).

Hip fracture in last 80 days — Note time frame (last 180 days).

Other fracture in last 180 days — Any fracture other than a hip fracture. Note time frame (last 180 days).

**Process:** New admissions — Consult with the resident and the resident's family. Review transfer documentation.

Current residents — Review the resident's records (including incident reports, current nursing care plan, and monthly summaries). Consult with the resident. Sometimes, a resident will fall, and believing that he or she “just tripped,” will get up and not report the event to anyone. Therefore, do not rely solely on the clinical records but also ask the resident directly if he or she has fallen during the indicated time frame.

**Coding:** Check all conditions that apply. If no conditions apply, check *NONE OF ABOVE*.

#### 5. Stability of Conditions

**Intent:** To determine if the resident's disease or health conditions present over the last seven days are acute, unstable, or deteriorating.

**Definition:** Fluctuating, precarious, deteriorating — Denotes the changing and variable nature of the resident's condition. For example, a resident may experience a variable response to the intensity of pain and the analgesic effect of pain medications. On “good days” over the last seven days, he or she will participate in ADLs, be in a good mood, and enjoy preferred leisure activities. On “bad days,” he or she will be dependent on others for care, be agitated, cry, etc. Likewise, this category reflects the degree of difficulty in achieving a balance between treatments for multiple conditions.

**Acute episode** — Resident is symptomatic for an acute health condition (e.g., new myocardial infarction; adverse drug reaction; influenza), a recurrent (acute) condition (e.g., aspiration pneumonia; urinary tract infection) or an acute phase of a chronic disease (e.g., shortness of breath, edema, and confusion in a resident with congestive heart disease; acute joint pain and swelling in a resident who has had arthritis for many years). An acute episode is usually of sudden onset, has a time-limited course, requires physician evaluation and a significant increase in licensed nursing monitoring.

**End-stage disease** — In one's best clinical judgement, the resident with any end-stage disease has only six or fewer months to live. This judgment should be substantiated by a well documented disease diagnosis and deteriorating clinical course.

**Process:** Observe the resident. Consult staff members, especially the resident's physician. Review the resident's clinical record.

**Coding:** Check all that apply during last seven days. If none apply, check *NONE OF ABOVE*.

#### Examples

Mrs. M is diabetic. She requires daily or more frequent blood sugar tests in conjunction with administering sliding-scale insulin dosages. She has been confused on one occasion in the past week when she was hypoglycemic. Check "a" for unstable — fluctuating, precarious, or deteriorating.

If Mrs. M (above) were also to have pneumonia and fever during her assessment period, check "a" for unstable and "b" for acute.

Ms. F had been doing well and was ready for discharge to her apartment in elderly housing until she came down with the flu. Currently she has a low grade fever, general aches and pains, and respiratory symptoms of productive cough and nasal congestion. Although she has taken to bed for a few days she has had no change in ADL function, mood, etc. and is looking forward to discharge in a few days. Check "b" for acute.

Mrs. T was admitted to the unit with a diagnosis of chronic congestive heart failure. During the past few months she has had 3 hospital admissions for acute CHF. Her heart has become significantly weaker despite maximum treatment with medications and oxygen. Her physician has discussed her deteriorating condition with her and her family and has documented that her prognosis for survival in the next couple of months is poor. Check "c" for end-stage disease.

(continued on next page)

**Examples  
(continued)**

Mr. R is a diabetic who receives a daily dose of NPH insulin 20 units sc QAM. He requires only monthly blood sugar determinations for follow-up, and has no current acute illness. Check "d" for *NONE OF ABOVE*.

## SECTION K. ORAL/NUTRITIONAL STATUS

### 1. Oral Problems

**Intent:** To record any oral problems present in the last seven days.

**Definition:** **Chewing problem** — Inability to chew food easily and without pain or difficulties, regardless of cause (e.g., resident uses ill-fitting dentures, or has a neurologically impaired chewing mechanism, or has temporomandibular joint pain, or a painful tooth).

**Swallowing problem** — Dysphagia. Clinical manifestations include frequent choking and coughing when eating or drinking, holding food in mouth for prolonged periods of time, or excessive drooling.

**Mouth pain** — Any pain or discomfort associated with any part of the mouth, regardless of cause. Clinical manifestations include favoring one side of the mouth while eating, refusing to eat, refusing food or fluids of certain temperatures (hot or cold).

**Process:** Ask the resident about difficulties in these areas. Observe the resident during meals. Inspect the mouth for abnormalities that could contribute to chewing or swallowing problems or mouth pain.

**Coding:** Check all that apply. If none apply, check *NONE OF ABOVE*.

### 2. Height and Weight

**Intent:** To record a current height and weight in order to monitor nutrition and hydration status over time; also, to provide a mechanism for monitoring stability of weight over time. For example, a resident who has had edema can

have an intended and expected weight loss as a result of taking a diuretic. Or weight loss could be the result of poor intake, or adequate intake accompanied by recent participation in a fitness program.

a. Height

*Process:* New admissions — Measure height in inches.

**Current resident** — Check the clinical records. If the last height recorded was more than one year ago, measure the resident's height again.

*Coding:* Round height upward to nearest whole inch. Measure height consistently over time in accord with standard facility practice (shoes off, etc.)

b. Weight

*Process:* Check the clinical records. If the last recorded weight was taken more than one month ago or weight is not available, weigh the resident again. If the resident's weight was taken more than once during the preceding month, record the most recent weight.

*Coding:* Round weight upward to the nearest whole pound. Measure weight consistently over time in accord with standard facility practice (after voiding, before meal, etc.).

### 3. Weight Change

*Intent:* To record variations in the resident's weight over time.

a. Weight Loss

*Definition:* Weight loss in percentages (e.g., 5% or more in last 30 days, or 10% or more in last 180 days).

*Process:* **New admission** — Ask the resident or family about weight changes over the last 30 and 180 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight loss in percentages during the specified time periods.

**Current resident** — Review the clinical records and compare current weight with weights of 30 and 180 days ago. Calculate weight loss in percentages during the specified time periods.

*Coding:* Code "0" for No or "1" for Yes. If there is no weight to compare to, enter NA or a circled dash ⊖.

**b. Weight Gain**

*Definition:* **Weight gain in percentages** (i.e., 5% or more in last 30 days, or 10% or more in last 180 days).

*Process:* **New admission** — Ask the resident or family about weight changes over the last 30 and 180 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight gain during the specified time periods.

**Current resident** — Review the clinical records and compare current weight with weights of 30 and 180 days ago. Calculate weight gain during the specified time periods.

*Coding:* Code "0" for No or "1" for Yes. If there is no weight to compare to, enter NA or a circled dash ⊖.

**4. Nutritional Problems**

*Intent:* To identify specific problems, conditions, and risk factors for functional decline present in the last seven days that affect or could affect the resident's health or functional status. Such problems can often be reversed and the resident can improve.

*Definition:* **Complains about the taste of many foods** — The sense of taste can change as a result of health conditions or medications. Also, complaints can be culturally based — e.g., someone used to eating spicy foods may find nursing home meals bland.

**Regular or repetitive complaints of hunger** — On most days (at least 2 out of 3), resident asks for more food or repetitively complains of feeling hungry (even after eating a meal).

**Leaves 25% or more of food uneaten at most meals** — Eats less than 75 percent of food (even when substitutes are offered) at least 2 out of 3 meals a day.

*Process:* Consult resident's records (including current nursing care plan), dietary/fluid intake flow sheets, dietary progress notes/assessments. Consult with direct-care staff and consulting dietician. Ask the resident if he or she experienced

any of these symptoms in the last seven days. Sometimes a resident will not complain to staff members because he or she attributes symptoms to "old age." Therefore, it is important to ask the resident directly. Observe the resident while eating. If he or she leaves food or picks at it, ask "Why are you not eating?" Note if resident winces or makes faces while eating.

**Coding:** Check all conditions that apply. If no conditions apply, check *NONE OF ABOVE*.

## 5. Nutritional Approaches

**Definition:** Parenteral/IV — Intravenous (IV) fluids or hyperalimentation given continuously or intermittently. This category also includes administration of fluids via IV lines with fluids running at KVO (keep vein open), or via heparin locks. This category does not include administration of IV medications. If the resident receives IV medications, check item P1c in "Special Treatments and Procedures".

**Feeding tube** — Presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tube.

**Mechanically altered diet** — A diet specifically prepared to alter the consistency of food in order to facilitate oral intake. Examples include soft solids, pureed foods, ground meat. Diets for residents who can only take liquids that have been thickened to prevent choking are also included in this definition.

**Syringe (oral feeding)** — Use of syringe to deliver liquid or pureed nourishment directly into the mouth.

**Therapeutic diet** — A diet ordered to manage problematic health conditions. Examples include calorie-specific, low-salt, low-fat lactose, no added sugar, and supplements during meals.

**Dietary supplement between meals** — Any type of dietary supplement provided between scheduled meals (e.g., high protein/calorie shake, or 3 p.m. snack for resident who receives q.a.m. dose of NPH insulin). Do not include snacks that everyone receives as part of the unit's daily routine.

Plate guard, stabilized built-up utensils, etc. — Any type of specialized, altered, or adaptive equipment to facilitate the resident's involvement in self-performance of eating.

On planned weight change program — Resident is receiving a program of which the documented purpose and goal are to facilitate weight gain or loss (e.g., double portions; high calorie supplements; reduced calories; 10 grams fat).

**Coding:** Check all that apply. If none apply, check *NONE OF ABOVE*.

**6. Parenteral or Enteral Intake — Skip to Section L if neither item K5a nor K5b is checked.**

**Intent:** To record the proportion of calories received, and the average fluid intake, through parenteral or tube feeding in the last seven days.

**a. CALORIE INTAKE**

**Definition:** Proportion of total calories received — the proportion of all calories during the last seven days ingested that the resident actually received (not ordered) by parenteral or tube feedings. Determined by calorie count.

**Process:** Review Intake record. If the resident took no food or fluids by mouth, or took just sips of fluid, stop here and code "4" (76%-100%). If the resident had more substantial oral intake than this, consult with the dietician who can derive a calorie count received from parenteral or tube feedings.

**Coding:** Code for the best response.

- 0. None
- 1. 1% to 25%
- 2. 26% to 50%
- 3. 51% to 75%
- 4. 76% to 100%

**Example of Calculation for Proportion of Total Calories  
from IV or Tube Feeding**

Mr. H has had a feeding tube since his surgery. He is currently more alert, and feeling much better. He is very motivated to have the tube removed. He has been taking soft solids by mouth, but only in small to medium amounts. For the past week he has been receiving tube feedings for nutritional supplementation. As his oral intake improves, the amount received by tube will decrease. The dietician has totalled his calories per day as follows:

Step #1:	Oral	+	Tube
Sun.	500	+	2000
Mon.	250	+	2250
Tues.	250	+	2250
Wed.	350	+	2250
Thurs.	500	+	2000
Fri.	800	+	1800
Sat.	<u>800</u>	+	<u>1800</u>
<b>TOTAL</b>	<b>3450</b>	<b>+</b>	<b>14350</b>

**Step #2:** Total calories = 3450 + 14350 = 17800

**Step #3:** Calculate percentage of total calories by tube feeding.

$$\frac{14350}{17800} \times \frac{x}{100} \text{ [multiply total tube amount by 100, then divide by total calories]}$$

1435000 divided by 17800 = 80.6% of total calories received by tube.

**Step #4:** Code "4" for 76% to 100%

**b. AVERAGE FLUID INTAKE**

**Definition:** Average fluid intake per day by IV or tube feeding in last seven days refers to the actual amount of fluid the resident received by these modes (not the amount ordered).

**Process:** Review the Intake and Output record from the last seven days. Add up the total amount of fluid received each day by IV and/or tube feedings only. Divide the week's total fluid intake by 7. This will give you the average of fluid intake per day.

**Coding:** Code for the average number of cc's of fluid the resident received per day by IV or tube feeding.

- Codes:**
- 0. None
  - 1. 1 to 500 cc/day
  - 2. 501 to 1000 cc/day
  - 3. 1001 to 1500 cc/day
  - 4. 1501 to 2000 cc/day
  - 5. 2001 to or more cc/day

**Example of Calculation for Average Daily Fluid Intake**

Ms. A has swallowing difficulties secondary to Huntington's disease. She is able to take oral fluids by mouth with supervision, but not enough to maintain hydration. She received the following daily fluid totals by supplemental tube feedings (including water, prepared nutritional supplements, juices) during the last 7 days.

**Step #1:**

Sun.	1250 cc
Mon.	775 cc
Tues.	925 cc
Wed.	1200 cc
Thurs.	1200 cc
Fri.	1200 cc
<u>Sat.</u>	<u>1000 cc</u>
TOTAL	7550

**Step #2:**  
7550 divided 7 = 1078.6 cc

**Step #3:**  
Code "3" for 1001 to 1500 cc/day

## SECTION L. ORAL/DENTAL STATUS

### 1. Oral Status and Disease Prevention

- Intent:** To document the resident's oral and dental status as well as any problematic conditions.
- Definition:** Carious — Pertains to tooth decay and disintegration (cavities).
- Process:** Ask the resident, and examine the resident's mouth. Ask direct care staff if they have noticed any problems. Review the clinical record.
- Coding:** Check all that apply. If none apply, check *NONE OF ABOVE*.

## SECTION M. SKIN CONDITION

To determine the condition of the resident's skin, identify the presence, stage, type, and number of ulcers, and document other problematic skin conditions. Additionally, to document any skin treatments for active conditions as well as any protective or preventive skin or foot care treatments the resident has received in the last seven days.

### 1. Ulcer (due to any cause)

- Intent:** To record the number of ulcers, of any type at each ulcer stage, on any part of the body.
- Definition:**
- Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.
  - 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.
  - Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

**Process:** Review the resident's record and consult with the nurse assistant about the presence of an ulcer. Examine the resident and determine the stage and number of any ulcers present. Without a full body check, an ulcer can be missed.

Assessing a Stage 1 ulcer requires a specially focused assessment for residents with darker skin tones to take into account variations in ebony-colored skin. To recognize Stage 1 ulcers in ebony complexions, look for: (1) any change in the feel of the tissue in a high-risk area; (2) any change in the appearance of the skin in high-risk areas, such as the "orange-peel" look; (3) a subtle purplish hue; and (4) extremely dry, crust-like areas that, upon closer examination, are found to cover a tissue break.

**Coding:** Record the number of ulcers at each stage on the resident's body, in the last 7 days, regardless of the ulcer cause. If necrotic eschar is present, prohibiting accurate staging, code the ulcer as Stage "4" until the eschar has been debrided (surgically or mechanically) to allow staging. If there are no ulcers at a particular stage, record "0" (zero) in the box provided. If there are more than 9 ulcers at any one stage, enter "9" in the appropriate box.

**Example**

Mrs. L has end-stage metastatic cancer and weighs 75 pounds. She has a Stage 3 ulcer over her sacrum and two Stage 1 ulcers over her heels.

Stage	Code
a. 1	2
b. 2	0
c. 3	1
d. 4	0

**2. Type of Ulcer**

**Intent:** To record the highest stage for two types of ulcers, Pressure and Stasis, that were present in the last 7 days.

**Definition:** **Pressure ulcer** — Any lesion caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include bed sores and decubitus ulcers.

**Stasis ulcer** — An open lesion, usually in the lower extremities, caused by decreased blood flow from chronic venous insufficiency; also referred to as a venous ulcer or ulcer related to peripheral vascular disease (PVD).

**Process:** Review the resident's record. Consult with the physician regarding the cause of the ulcer(s).

**Coding:** Using the ulcer staging scale in item M1 record the highest ulcer stage for pressure and stasis ulcers present in the last 7 days. Remember that there are other types of ulcers than the two listed in this item (e.g., ischemic ulcers). An ulcer recorded in item M1 may not necessarily be recorded in item M2. (See last example below).

**Example**

Mr. C has diabetes and poor circulation to his lower extremities. Last month Mr. C spent 2 weeks in the hospital where he had a left below the knee amputation (BKA) for treatment of a gangrenous foot. His hospital course was complicated by delirium (acute confusion) and he spent most of his time on bedrest. Nurses remarked that he would only stay lying on his back. He had only an eggcrate mattress on his bed to relieve pressure. A water mattress and air mattress were both tried but aggravated his agitation. He was readmitted to the nursing home 3 days ago with a Stage II pressure ulcer over his sacrum and a Stage I pressure ulcer over his right heel and both elbows. No other ulcers were present.

Type of Ulcer	Code (highest stage)
a. Pressure ulcer	2
b. Stasis ulcer	0

**Rationale for coding:** Mr. C has 4 pressure ulcers, the highest stage of which is Stage 2.

Mrs. B has a blockage in the arteries of her right leg causing impaired arterial circulation to her right foot (ischemia). She has only 1 ulcer, a Stage 3 ulcer on the dorsal surface (top) of her right foot.

Type of Ulcer	Code (highest stage)
a. Pressure ulcer	0
b. Stasis ulcer	0

**Rationale for coding:** Mrs. B's ulcer is an ischemic ulcer rather than caused by pressure or venous stasis.

### 3. History of Resolved/Cured Ulcers

**Intent:** To determine if the resident previously had an ulcer that was resolved or cured during the past 90 days. Identification of this condition is important because it is a risk factor for development of subsequent ulcers.

**Process:** Review clinical records, including the last Quarterly Assessment

**Coding:** Code "0" for No or "1" for Yes.

### 4. Other Skin Problems or Lesions Present

**Intent:** To document the presence of skin problems other than ulcers, and conditions that are risk factors for more serious problems.

**Definition:** **Abrasions, bruises** — Includes skin scrapes, ecchymoses, localized areas of swelling, tenderness and discoloration.

**Burns (second or third degree)** — Includes burns from any cause (e.g., heat, chemicals) in any stage of healing. This category does not include first degree burns (changes in skin color only).

**Rashes** — Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (e.g., heat, drugs, bacteria, viruses, contact with irritating substances such as urine or detergents; allergies, etc.). Intertrigo refers to rashes (dermatitis) within skin folds.

**Skin desensitized to pain or pressure** — The resident is unable to perceive sensations of pain or pressure.

Review the resident's record for documentation of impairment of this type. An obvious example of a resident with this problem is someone who is comatose. Other residents at high risk include those with quadriplegia, paraplegia, hemiplegia or hemiparesis, peripheral vascular disease and neurological disorders. In the absence of documentation in the clinical record, sensation can be tested in the following way:

- To test for pain, use a new, disposable safety pin or wooden "orange stick" (usually used for nail care). Always dispose of the pin or stick after each use to prevent contamination.

- Ask the resident to close his or her eyes. If the resident cannot keep his or her eyes closed or cannot follow directions to close eyes, block what you are doing (in local areas of legs and feet) from view with a cupped hand or towel.
- Lightly press the pointed end of the pin or stick against the resident's skin. Do not press hard enough to cause pain, injury, or break in the skin. Use the pointed and blunt ends of the pin or stick alternately to test sensations on the resident's arms, trunk, and legs. Ask the resident to report if the sensation is "sharp" or "dull."
- Compare the sensations in symmetrical areas on both sides of the body.
- If the resident is unable to feel the sensation, or cannot differentiate sharp from dull, the area is considered desensitized to pain sensation.
- For residents who are unable to make themselves understood or who have difficulty understanding your directions, rely on their facial expressions (e.g., wincing, grimacing, surprise), body motions (e.g., pulling the limb away, pushing the examiner) or sounds (e.g., "Ouch!") to determine if they can feel pain.
- Do not use pins with agitated or restless residents. Abrupt movements can cause injury.

**Skin tears or cuts (other than surgery)** — Any traumatic break in the skin penetrating to subcutaneous tissue. Examples include skin tears, lacerations, etc.

**Surgical wounds** — Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. This category does not include healed surgical sites or stomas.

**Process:** Ask the resident if he or she has any problem areas. Examine the resident. Ask nurse assistant. Review the resident's record.

**Coding:** Check all that apply. If there is no evidence of such problems in the last seven days, check *NONE OF ABOVE*.

## 5. Skin Treatments

**Intent:** To document any specific or generic skin treatments the resident has received in the past seven days.

**Definition:** **Pressure relieving device(s) for chair** — Includes gel, air (e.g., Roho), or other cushioning placed on a chair or wheelchair. Do not include egg crate cushions in this category.

**Pressure relieving device(s) for bed** — Includes air fluidized, low airloss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Do not include egg crate mattresses in this category.

**Turning/repositioning program** — Includes a continuous, consistent program for changing the resident's position and realigning the body.

**Nutrition or hydration intervention to manage skin problems** — Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions — e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing.

**Ulcer care** — Includes any intervention for treating an ulcer at any ulcer stage. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.

**Surgical wound care** — Includes any intervention for treating or protecting any type of surgical wound. Examples of care include topical cleansing, wound irrigation, application of antimicrobial ointments, dressings of any type, suture removal, and warm soaks or heat application.

**Application of dressings (with or without topical medications) other than to feet** — Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

**Application of ointments/medications (other than to feet)** — Includes ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents, etc.). This definition does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).

**Other preventative or protective skin care (other than to feet)** — Includes application of creams or bath soaks to prevent dryness, scaling; application of protective elbow pads (e.g., down, sheepskin, padded, quilted).

**Process:** Review the resident's records. Ask the resident and nurse assistant.

**Coding:** Check all that apply. If none apply in the past seven days, check *NONE OF ABOVE*

## 6. Foot Problems and Care

**Intent:** To document the presence of foot problems and care to the feet during the last seven days.

**Definition:** Open lesions on the foot — Includes cuts, ulcers, fissures.

**Nails or callouses trimmed during the last 90 days** — Pertains to care of the feet. Includes trimming by nurse or any health professional, including a podiatrist.

**Received preventative or protective foot care** — Includes any care given for the purpose of preventing skin problems on the feet, such as diabetic foot care, foot soaks, protective booties (e.g., down, sheepskin, padded, quilted), special shoes, orthotics, application of toe pads, toe separators, etc.

**Application of dressings with or without topical medications** — Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

**Process:** Ask the resident and nurse assistant. Inspect the resident's feet. Review the resident's clinical records.

**Coding:** Check all that apply. If none apply in the past seven days, check *NONE OF ABOVE*

## SECTION N. ACTIVITY PURSUIT PATTERNS

**Intent:** To record the amount and types of interests and activities that the resident currently pursues; as well as activities the resident would like to pursue that are not currently available at the facility.

**Definition:** Activity pursuits. Refers to any activity other than ADLs that a resident pursues in order to enhance a sense of well-being. These include activities that

provide increased self-esteem, pleasure, comfort, education, creativity, success, and financial or emotional independence.

## 1. Time Awake

**Intent:** To identify those periods of a typical day (over the last seven days) when the resident was awake all or most of the time (i.e., no more than one hour nap during any such period). For careplanning purposes this information can be used in at least two ways:

- The resident who is awake most of the time could be encouraged to become more mentally, physically, and/or socially involved in activities (solitary or group).
- The resident who naps a lot may be bored or depressed and could possibly benefit from greater activity involvement.

**Process:** Consult with direct care staff, the resident, and the resident's family.

**Coding:** Check all periods when resident was awake all or most of the time. Morning is from 7 am (or when resident wakes up, if earlier or later than 7 am) until noon. Afternoon is from noon to 5 pm. Evening is from 5 pm to 10 pm (or bedtime, if earlier). If resident is comatose, this is the only Section N item to code, skip all other Section N items and go to Section O.

## 2. Average Time Involved in Activities

**Intent:** To determine the proportion of available time that the resident was actually involved in activity pursuits as an indication of his or her overall activity-involvement pattern. This time refers to free time when the resident was awake and was not involved in receiving nursing care, treatments, or engaged in ADL activities and could have been involved in activity pursuits and Therapeutic Recreation.

**Process:** Consult with direct care staff, activities staff members, the resident, and the resident's family. Ask about time involved in different activity pursuits.

**Coding:** In coding this item, exclude time spent in receiving treatments (e.g., medications, heat treatments, bandage changes, rehabilitation therapies, or ADLs). Include time spent in pursuing independent activities (e.g., watering plants, reading, letter-writing); social contacts (e.g., visits, phone calls) with family,

other residents, staff, and volunteers; recreational pursuits in a group, one-on-one or an individual basis; and involvement in Therapeutic Recreation.

### 3. Preferred Activity Settings

**Intent:** To determine activity circumstances/settings that the resident prefers, including (though not limited to) circumstances in which the resident is at ease.

**Process:** Ask the resident, family, direct care staff, and activities staff about the resident's preferences. Staff's knowledge of observed behavior can be helpful, but only provides part of the answer. Do not limit preference list to areas to which the resident now has access, but try to expand the range of possibilities for the resident.

#### Example

Ask the resident, "Do you like to go outdoors? Outside the facility (to a mall)? To events downstairs?" Ask staff members to identify settings that resident frequents or where he or she appears to be most at ease.

**Coding:** Check all responses that apply. If the resident does not wish to be in any of these settings, check *NONE OF ABOVE*.

### 4. General Activity Preferences (adapted to resident's current abilities)

**Intent:** Determine which activities of those listed the resident would prefer to participate in (independently or with others). Choice should not be limited by whether or not the activity is currently available to the resident, or whether the resident currently engages in the activity.

**Definition:** **Exercise/sports** — Includes any type of physical activity such as dancing, weight training, yoga, walking, sports (e.g., bowling, croquet, golf, or watching sports).

**Music** — Includes listening to music or being involved in making music (singing, playing piano, etc.)

**Reading/writing** — Reading can be independent or done in a group setting where a leader reads aloud to the group or the group listens to "talking books." Writing can be solitary (e.g., letter-writing or poetry writing) or done as part of a group program (e.g., recording oral histories). Or a volunteer can record the thoughts of a blind, hemiplegic, or apraxic resident in a letter or journal.

**Spiritual/religious activities** — Includes participating in religious services as well as watching them on television or listening to them on the radio.

**Gardening or plants** — Includes tending one's own or other plants, participating in garden club activities, regularly watching a television program or video about gardening.

**Talking or conversing** — Includes talking and listening to social conversations and discussions with family, friends, other residents, or staff. May occur individually, in groups, or on the telephone; may occur informally or in structured situations.

**Helping others** — Includes helping other residents or staff, being a good listener, assisting with unit routines, etc.

**Process:** Consult with the resident, the resident's family, activities staff members, and nurse assistants. Explain to the resident that you are interested in hearing about what he or she likes to do or would be interested in trying. Remind the resident that a discussion of his or her likes and dislikes should not be limited by perception of current abilities or disabilities. Explain that many activity pursuits are adaptable to the resident's capabilities. For example, if a resident says that he used to love to read and misses it now that he is unable to see small print, explain about the availability of taped books or large print editions.

For residents with dementia or aphasia, ask family members about resident's former interests. A former love of music can be incorporated into the care plan (e.g., bedside audiotapes, sing-a-longs). Also observe the resident in current activities. If the resident appears content during an activity (e.g., smiling, clapping during a music program) check the item on the form.

**Coding:** Check each activity preferred. If none are preferred, check *NONE OF ABOVE*.

## 5. Prefers Change in Daily Routine

**Intent:** To determine if the resident has an interest in pursuing activities not offered at the facility (or on the nursing unit), or not made available to the resident. This includes situations in which an activity is provided but the resident would like to have other choices in carrying out the activity (e.g., the resident would like to watch the news on TV rather than the game shows and soap operas preferred by the majority of residents; or the resident would like a Methodist service rather than the Baptist service provided for the majority of residents). Residents who resist attendance/involvement in activities offered at the facility

are also included in this category in order to determine possible reasons for their lack of involvement.

**Process:** Review how the resident spends the day. Ask the resident if there are things he or she would enjoy doing (or used to enjoy doing) that are not currently available or, if available, are not "right" for him or her in their current format. If the resident is unable to answer, ask the same question of a close family member, friend, activity professional, or nurse assistant. Would the resident prefer slight or major changes in daily routines, or is everything OK?

**Coding:** For each of the items, code for the resident's preferences in daily routines using the codes provided.

- 0. No change — Resident is content with current activity routines.
- 1. Slight change — Resident is content overall but would prefer minor changes in routine (e.g., a new activity, modification of a current activity).
- 2. Major change — Resident feels bored, restless, isolated, or discontent with daily activities or resident feels too involved in certain activities, and would prefer a significant change in routine.

**Example**

Mrs. B is regularly involved in several small group activities. She also has expressed a preference for music. However, she has consistently refused to go to group sing-alongs when the activity staff offer to bring her. She says she doesn't like big groups and prefers to relax and listen to classical music in her room. She wishes she had a radio or tape player to do this.

	<b>Code</b>
a. Type of activities in which resident is currently involved	1 (Slight change)
b. Extent of resident involvement in activities.	1 (Slight change)

## SECTION O. MEDICATIONS

### 1. Number of Medications

**Intent:** To determine the number of different medications (over-the-counter and prescription drugs) the resident has received in the past seven days.

**Process:** Count the number of different medications (not the number of doses or different dosages) administered by any route (e.g., oral, IV, injections, patch) at any time during the last seven days. Include any routine, prn, and stat doses given. "Medications" can also include topical preparations, ointments, creams used in wound care (e.g., Elase), eyedrops, vitamins, and suppositories. Include any medication that the resident administers to self, if known. If the resident takes both the generic and brand name of a single drug, count as only one medication. If the resident received a long-acting antipsychotic medication prior to the assessment period (e.g., if a fluphenazine deconoate or haloperidol deconoate is given once a month) count as one drug.

**Coding:** Write the appropriate number in the answer box. Count only those medications actually administered and received by the resident over the last seven days. Do not count medications ordered but not given.

#### Example

Resident was given Digoxin 0.25 mg po on Tuesday and Thursday and Digoxin 0.125 mg po on Monday, Wednesday, and Friday. Although the dosage is different for different days of the week, the medication is the same. Code "1" (one medication received).

### 2. New Medications

**Intent:** To record whether the resident is currently receiving medications that were initiated in the last 90 days.

**Coding:** Code "1" if the resident received (and continues to receive) new medications in the last 90 days. Code "0" if the resident did not receive any new medications in the past 90 days. If the resident received new medication(s) in the last 90 days but they were discontinued prior to this assessment period, code "0" (no new medication).

### 3. Injections

**Intent:** To determine the number of days during the past seven days that the resident received any type of medication, antigen, vaccine, by subcutaneous, intramuscular or intradermal injection. Although antigens and vaccines are considered "biologicals" and not medication per se, it is important to track when they are given to monitor for localized or systemic reactions. This category does not include intravenous (IV) fluids or medications. If the resident received IV fluids, record in Item K5a, Parenteral/IV. If IV medications were given, record in Item P1c, IV medications.

**Coding:** Record the number of DAYS in the answer box.

#### Example

During the last seven days, Mr. T received a flu shot on Monday, a PPD test (for tuberculosis) on Tuesday, a Vitamin B<sub>12</sub> injection on Wednesday. Code "3" for Resident received injections on three days during the last seven days.

### 4. Days Received the Following Medication

**Intent:** To record the number of days that the resident received each type of medication listed (antipsychotics, antianxiety, antidepressants, hypnotics, diuretics) in the past seven days. See Appendix E for list of drugs by category. Includes any of these medications given to the resident by any route (po, IM, or IV) in any setting (e.g., at the nursing home, in a hospital emergency room).

**Process:** Review the resident's clinical record for documentation that a medication was received by the resident during the past seven days. In the case of a new admission, review transmittal records.

**Coding:** Enter the number of days each of the listed types of medications was received by the resident during the past seven days. In the case of a new admission, if it is clearly documented that the resident received any type of medication (listed in this item) at the sending facility, record the number of days each listed medication was received during the past seven days. If transmittal records are not clear or do not reference that the resident received one of these medications, record "0" (not used) in the corresponding box. If the resident did not use any medications from a drug category, enter "0". If the resident uses long-lasting drugs that are taken less often than weekly (e.g., Prolixin (Fluphenazine deconate) or Haldol (Haloperidol deconate) given every few weeks or monthly) enter "1."

**Example 1**

**Medication Record for Mrs. P**

- Haldol 0.5 mg po BID p.r.n.: Received once a day on Monday, Wednesday, and Thursday [Note: Haldol = Antipsychotic drug]
- Ativan 1 mg po QAM: Received every day [Note: Ativan = Antianxiety drug]
- Restoril 15 mg po QHS p.r.n.: Received at H.S. on Tuesday and Wednesday only [Note: Restoril = Hypnotic]
- Mrs. P became severely short of breath in the middle of the night during the last seven days. She was transferred (but not admitted) to the emergency room (ER) at the local hospital. Upon her return to the nursing home the ER transmittal record stated that she had received 1 dose of IV Lasix [Note: Lasix = Diuretic].

**Coding**

<u>Medication</u>	<u>No. of days received</u>
a. Antipsychotic:	"3" (days)
b. Antianxiety:	"7" (days)
c. Antidepressant:	"0" (days)
d. Hypnotic:	"2" (days)
e. Diuretic:	"1" (days)

**Example 2**

Mr. S was admitted to the nursing home on 9/12/94 (Date of Entry) from an acute care hospital. The clinical staff established that 9/16/94 would be the MDS assessment reference date (last day of MDS observation period). By establishing 9/16/94 as the reference date, the observation period of 7 days extended back to 9/10/94 when Mr. S was still in the hospital. His hospital discharge summary mentioned that Mr. S was started on a daily dose of Prozac (an antidepressant) on 8/20. The hospital discharge summary was too sketchy to accurately determine if Mr. S received other medications during his hospital stay. Since admission to the nursing home Mr. S continues to receive the same dose of Prozac.

**Coding**

<u>Medication</u>	<u>No. of days received</u>
a. Antipsychotic:	"0" (days)
b. Antianxiety:	"0" (days)
c. Antidepressant:	"7" (days)
d. Hypnotic:	"0" (days)
e. Diuretic:	"0" (days)

## SECTION P. SPECIAL TREATMENTS AND PROCEDURES

### 1. Special Treatments, Procedures, and Programs

**Intent:** To identify any special treatments, therapies, or programs that the resident received in the specified time period.

#### a. SPECIAL CARE

**TREATMENTS** — The following treatments may be received by a nursing facility resident either at the facility, as a hospital out-patient, or in-patient basis, etc. Check the appropriate MDS item regardless of where the resident received the treatment.

**Definition:** **Chemotherapy** — Includes any type of chemotherapy (anticancer drug) given by any route.

**Alzheimer's/dementia special care unit** — Any identifiable part of the nursing facility, such as an entire or a contiguous unit, wing, or floor where staffing patterns and resident care interventions are designed specifically for cognitively impaired residents who may or may not have a specific diagnosis of Alzheimer's disease.

**Hospice care** — The resident is identified as being in a program for terminally ill persons where services are necessary for the palliation and management of terminal illness and related conditions.

**Pediatric unit** — Any identifiable part of the nursing facility, such as an entire or contiguous unit or wing where staffing patterns and resident care interventions are designed specifically for persons aged 22 or younger.

**Respite care** — Resident's care program involves a short-term stay in the facility for the purpose of providing relief to a nursing home-eligible resident's primary home based caregiver(s). Following this planned short stay, it is anticipated that the resident will return to his or her home in the community.

**Training in skills required to return to the community** — Resident is regularly involved in individual or group activities with a licensed skilled professional to attain goals necessary for community living (e.g., medication management, housework, shopping, using transportation, activities of daily living).

**Process:** Review the resident's clinical record.

**Coding:** Check all treatments and procedures that were received during the last 14 days. If no items apply in the last 14 days, check NONE OF ABOVE.

#### **b. THERAPIES**

Therapies that occurred after admission to the nursing home, were ordered by a physician, and were performed by a qualified therapist (i.e., one who meets state credentialing requirements or in some instances, under such a person's direct supervision).

The therapy treatment may occur either inside or outside the facility. Includes only therapies based on a therapist's assessment and treatment plan that is documented in the resident's clinical record.

**Intent:** To record the (A) number of days and (B) total number of minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 days.

**Definition:** **Speech-language pathology, audiology services** — Services that are provided by a qualified speech-language pathologist.

**Occupational therapy** — Therapy services that are provided or directly supervised by a qualified occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified occupational therapy assistant who is employed by (or under contract to) the nursing facility only if he or she is under the direction of a qualified occupational therapist.

**Physical therapy** — Therapy services that are provided or directly supervised by a qualified physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include service provided by a qualified physical therapy assistant who is employed by (or under contract to) the nursing facility only if he or she is under the direction of a qualified physical therapist.

**Respiratory therapy** — Included are coughing, deep breathing, heated nebulizers, aerosol treatments, and mechanical ventilation, etc., which must be provided by a qualified professional (i.e., trained nurse, respiratory therapist). Does not include hand held medication dispensers. Count only the time that the qualified professional spends with the resident.

**Psychological therapy** — Therapy given by any licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker.

**Process:** Review the resident's clinical record and consult with each of the qualified therapists.

**Coding:** **Box A:** In the first column, enter the number (#) of days the therapy was administered for 15 minutes or more in the last seven calendar days. Enter "0" if none.

**Box B:** In the second column, enter the total number (#) of minutes the particular therapy was provided in the last seven days even if you entered "0" in Box A (e.g., less than 15 minutes of therapy provided). The time should include only the actual treatment time (not time waiting or writing reports). Enter "0" if none.

**Example**

Following a stroke Mrs. F was admitted to the nursing home in stable condition for rehabilitation therapies. Since admission she has been receiving speech therapy twice weekly for 30-minute sessions, occupational therapy twice weekly for 30-minute sessions, and physical therapy twice a day (30 minute sessions) for 5 days and respiratory therapy for 10 minutes per day on each of the last 7 days. During the last seven days Mrs. F has participated in all of her scheduled sessions.

Coding	A	B
a. Speech-language pathology, audiology services	2	60
b. Occupational therapy	2	60
c. Physical therapy	5	300
d. Respiratory therapy	0	70
e. Psychological therapy	0	0

## 2. Intervention Programs for Mood, Behavior, Cognitive Loss

**Definition:** Special behavior symptom evaluation program — A program of ongoing, comprehensive, interdisciplinary evaluation of behavioral symptoms (such as the symptoms described in item E4). The purpose of such a program is to attempt to understand the “meaning” behind the resident's behavioral symptoms in relation to the resident's health and functional status, and social and physical environment. The ultimate goal of the evaluation is to develop and implement a plan of care that serves to reduce distressing symptoms.

**Evaluation by a licensed mental health specialist in the last 90 days** — An assessment of a mood, behavior disorder, or other mental health problem by a qualified clinical professional such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker, depending on State practice acts. Do not check this item for routine visits by the facility social worker. Evaluation may take place at the nursing home, private office, clinic, community mental health center, etc.

**Group therapy** — Resident regularly attends sessions at least weekly. Therapy is aimed at helping to reduce loneliness, isolation, and the sense that one's problems are unique and difficult to solve. The session may take place either at the nursing home (e.g., support group run by the facility's social worker) or outside the facility (e.g., group program at community mental health center, Alcoholics Anonymous meeting at a local church, Parkinson's Disease support

group at local hospital). This item does not include group recreational or leisure activities.

**Resident-specific deliberate changes in the environment to address mood/behavior/cognitive patterns** — Adaptation of the milieu focused on the resident's individual mood/behavior/cognitive pattern. Examples include placing a banner labeled "wet paint" across a closet door to keep the resident from repetitively emptying all the clothes out of the closet, or placing a bureau of old clothes in an alcove along a corridor to provide diversionary "props" for a resident who frequently stops wandering to rummage. The latter diverts the resident from rummaging through belongings in other residents' rooms along the way.

**Reorientation** — Individual or group sessions that aim to reduce disorientation in confused residents. Includes environmental cueing in which all staff involved with the resident provide orienting information and reminders.

**Process:** Review the resident's clinical record for documentation of intervention programs. These interventions also should be documented in the care plan.

**Coding:** Check all that apply. If none apply, check *NONE OF ABOVE*.

### 3. Nursing Rehabilitation/Restorative Care

**Intent:** To determine the extent to which the resident receives nursing rehabilitation or restorative services from other than specialized therapy staff (e.g., occupational therapist, physical therapist, etc.). Rehabilitative or restorative care refers to nursing interventions that promote the resident's ability to adapt and adjust to living as independently and safely as is possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.

Skill practice in such activities as walking and mobility, dressing and grooming, eating and swallowing, transferring, amputation care, and communication can improve or maintain function in physical abilities and ADLs and prevent further impairment.

**Definition:** **Rehabilitation/restorative care** — Included are nursing interventions that assist or promote the resident's ability to attain his or her maximum functional potential. This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in item P1b. In addition, to be included in this section, a rehabilitation or restorative practice must meet all of the following additional criteria:

- Measurable objectives and interventions must be documented in the care plan and in the clinical record.
- Evidence of periodic evaluation by licensed nurse must be present in the clinical record.
- Nurse assistants/aides must be trained in the techniques that promote resident involvement in the activity.
- These activities are carried out or supervised by members of the nursing staff. Sometimes under licensed nurse supervision, other staff and volunteers will be assigned to work with specific residents.
- This category does not include exercise groups with more than four residents per supervising helper or caregiver.

**Range of motion** — The extent to which, or the limits between which, a part of the body can be moved around a fixed point, or joint. Range of motion exercise is a program of passive or active movements to maintain flexibility and useful motion in the joints of the body.

**Active range of motion** — Exercises performed by a resident, with cueing or supervision by staff, that are planned, scheduled, and documented in the clinical record.

**Splint or brace assistance** — Assistance can be of 2 types: 1) where staff provide verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint, or 2) where staff have a scheduled program of applying and removing a splint or brace, assess the resident's skin and circulation under the device, and reposition the limb in correct alignment. These sessions are planned, scheduled, and documented in the clinical record.

**Training and skill practice** — Activities including repetition, physical or verbal cueing, and task segmentation provided by any staff member or volunteer under the supervision of a licensed nurse.

**Bed mobility** — Activities used to improve or maintain the resident's self-performance in moving to and from a lying position, turning side to side, and positioning him or herself in bed.

**Transfer** — Activities used to improve or maintain the resident's self-performance in moving between surfaces or planes either with or without assistive devices.

**Walking** — Activities used to improve or maintain the resident's self-performance in walking, with or without assistive devices.

**Dressing or grooming** — Activities used to improve or maintain the resident's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.

**Eating or swallowing** — Activities used to improve or maintain the resident's self-performance in feeding one's self food and fluids, or activities used to improve or maintain the resident's ability to ingest nutrition and hydration by mouth.

**Amputation/prosthesis care** — Activities used to improve or maintain the resident's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket).

**Communication** — Activities used to improve or maintain the resident's self-performance in using newly acquired functional communication skills or assisting the resident in using residual communication skills and adaptive devices.

**Other** — Any other activities used to improve or maintain the resident's self-performance in functioning. This includes, but is not limited to, teaching self-care for diabetic management, self-administration of medications, ostomy care, and cardiac rehabilitation.

**Process:** Review the clinical record and the current care plan. Consult with facility staff. Look for rehabilitation, restorative care schedule, assignment, and implementation record sheet on the nursing unit.

**Coding:** For the last seven days, enter the number of days on which the technique, procedure, or activity was practiced for a total of at least 15 minutes during the 24-hour period. The 15 minutes does not have to occur all at once. Remember that persons with dementia learn skills best through repetition that occurs multiple times per day. Review for each activity throughout the 24-hour period. Enter zero "0" if none.

### Examples of Nursing Rehabilitation/Restoration

Mr. V has lost range of motion (ROM) in his right arm, wrist and hand due to a CVA experienced several years ago. He has moderate to severe loss of cognitive decision-making skills and memory. To avoid further ROM loss and contractures to his right arm, the occupational therapist fabricated a right resting handsplint and instructions for its application and removal. The nursing coordinator developed instructions for providing passive range of motion exercises to his right arm, wrist and hand 3 times per day. The nursing assistants and Mr. V's wife have been instructed on how and when to apply and remove the handsplint and how to do the passive ROM exercises. These plans are documented on Mr. V's care plan. The total amount of time involved each day in removing and applying the handsplint and completing the ROM exercises is 30 minutes. The nursing assistants report that there is less resistance in Mr. V's affected extremity when bathing and dressing him. For both Splint or Brace assistance and Range of Motion (passive), enter "7" as the number of days these nursing rehabilitative techniques were provided.

Mrs. K was admitted to the nursing facility 7 days ago following repair to a fractured hip. Physical therapy was delayed due to complications and a weakened condition. Upon admission, she had difficulty moving herself in bed and required total assistance for transfers. To prevent further deterioration and increase her independence, the nursing staff implemented a plan on the second day following admission to teach her how to move herself in bed and transfer from bed to chair using a trapeze, the bedrails, and a transfer board. The plan was documented in Mrs. K's clinical record and communicated to all staff at the change of shift. The charge nurse documented in the nurses notes that in the five days Mrs. K has been receiving training and skill practice for bed mobility and transferring, her endurance and strength are improving, and she requires only extensive assistance for transferring. Each day the amount of time to provide this nursing rehabilitation intervention has been decreasing so that for the past five days, the average time is 45 minutes. Enter "5" as the number of days training and skill practice for bed mobility and transfer was provided.

Mrs. J had a CVA less than a year ago resulting in left-sided hemiplegia. Mrs. J has a strong desire to participate in her own care. Although she cannot dress herself independently, she is capable of participating in this activity of daily living. Mrs. J's overall care plan goal is to maximize her independence in ADL's. A plan, documented on the care plan, has been developed to teach Mrs. J how to put on and take off her blouse with no physical assistance from the staff. All of her blouses have been adapted for front closure with velcro. The nursing assistants have been instructed in how to verbally guide Mrs. J as she puts on and takes off her blouse. It takes approximately 20 minutes per day for Mrs. J to complete this task (dressing and undressing). Enter "7" as the number of days training and skill practice for dressing and grooming was provided.

(continued on next page)

**Examples of Nursing Rehabilitation/Restoration  
(continued)**

Using a quad cane and a short leg brace, Mrs. D is receiving training and skill practice in walking. Together, Mrs. D and the nursing staff have set progressive walking distance goals. The nursing staff have received instruction on how to provide Mrs. D with the instruction and guidance she needs to achieve the goals. She has three scheduled times each day where she learns how to apply her short leg brace followed by walking. Each teaching and practice episode for brace application and walking, supervised by a nursing assistant, takes approximately 15 minutes. Enter "7" as the number of days for splint and brace assistance and training and skill practice in walking were provided.

Experiencing a slow recovery from Guillain Barre syndrome, Mr. B is receiving daily training and skill practice in swallowing. Along with specially designed cups and appropriate food consistency, the documented plan of care to improve his ability to swallow involves proper body positioning, consistent verbal instructions, and jaw control techniques. Mr. B requires close monitoring when given food and fluids as he is at risk for choking and aspiration. Therefore, only licensed nurses provide this nursing rehabilitative intervention. It takes approximately 35 minutes each meal for Mr. B to finish his food and liquids. He receives supplements via a gastrostomy tube if he does not achieve the prescribed fluid and caloric intake by mouth. Enter "7" as the number of days training and skill practice in swallowing was provided.

Mr. W's cognitive status has been deteriorating progressively over the past several months. Despite deliberate nursing restoration, attempts to promote his independence in feeding himself, he will not eat unless he is fed. Because Mr. W did not receive nursing rehabilitation/restoration for eating in the last 7 days, enter "0" as the number of days training and skill practice for eating was provided.

Mrs. E has amyotrophic lateral sclerosis. She no longer has the ability to speak or even to nod her head "yes" and "no". Her cognitive skills remain intact, she can spell, and she can move her eyes in all directions. The speech language pathologist taught both Mrs. E and the nursing staff to use a communication board so that Mrs. E. could communicate with staff. The communication board has proven very successful and the nursing staff, volunteers and family members are reminded by a sign over Mrs. E's bed that they are to provide her with the board to enable her to communicate with them. This is also documented in Mrs. E's care plan. Because the teaching and practice in using the communication board had been completed two weeks ago and Mrs. E is able to use the board to communicate successfully, she no longer receives skill and practice training in communication. Enter "0" as the number of days training and skill practice in communication was provided.

#### 4. Devices and Restraints

**Intent:** To record the frequency, over the last seven days, with which the resident was restrained by any of the devices listed below at any time during the day or night.

**Definition:** This category includes the use of any device (e.g., physical or mechanical device, material, or equipment attached or adjacent to the resident's body) that the resident cannot easily remove and that restricts freedom of movement or normal access to his or her body.

- **Full bed rails** — Full rails may be one or more rails along both sides of the resident's bed that block three-quarters to the whole length of the mattress from top to bottom. This definition also includes beds with one side placed against the wall (prohibiting the resident from entering and exiting on that side) and the other side blocked by a full rail (one or more rails). A veil screen (used in pediatric units) is included in this category.
- **Other types of bed rails used** (e.g., one-side half rail, one-side full rail, two-sided half rails).
- **Trunk restraint** — Includes any device or equipment or material that the resident cannot easily remove (e.g., vest or waist restraint).
- **Limb restraint** — Includes any device or equipment or material that the resident cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm) or lower extremity (i.e., foot, leg).
- **Chair prevents rising** — Any type of chair with locked lap board or chair that places resident in a recumbent position that restricts rising or a chair that is soft and low to the floor (e.g., bean bag chair). Includes "comfort cushions" (e.g., lap buddy), "merry walkers."

**Process:** Check the resident's clinical records and restraint flow sheets. Consult nursing staff. Observe the resident.

**Coding:** For each device type, enter:

0. Not used in last seven days
1. Used, but used less than daily in last seven days
2. Used on a daily basis in last seven days

## 5. Hospital Stay(s)

- Intent:** To record how many times the resident was admitted to the hospital with an overnight stay in the last 90 days or since the last assessment if less than 90 days [regardless of payment status for these days either by the hospital or by the nursing home]. If the resident is a new admission to the facility, this item includes admissions during the period prior to admission.
- Definition:** The resident was formally admitted by a physician as an in-patient with the expectation that he or she will stay overnight. It does not include day surgery, out-patient services, etc.
- Process:** Review the resident's record. If the resident is a new admission, ask the resident and resident's family. Sometimes transmittal records from recent hospital admissions are not readily available during a nursing home admission from the community.
- Coding:** Enter the number of hospital admissions in the box. Enter "0" if no hospital admissions.

### Examples

Mrs. D, an insulin-dependent diabetic, was admitted to the nursing home yesterday from her own home. At home she had been having a lot of difficulty with insulin regulation since developing an ulcer on her left foot six weeks ago. During the last 90 days prior to admission, Mrs. D had two hospitalizations, for 3 and 5 days respectively. Code "2" for two hospital admissions in the last 90 days.

Mr. W has been a resident of the nursing facility for two years. He has a blood dyscrasia and receives transfusions at the local emergency room twice monthly. In the last month Mr. W was admitted to the hospital for 2 days after developing a fever during his blood transfusion. Code "1" for one hospital admission in the last 90 days.

## 6. Emergency Room (ER) Visit(s)

- Intent:** To record if during the last 90 days the resident visited a hospital emergency room (e.g., for treatment or evaluation) but was not admitted to the hospital for an overnight stay at that time. If the resident is a new admission to the facility, this item includes emergency room visits during the period prior to admission.

**Definition:** Emergency room visit — A visit to an emergency room not accompanied by an overnight hospital stay. Exclude prior scheduled visits for physician evaluation, transfusions, chemotherapy, etc.

**Process:** Review the resident's clinical record. For new admissions, ask the resident and the resident's family and review the transmittal record.

**Coding:** Enter the number of ER visits in the last 90 days (or since last assessment if less than 90 days). Enter "0" if no ER visits.

#### Examples

One evening, Mr. X complained of chest pain and shortness of breath. He was transferred to the local emergency room for evaluation. In the emergency room Mr. X was given IV Lasix, nitrates, and oxygen. By the time he stabilized, it was late in the evening and he was admitted to the hospital for observation. He was transferred back to the nursing home the next afternoon. Code "0" for No ER visits. The rationale for this coding is that although Mr. X was transferred to the emergency room, he was admitted to the hospital overnight. An overnight stay is not part of the definition of this item.

During the night shift, Mrs. F slipped and fell on her way to the bathroom. She complained of pain in her right hip and was transferred to the local emergency room for x-rays. The x-rays were negative for a fracture and Mrs. F was transferred back to the nursing home within several hours. Code "1" for 1 ER visit.

Once during the last 90 days, Mr. P's gastrostomy tube became dislodged and nursing home staff were unsuccessful in reinserting it after multiple attempts. Mr. P was then transferred to the local emergency room where the on-call physician reinserted the tube. Code "1" for ER visit.

## 7. Physician Visits

**Intent:** To record the number of days during the last 14-day period a physician has examined the resident (or since admission if less than 14 days ago). Examination can occur in the facility or in the physician's office. In some cases the frequency of physician's visits is indicative of clinical complexity.

**Definition:** Physician — Includes MD, osteopath, podiatrist, or dentist who is either the primary physician or consultant. Also include an authorized physician assistant, or nurse practitioner working in collaboration with the physician.

**Physician exam** — May be a partial or full exam at the facility or in the physician's office. This does not include exams conducted in an emergency

room. If the resident was examined by a physician during an unscheduled emergency room visit, record the number of times this happened in the last 90 days in Item P6, "Emergency Room (Visits)".

**Coding:** Enter the number of days the physician examined the resident. If none, enter "0".

## 8. Physician Orders

**Intent:** To record the number of days during the last 14-day period (or since admission, if less than 14 days ago) in which a physician has changed the resident's orders. In some cases the frequency of physician's order changes is indicative of clinical complexity.

**Definition:** **Physician** — Includes MD, DO (osteopath), podiatrist, or dentist who is either the primary physician or a consultant. Also includes authorized physician assistant or nurse practitioner working in collaboration with the physician.

**Physician orders** — Includes written, telephone, fax, or consultation orders for new or altered treatment. Does NOT include admission orders, return admission orders, or renewal orders without changes.

**Coding:** Enter the number of days on which physician orders were changed. Do not include order renewals without change. If no order changes, enter "0".

## 9. Abnormal Lab Values

**Intent:** To document whether the resident had any abnormal laboratory values during the last 90 days. This item refers only to laboratory tests performed after admission to the nursing home. "Abnormal" refers to laboratory values that are abnormal when compared to standard values, not abnormal for the particular resident.

### Example

An elevated prothrombin time in a resident receiving coumadin therapy is coded "1" for Yes (Abnormal) even though this may be the desired effect.

**Process:** Check medical records, especially laboratory reports.

**Coding:** Enter "0" if no abnormal value was noted in the record, and "1" if the resident has had at least one abnormal laboratory value.

## SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

### 1. Discharge Potential

**Intent:** To identify residents who are potential candidates for discharge within the next three months. Some residents will meet the "potential discharge" profile at admission; others will move into this status as they continue to improve during the first few months of residency.

**Definition:** Discharge — Can be to home, another community setting, another care facility, or a residential setting. A prognosis of death should not be considered as an expected discharge.

Support person — Can be a spouse, family member, or significant other.

**Process:** For new and recent admissions, ask the resident directly. The longer the resident lives at the facility, the tougher it is to ask about preferences to return to the community. After one year of residency, many persons feel settled into the new lifestyle at the facility. Creating unrealistic expectations for a resident can be cruel. Use careful judgement. Listen to what the resident brings up (e.g., Calls out, "I want to go home"). Ask indirect questions that will give you a better feel for the resident's preferences. For example, say, "It's been about 1 year that we've known each other. How are things going for you here at (facility)".

Consult with primary care and social service staff, the resident's family, and significant others. Review clinical records. Discharge plans are often recorded in social service notes, nursing notes, or medical progress notes.

- Coding:**
- a. Resident expresses/indicates preference to return to the community. Enter "0" for No or "1" for Yes.
  - b. Resident has a support person who is positive towards discharge. Enter "0" for No or "1" for Yes.
  - c. Stay projected to be of a short duration — Discharge projected within 90 days (do not include expected discharge due to death). Enter "0" for No, "1" for within 30 days, "2" for within 31-90 days, or "3" for discharge status uncertain.

**Examples**

Mrs. F is a 65 year old married woman who sustained a CVA 2 months ago. She was admitted to the nursing facility one week ago from a rehabilitation facility for further rehab, particularly for transfer, gait training, and wheelchair mobility. Mrs. F is extremely motivated to return home. Her husband is supportive and has been busy making their home "user friendly" to promote her independence. Their goal is to be ready for discharge within 2 months.

<b>Discharge Potential</b>	<b>Coding</b>
a. Resident expresses/indicates preference to return to the community.	1 (Yes)
b. Resident has a support person who is positive towards discharge.	1 (Yes)
c. Stay projected to be of a short duration — discharge projected within 90 days (do not include expected discharge due to death).	2 (Within 31-90 days)

Mrs. D is a 67 year old widow with end-stage metastatic cancer to bone with pathological fractures. Currently her major problems are pain control and confusion secondary to narcotics. Mrs. D periodically calls out for someone to take her home to her own bed. Her daughter is unwilling and unable to manage her hospice care at home. Because of the fractures, Mrs. D is totally dependent in all ADLs except eating (she can hold a straw).

<b>Discharge Potential</b>	<b>Coding</b>
a. Resident expresses/indicates preference to return to the community	1 (Yes)
b. Resident has a support person who is positive towards discharge	0 (No)
c. Stay projected to be of short duration — discharge projected within 90 days (do not include expected discharge due to death).	0 (No)

***Rationale for coding:***

Although Mrs. D is near death, you should apply a code of "0" (No). This MDS item instructs you "do not include expected discharge due to death."

## Examples (continued)

Mr. S is a 70 year old married gentleman who was admitted to the facility 2 weeks ago from the hospital following surgical repair of a left hip fracture. Mr. S has a long history of alcoholism and cirrhosis of the liver. His daughter reports that when he is drinking he is abusive towards his wife of 40 years. Though he has a strong wish to return home, his wife states she can't take it anymore and doesn't want him to return home. He has basically worn out all his family options. Other social support options are being explored. At this time plans for discharge remain uncertain.

Discharge Potential	Coding
a. Resident expresses/indicates preference to return to the community.	1 (Yes)
b. Resident has a support person who is positive towards discharge.	0 (No)
c. Stay projected to be of a short duration — discharge projected within 90 days (do not include expected discharge due to death).	3 (Uncertain)

## 2. Overall Change in Care Needs

**Intent:** To monitor the resident's overall progress at the facility over time. Document changes as compared to his or her status of 90 days ago (or since last assessment if less than 90 days ago). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

**Definition:** Overall self-sufficiency — Includes self-care performance and support, continence patterns, involvement patterns, use of treatments, etc.

**Process:** Review clinical record, transmittal records (if new admission or readmission), previous MDS assessments (including quarterly reviews), and care plan. Discuss with direct caregivers.

**Coding:** Record the number corresponding to the most correct response. Enter "0" for No change, "1" for Improved (receives fewer supports, needs less restrictive level of care), or "2" for Deteriorated (receives more support).

**Examples**

Mr. R is a 90 year old comatose gentleman admitted to the facility from a 6 months stay at another nursing facility to be closer to his wife's residence. His condition has remained unchanged for approximately 6 months. Code "0" for No change.

Mrs. T has a several year history of Alzheimer's disease. In the past four months her overall condition has generally improved. Although her cognitive function has remained unchanged, her mood is improved. She seems happier, less agitated, sleeps more soundly at night, and is more socially involved in daily activity programming. Code "1" for Improved.

Mr. D also has a several year history of Alzheimer's disease. Although for the past year he was quite dependent on others in most areas, he was able to eat and walk with supervision until recently. In the past 90 days he has become more dependent. He no longer feeds himself. Additionally, he fell 2 weeks ago and has been unable to learn how to use a walker. He requires a 2 person assist for walking even short distances. Code "2" for Deteriorated.

**SECTION R.  
ASSESSMENT INFORMATION**

**1. Participation in Assessment**

**Intent:** To record the participation of the resident, family and/or significant others in the assessment, and to indicate reason if the resident's assessment is incomplete.

**Definition:** Family — A spousal, kin (e.g., sibling, child, parent, nephew), or in-law relationship.

Significant other — May include close friend, lover, house mate, legal guardian, trust officer, or attorney. Significant other does not, however, include staff at the nursing facility.

**Process:** Preparing residents and family members to participate in the care-planning process begins with assessment. When staff members explain the assessment process to a resident, they should also explain that the outcome of assessment is care delivery guided by a care plan. Every assessment team member can establish an expectation of resident participation by asking for and respecting the resident's perspective during assessment.

Asking family members about their expectations of the nursing facility and their concerns during the assessment process can prove beneficial. Relatives may need to talk to a staff member or they may need information. Some family concerns and expectations can be appropriately addressed in the care-planning conference. Discussing these matters with the family during the assessment process can assist in maintaining a focus on the resident during the care-planning meeting.

Staff should consider some important aspects of resident and/or family participation in assessment and care planning. Attention to seating arrangements that will facilitate communication is necessary for several reasons:

- To keep the resident from feeling intimidated and/or powerless in front of professionals.
- To accommodate any communication impairments.
- To minimize any tendencies for family members to dominate the resident in the conference yet encourage them to support the resident if that is needed.
- To facilitate nonverbal support of the resident by staff with whom the resident is close.

Verbal communication should be directed to the resident, even when the resident is cognitively impaired. The terms used should be tailored to facilitate understanding by the resident. The resident's opinions, questions, and responses to the developing care plan should be solicited if they are not forthcoming.

**Coding:**

- a) **Resident** — Enter zero "0" for No or "1" for Yes to indicate whether the resident participated in the assessment. This item should be completed last.
- b) **Family** — Enter zero "0" for No or "1" for Yes to indicate whether the family participated; enter "2" for No family.
- c) **Significant other** — Enter "0" for No or "1" for Yes to indicate whether a significant other participated; enter "2" for None if there is no significant other.

## 2. Signatures of Persons Completing the Assessment

**Intent:** Federal regulations at 42 CFR 483.20 (c) (1) and (2) require each individual who completes a portion of the assessment to sign and certify its accuracy. These regulations also require the RN Assessment Coordinator to sign and certify that the assessment is complete.

**Process:** Each staff member who completes any portion of the MDS must sign and date the MDS and indicate beside their signature which portions they completed. Two or more staff members can complete items within the same section of the MDS. The RN Assessment Coordinator must not sign and attest to completion of the assessment until all other assessors have finished their portions of the MDS. The RN Assessment Coordinator is not certifying the accuracy of portions of the assessment that were completed by other health professionals.

**Coding:** All persons completing part of this assessment, including the RN Assessment Coordinator, must sign their names in the appropriate locations. To the right of the name, enter title and the letters that correspond to sections of the MDS for which the assessor was responsible, and also enter the date on which the form is signed. Federal regulation requires the RN Assessment Coordinator to sign and thereby certify that the assessment is complete.

## SECTION S. STATE DEFINED SECTION

**SECTION S IS RESERVED FOR ADDITIONAL STATE-DEFINED ITEMS. THERE IS NO SECTION S IN THE FEDERAL VERSION 2.0 MDS FORM. YOUR STATE MAY CHOOSE TO DESIGNATE A SECTION S.**

**SECTIONS T AND U ARE SUPPLEMENTAL SECTIONS FOR USE IN THE CASE-MIX AND QUALITY DEMONSTRATION STATES. COPIES OF THE SECTION T AND U FORMS ARE AT THE END OF THIS CHAPTER AND IN APPENDIX B.**

## SECTION T.

# SUPPLEMENT ITEMS FOR MDS 2.0 IN CASE-MIX AND QUALITY DEMONSTRATION STATES

### 1. Special Treatments and Procedures

#### a. RECREATION THERAPY

**Intent:** To record the (A) number of days and (B) total number of minutes recreation therapy was administered (for at least 15 minutes a day) in the last 7 days.

**Definition:** Recreation Therapy -- Therapy ordered by a physician that provides therapeutic stimulation beyond the general activity program in a facility. The physician's order must include a statement of frequency, duration and scope of the treatment. Such therapy must be provided by a State licensed or nationally certified Therapeutic Recreation Specialist or Therapeutic Recreation Assistant. The therapeutic recreation assistant must work under the direction of a therapeutic recreation specialist.

**Process:** Review the resident's clinical record and consult with the qualified recreation therapists.

**Coding:** Box A: In the first column, enter the number (#) of days the therapy was administered for 15 minutes or more in the last seven days. Enter "0" if none.

Box B: In the second column, enter the total number (#) of minutes recreational therapy was provided in the last seven days. The time should include only the actual treatment time (not resident time waiting for treatment or therapist time documenting a treatment). Enter "0" if none.

#### b. ORDERED THERAPIES (item b, c, and d)

Skip this item unless this is a Medicare 5 day assessment, or initial admission assessment.

**Intent:** To recognize ordered and scheduled therapy services [physical therapy (PT), occupational therapy (OT) and speech pathology services (SP)] during the early days of the resident's stay. Often therapies are not initiated until after the end of the observation assessment period. This section provides an overall picture of the amount of therapy that a resident will likely receive through the fifteenth day from admission.

**Process:** For Item 1B: Review the resident's clinical record to determine if the physician has ordered one or more of the therapies to begin in first 14 days of stay. Therapies include physical therapy (PT), occupational therapy (OT), speech pathology services. If not, skip to item 2. If orders exist, consult with the therapists involved to determine if the initial evaluation is completed and therapy treatment(s) has been scheduled. If therapy treatment(s) will not be scheduled, skip to item 2.

If the resident is scheduled to receive at least one of the therapies, have the therapist(s) calculate the total number of days through the resident's fifteenth day since admission when at least one therapy service will be delivered. Then have the therapist(s) estimate the total PT, OT, and SP treatment minutes that will be delivered through the fifteenth day of admission.

**Coding:** Item c. Enter the number (#) of days at least one therapy service can be expected to have been delivered through the resident's fifteenth day of admission.

Item d. Enter the estimated total number of therapy minutes (across all therapies) it is expected the resident will receive through the resident's fifteenth day of admission.

#### Example of Ordered Therapies

**Medicare 5 day assessment:**

Mr. Z was admitted to the nursing home late Thursday afternoon. The physician's orders for both physical therapy and speech language pathology evaluation were obtained on Friday. Both therapy evaluations were completed on Monday and physical and speech therapy were scheduled to begin on Tuesday. Physical therapy was scheduled 5 days a week for 60 minutes each day. Speech therapy was scheduled for 3 days a week for 60 minutes each day. The RN Assessment Coordinator identified Monday as the end of the observation assessment period for this Medicare 5 day assessment. Within the 15 days from the resident's admission date (Thursday), the resident will receive 8 days of physical therapy (480 minutes) and 4 days of speech therapy (240 minutes) for a total of 720 minutes in the fifteen days.

Enter "8" in 1.c for the number of days that at least one therapy service is expected to be delivered.

*Because physical therapy was scheduled more frequently than speech therapy, the total number of days of physical therapy would be used.*

Enter "720" in 1.d for the estimated total number of minutes that both physical therapy and speech therapy are expected to be delivered.

(continued on next page)

information will provide a picture of the resident's problems and level of functioning for comparison to the most self-sufficient walking episode. This information will assist all members of the interdisciplinary care team to differentiate the resident's "best walking effort" and the resident's usual walking performance. Discussions between the physical therapist working with the resident on walking and the RN Assessment Coordinator regarding these differences should lead to better coordination of care and foster continuity of physical therapy treatment for the resident on the nursing unit.

Assessment of the resident's most self-sufficient walking episode can be used to evaluate 1) the effectiveness of physical therapy and nursing rehabilitation, 2) the continued need for therapy and nursing rehabilitation, and 3) maintenance of walking ability after therapy or nursing rehabilitation was discontinued.

Complete item 2 when the following conditions are present. Otherwise, skip to item 3.

- |  |
|--|
| <ul style="list-style-type: none"> <li>• ADL self-performance score for TRANSFER (G.1.bA) is 0, 1, 2, or 3</li> <li style="text-align: center;">AND</li> <li>• Resident receives physical therapy (P.1.b.c) involving gait training;</li> <li style="text-align: center;">OR</li> <li>• Physical therapy is ORDERED for gait training (T.1.b)</li> <li style="text-align: center;">OR</li> <li>• Resident is receiving nursing rehabilitation for walking (P.3.f)</li> <li style="text-align: center;">OR</li> <li>• Physical therapy involving gait training has been discontinued within the past six months.</li> </ul> |
|--|

**Definition:** Most self-sufficient episode--In the last seven days, the episode in which the resident used the LEAST amount of assistance and support while walking the longest and farthest without sitting down. The most self-sufficient episode can include physical help from others or assistive devices. Only episodes using a safe, functional gait should be used in determining the walking episode that was the most self-sufficient.

**Assistive devices:** Prostheses, different types of canes and walkers, crutches, splints, parallel bars, and pushing a wheel chair for support.

**Coding:**

a. **Furthest distance walked**--For the most self-sufficient episode using a safe and functional gait pattern, record the distance that the resident walked. Use the following codes:

0. 150 or more feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. **Time walked**--For the same episode (T.3.a), record the time it took the resident to walk the distance. Use the following codes:

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31 or more minutes

c. **Self-performance in walking**--For the same episode (T.3.a), record the amount of assistance the resident received during the walking episode. Use the following codes:

0. **INDEPENDENT**--No help or oversight provided while walking.
1. **SUPERVISION**--Oversight, encouragement, or cuing provided while walking.
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**--For the same episode (T.3.a), record the amount of support the resident received during the walking episode. Use the following codes:

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two or more persons physical assist

e. **Parallel bars used during walking**--For the same episode(T.3.a), record if parallel bars were used. Code "0" if parallel bars were NOT used and "1" if parallel bars were used.

**CODING EXAMPLES FOR WALKING WHEN MOST SELF SUFFICIENT**

Mrs. D was admitted to the nursing facility 1 month ago for rehabilitation following a CVA. She has left sided hemiplegia and receives physical therapy 5 days a week for a 45 minute session twice daily. Mrs. D enjoys her PT sessions and puts forth her best efforts in walking when her therapist is present. During the last 7 days, Mrs. D's most self-sufficient episode was during a physical therapy session when she walked the length of the hallway outside the physical therapy room (approximately 50 feet) in 15 minutes without sitting down. Mrs. D used a short leg brace to prevent foot drop and a quad cane for support. The physical therapist walked beside Mrs. D, encouraging her and cueing her to pick up her left foot, but not providing physical support.

Code a (furthest distance walked) as "2"

Code b (longest time) as "3"

Code c (self-performance) as "1"

Code d (walking support provided) as "0"

\*\*\*\*\*

Mr. G was admitted to the nursing facility following a lengthy hospitalization related to injuries sustained in a motor vehicle accident. Mr. G received physical therapy for 8 weeks to strengthen his lower extremities. Physical therapy was discontinued last week. Mr. G tires during the day, requiring more assistance with ambulation as the day progresses. During the morning, Mr. G walks from his bed to the toilet room (8 feet) with oversight from a staff person. It takes about 6 minutes for Mr. G to reach the toilet room. He uses a brace on his right leg and a walker which the staff put on for Mr. G.

During the night shift, Mr. G has much difficulty in bearing weight and manipulating his lower extremities. To walk to the toilet room, two nursing assistants are needed to provide weight-bearing support and to help Mr. G position his legs in taking steps. It takes approximately 6 minutes to reach the toilet room.

Code a (furthest distance) as "4"

Code b (longest time) as "2"

Code c (self-performance) as "1"

Code d (walking support provided) as "1"

## SECTION U. MEDICATIONS

Nursing home residents are highly susceptible to adverse drug reactions and drug interactions. It is estimated that approximately 30% of all geriatric hospital admissions are due to drug-related problems. Polypharmacy is the use of two or more medications for no apparent reasons or for the same purpose. Polypharmacy also occurs when a medication is used to treat an adverse reaction from another medication. Polypharmacy can occur in nursing homes when there is no regular and careful monitoring of residents' prescribed medications.

**Intent:** This section will assist staff in identifying potential problems related to polypharmacy, drug reactions and interactions. Further, this section can also help staff to identify potential physical and emotional problems a resident may be experiencing. For example, reviewing and documenting the frequency a resident uses a PRN pain medication, sleeping medication, or laxative may lead the interdisciplinary team to do further assessment related to underlying causes associated with the use of PRN medications. Many of the RAPs and Triggers refer to assessment of medications in which this section would be very helpful.

In addition to using the medication information collected in Section U for resident care planning purposes, this section can be integrated into a facility's quality assurance program to monitor for quality care issues such as polypharmacy, overuse of different medications, and medication administration errors and omissions.

Finally, facilities in Case-mix Demonstration States are required to collect medication information. The drug-use data are linked to the assessment data for monitoring the quality and cost-efficiency of care in a Medicare/Medicaid payment system.

**Definitions:** Amount Administered--the number of tablets, capsules, suppositories, or amount of liquid (cc's, mls, units) per dose that is administered to a resident.

NDC--the National Drug Code (NDC) is a standardized system for coding medications. An individual NDC provides coded information on the drug name, dose, and form of the drug.

Medication Administration Record (MAR)--the part of the resident's clinical record that is used by the nurse administering medications to record the medication administered. The MAR typically is the form or document used specifying the medication, dose, frequency, and route for each medication that a resident is to receive on a scheduled or PRN basis.

**Process:** Recording all of the information required in this section can be done efficiently by having the following information: 1) current physician order sheets; 2) current Medication Administration Record (MAR), 3) NDC codes. Use the Medication Administration Record (MAR) as your primary document for identifying all medications administered in the last seven days. Check the physician's order sheet to determine if any medications had recently been ordered.

In some facilities, the pharmacist may complete some portions of Section U, particularly the NDC codes and the amount administered. The pharmacy may also be able to supply you with the NDC codes for the medications ordered for each resident. Talk to the pharmacist for your facility and engage their participation in assisting with the completion of this section. If the pharmacist does not complete any portions of the medication section of the MDS, you will need to consult the list of NDC codes. The manual provides the NDC codes for medications frequently used in nursing facilities. In addition, NDC codes can be found in the *Physicians Drug Reference (PDR)* or you may be able to obtain a list of NDC codes from your pharmacy.

Take special care to ensure that you have identified and recorded all medications that were administered in the last 7 days. Often residents can have several MAR pages, especially if medications have been discontinued and new ones ordered or if there are a lot of PRN medications ordered. Recheck the MAR at least twice to avoid missing any medications administered in the last seven days. Make sure you count medications that may have been discontinued, but were administered in the last seven days.

To accurately complete the NDC codes and amount administered, it will be necessary to look at the actual medications that are given to the resident. For example, some injectable medications can be provided in vials, ampules, or premeasured syringes.

If Section U is completed by the pharmacist or other nursing home personnel, these persons must certify its accuracy with their signature in section R.2. The RN Assessment Coordinator must review Section U to ensure that it is complete.

**Coding:** The coding instructions are extensive. Review them carefully. Study the examples. Complete the coding exercises at the end of this section.

1. **Medication Name and Dose Ordered.** Identify and record all medications that the resident received in the last seven days. Also identify and record any medications that may not have been given in the last seven days, but are part of the residents regular medication regimen (e.g. monthly B-12 injections). Do not record PRN medications that were not administered in the last seven days.

Record the name of the medication and dose that was ordered by the physician in column 1. Write the name of the medication and dose ordered *EXACTLY* as it appears on the MAR. For example, if the MAR indicates Acetaminophen 650 mg, do not write Acetaminophen 325 mg. 2 tabs—even if two 325 mg. tablets are administered to the resident.

Occasionally, dosages of medications may be changed during the seven day assessment period. The medication with dosage changes should be recorded separately.

**EXAMPLE FOR MEDICATION NAME AND DOSE ORDERED**

Medications as listed on MAR for assessment period of 8/11/94-8/17/94

- A. Lasix 40 mg. daily p.o.
- B. Acetaminophen 325 mg. 2 tabs q3-4 hrs PRN p.o. (given 3 times in last seven days)
- C. B-12 1cc q month IM (given 8/8/94)
- D. Isopto Carbachol 1.5% 2 drops OD TID
- E. Robitussin-DM 5cc HS PRN p.o. (not given in last 7 days)
- F. Motrin 300 mg. QID p.o. (discontinued 8/15/94)
- G. Dilantin 300 mg. HS p.o. (ordered 8/15/94)
- H. Theo-Dur 200 mg. BID p.o. (given 8/11-8/13/94 and then order discontinued)
- I. Theo-Dur 200 mg TID p.o. (given 8/14-8/16/94 and then order discontinued)
- J. Theo-Dur 400 mg BID p.o. (given 8/17)

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN- n	6. NDC Codes															
Lasix 40 mg.																				
Acetaminophen 325 mg. 2 tabs																				
B-12 1cc																				
Isopto Carbachol 1.5% 2 drops																				
Motrin 300 mg.																				
Dilantin 300 mg.																				
Theo-Dur 200 mg.																				
Theo-Dur 200 mg.																				
Theo-Dur 400 mg.																				

\*Note that Robitussin-DM was not recorded because it was not given in the last 7 days.

2. Route of Administration. Determine the Route of Administration (RA) used to administer each medication. The MAR and the physician's orders should identify the RA for each medication. Record the RA in column 2 using the following codes:

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

**EXAMPLE FOR ROUTE OF ADMINISTRATION**

Medications as listed on MAR for assessment period of 8/11/94-8/17/94

- A. Mylanta 15 cc after meals p.o.
- B. Zantac 150 mg. q 12 hrs. Per tube
- C. Transderm nitro patch 2.5 1 patch daily
- D. Humulin N 15 U before breakfast daily SQ
- E. Lasix 80 mg. IV STAT
- G. Acetaminophen suppository 650 mg. q 4 hrs. PRN (given on 2 occasions in last 7 days)

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN-n	6. NDC Codes
Mylanta 15cc	1				
Zantac 150 mg.	9				
Transderm nitro patch 2.5 1 patch	7				
Humulin N 15 U	5				
Lasix 80 mg.	4				
Acetaminophen suppository 650 mg.	6				

3. Frequency. Determine the number of times per day, week, or month that each medication is given. Record the frequency in column 3 using the following codes:

PR=(PRN) as necessary	2D=(BID) two times daily	QO=every other day
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
4H=(Q4H) every four hours	5D=five times daily	1M=(Q mo) 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

Be careful to differentiate between similar frequencies. For example, some nursing facilities have a policy that antibiotics are to be administered around the clock. Therefore, if an antibiotic is ordered as T.I.D., the medication may actually be given q 8 hours. There is a different frequency code for T.I.D. (3D) and q 8 hrs (8H). In this case, the frequency code would be 8H (q 8 hrs.).

If insulin is given on a sliding scale, each different dose of insulin given is entered as a PRN medication.

#### EXAMPLE FOR FREQUENCY

Medications as listed on MAR for assessment period of 8/11/94-8/17/94

- A. Ampicillin 250 mg. q 6 hrs x 10 days p.o. (8/10-8/20)
- B. Beconase nasal inhaler 1 puff BID
- C. Compazine suppository 5 mg. STAT
- D. Lanoxin 0.25 mg. p.o. every other day. On alternate days, give Lanoxin 0.125 mg. p.o.
- E. Peri-colace 2 capsules HS p.o.
- F. Humulin N 15 U before breakfast daily SQ
- G. Check blood sugar daily at 4 p.m. Sliding scale insulin: Humulin R 5 units if blood sugar 200-300; 10 units if over 300. (5 units given on 8/11/94 for BS of 255; 5 units given on 8/13/94 for BS of 233; 10 units given on 8/17/94 for BS of 305)

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN-n	6. NDC Codes
Ampicillin 250 mg.	1	6H			
Beconase nasal inhaler 1 puff	8	2D			
Compazine suppository 5 mg.	6	PR			
Lanoxin 0.25 mg.	1	QO			
Lanoxin 0.125 mg.	1	QO			
Peri-colase 2 capsules	1	1D			
Humulin N 15 U	5	1D			
Humulin R 5U	5	PR			
Humulin R 10 U	5	PR			

**4. Amount Administered (AA).** Determine the amount of medication administered each time the medication was given. Amount administered is not always the dose. Rather, it is the number of tablets, capsules, suppositories, or amount of liquid (cc's, mls, units) per dose that is administered to a resident. For tablets, capsules or suppositories, enter the *number* of tablets or capsules that were given for each *administration* in column 4 (e.g. 1, 2, 1.5) For liquids, enter the *number* of cc's, mls, or units that were given for each *administration* in column 4 (e.g. 0.5 ml, 2.5 cc, 10 units). For topical medications (e.g. creams, ointments, eye drops), inhalation medications, and oral medications that are dissolved in water, enter the numeric code 999 in column 4. If a half of tablet or half of cc is administered, enter it as a decimal (0.5) rather than a fraction.