

EXAMPLE FOR AMOUNT ADMINISTERED (AA)

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

- A. Lanoxin 0.125 mg. daily p.o.
- B. Haldol 1 mg. liquid q8 hrs PRN p.o. (received 2 times in last 7 days)
- C. Ampicillin 250 mg. q 6 hrs liquid p.o.
- D. Acetaminophen 650 mg. QID p.o. (pharmacy supplies two 325 mg. tablets)
- E. Acetaminophen 325 mg. 3 tabs q3-4 hrs PRN for pain p.o. (received 5 times in last 7 days)
- 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)
- H. Elase ointment to necrotic tissue on left heel TID
- I. Diazepam 3 mg. HS p.o.
- J. Dilantin 300 mg. HS p.o.
- K. Metamucil powder 1 tbsp. in a.m. p.o.

| 1. Medication Name and Dose Ordered | 2. RA | 3. Freq | 4. AA | 5. PRN-n | 6. NDC Codes | | | | | | | | | | | | | | | |
|-------------------------------------|-------|---------|-------|----------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Lanoxin 0.125 mg. | 1 | 1D | 1 | | | | | | | | | | | | | | | | | |
| Haldol 1 mg. | 1 | PR | .5cc | | | | | | | | | | | | | | | | | |
| Ampicillin 250 mg. | 1 | 6H | 5ml | | | | | | | | | | | | | | | | | |
| Acetaminophen 650 mg. | 1 | 4D | 2 | | | | | | | | | | | | | | | | | |
| Acetaminophen 325 mg . 3 tabs | 1 | PR | 3 | | | | | | | | | | | | | | | | | |
| Humulin N 15 U | 5 | 1D | 15U | | | | | | | | | | | | | | | | | |
| Humulin R 5 U | 5 | PR | 5U | | | | | | | | | | | | | | | | | |
| Humulin R 10 U | 5 | PR | 10U | | | | | | | | | | | | | | | | | |
| Elase ointment | 7 | 3D | 999 | | | | | | | | | | | | | | | | | |
| Diazepam 3 mg. | 1 | 1D | 1.5 | | | | | | | | | | | | | | | | | |
| Dilantin 300 mg. | 1 | 1D | 3 | | | | | | | | | | | | | | | | | |
| Metamucil powder 1 tbsp. | 1 | 1D | 999 | | | | | | | | | | | | | | | | | |

5. PRN-number of doses (PRN-n). The PRN-n column is only completed for medications that have a route of administration coded as PR. Record the number of times in the past seven days that each medication coded as PR was given. STAT medications are recorded as a PRN medication. Remember, if a PRN medication was not given in the past seven days, it should not be listed in Section U.

EXAMPLE FOR PRN-number (PRN-n)

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

- A. Mylanta 15 cc after meals PRN p.o. (administered 12 times in last 7 days)
- B. Haldol 1 mg. liquid q8 hrs PRN p.o. (administered 2 times in last 7 days)
- C. Hydrocortisone cream 1% PRN to back and chest (administered 5 times in last 7 days)
- D. Lasix 80 mg. IV STAT
- E. 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)
- F. Nitroglycerin 0.3 mg 1 tab SL for chest pain; repeat 2 times at 5 minute intervals if pain is not relieved (given on 8/12/94 once and another five minutes following)

| 1. Medication Name and Dose Ordered | 2. RA | 3. Freq | 4. AA | 5. PRN-n | 6. NDC Codes | | | | | | | | | | | | | | | |
|-------------------------------------|-------|---------|-------|----------|--------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Mylanta 15 cc | 1 | PR | 15cc | 12 | | | | | | | | | | | | | | | | |
| Haldol 1 mg . | 1 | PR | 0.5cc | 2 | | | | | | | | | | | | | | | | |
| Hydrocortisone cream 1% | 7 | PR | 999 | 5 | | | | | | | | | | | | | | | | |
| Lasix 80 mg. | 4 | PR | 8cc | 1 | | | | | | | | | | | | | | | | |
| Humulin R 5 Units | 5 | PR | 5U | 2 | | | | | | | | | | | | | | | | |
| Humulin R 10 Units | 5 | PR | 10U | 1 | | | | | | | | | | | | | | | | |
| Nitroglycerin 0.3 mg: | 2 | PR | 1 | 2 | | | | | | | | | | | | | | | | |

EXAMPLE FOR NDC CODES

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

- A. Lanoxin 0.125 mg. daily p.o.
- B. Haldol 1 mg. liquid q8 hrs PRN p.o. (administered 2 times in last 7 days)
- C. Ampicillin 250 mg. q 6 hrs. liquid p.o.
- D. Acetaminophen 650 mg. QID p.o. (pharmacy supplies two 325 mg. tablets)
- 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).
- H. Transderm Nitro 1 Patch QD
- I. Lasix 80 mg. IV STAT
- J. Diazepam 3 mg. HS p.o.
- K. Dilantin 300 mg. HS p.o.

| 1. Medication Name and Dose Ordered | 2.RA | 3. Freq | 4. AA | 5.PRN-n | 6. NDC Codes |
|-------------------------------------|------|---------|-------|---------|--------------|
| Lanoxin 0.125 mg. | 1 | 1D | 1 | | 000810242 |
| Haldol 1 mg. | 1 | PR | .5cc | 2 | 000450250 |
| Ampicillin 250 mg. | 1 | 6H | 5ml | | 000472302 |
| Acetaminophen 650 mg. | 1 | 4D | 2 | | 007811294 |
| Humulin N 15 U | 5 | 1D | 15U | | 000028315 |
| Humulin R 5 U | 5 | PR | 5U | 2 | 000028215 |
| Humulin R 10 U | 5 | PR | 10U | 1 | 000028215 |
| Transderm Nitro 1 patch | 7 | 1D | 999 | | 000832025 |
| Lasix 80 mg. | 4 | PR | 8cc | 1 | 000390063 |
| Diazepam 3 mg. | 1 | 1D | 1.5 | | 003640774 |
| Dilantin 300 mg. | 1 | 1D | 3 | | 000710362 |

Coding Exercises for Section U

Complete Section U for the following medications during a 7 day period (9/1/94-9/7/94):

1. Inderal 40 mg. BID p.o.
2. Sinemet 10/100 TID p.o.
3. Artificial Tears 1 drop OU QID
4. Anusol HC suppository 1 PRN (given 1 time in last seven days)
5. Amoxicillin 500 mg q 6 hrs per tube
6. Benylin cough syrup 2 tbs. PRN p.o. (given 10 times in last seven days)
7. Darvocet-N 100 2 tabs q 4-6 hrs PRN p.o. (given 5 times in last seven days)
8. Heparin lock flush 10 U daily
9. Ditropan syrup 2.5 mg daily p.o.
10. Nitrotransdermal .4 mg 1 patch daily
11. Novolin N 24 U before breakfast SQ
12. Check blood sugar before breakfast. Sliding scale insulin: Novolin R 10 units if blood sugar over 200. (10 units given on 2 days in last 7 days)
13. Questran 1 packet with each meal p.o.
14. Quinine sulfate 325 mg. HS
15. Coumadin 2.5 mg daily p.o. (discontinued 9/3/94)
16. Coumadin 5 mg. daily p.o. (ordered to start on 9/4/94)
17. Maalox 15 cc PRN for indigestion p.o. (not administered in last 7 days)

| 1. Medication Name and Dose Ordered | 2. RA | 3. Freq | 4. AA | 5. PRN-n | 6. NDC Codes |
|-------------------------------------|-------|---------|-------|----------|--------------|
| Inderal 40 mg. | 1 | 2D | 1 | | 000460424 |
| Sinemet 10/100 | 1 | 3D | 1 | | 000060647 |
| Artificial Tears 1 drop | 7 | 4D | 999 | | 003498615 |
| Anusol HC suppository 1 | 6 | PR | 1 | 1 | 000711088 |
| Amoxicillin 500 mg | 9 | 6H | 10 ml | | 003040587 |
| Benylin cough syrup 2 Tbs. | 1 | PR | 30 cc | 10 | 000712195 |
| Darvocet-N 100 2 tabs | 1 | PR | 2 | 5 | 000020363 |
| Heparin lock flush 10 U | 4 | 1D | 1 ml | | 004693001 |
| Ditropan syrup 2.5 mg | 1 | 1D | 2.5ml | | 000881373 |
| Nitrotransdermal .4 mg. | 7 | 1D | 999 | | 472022832 |
| Novolin N 24 U | 5 | 1D | 24 U | | 000031834 |
| Novolin R 10 U | 5 | PR | 10 U | 2 | 000031833 |
| Questran 1 packet | 1 | 3D | 999 | | 000870580 |
| Quinine sulfate 325 mg. | 1 | 1D | 1 | | 000020629 |
| Coumadin 2.5 mg. | 1 | 1D | 1 | | 000560176 |
| Coumadin 5 mg. | 1 | 1D | 1 | | 000560172 |

CHAPTER 4: PROCEDURES FOR COMPLETING THE RESIDENT ASSESSMENT PROTOCOLS (RAPs)



This chapter gives instructions on using the Resident Assessment Protocols (RAPs) to assess conditions identified by the Minimum Data Set (MDS) triggering mechanism. The goal of the RAPs is to guide the interdisciplinary team through a structured comprehensive assessment of a resident's functional status. Functional status differs from medical or clinical status in that the whole of a person's life is reviewed with the intent of assisting that person to function at his or her highest practicable level of well-being. Going through the RAI process will help staff set resident-specific objectives in order to meet the physical, mental and psychosocial needs of residents.

4.1 What are the Resident Assessment Protocols (RAPs)?

The MDS alone does not provide a comprehensive assessment. Rather, the MDS is used for preliminary screening to identify potential resident problems, strengths, and preferences. The RAPs are problem-oriented frameworks for additional assessment based on problem identification items (triggered conditions). They form a critical link to decisions about care planning. The RAP Guidelines provide guidance on how to synthesize assessment information within a comprehensive assessment. The Triggers target conditions for additional assessment and review, as warranted by MDS item responses; the RAP Guidelines help facility staff evaluate "triggered" conditions.

There are 18 RAPs in Version 2.0 of the RAI. The RAPs in the RAI cover the majority of areas that are addressed in a typical nursing home resident's care plan. The RAPs were created by clinical experts in each of the RAP areas.

The care delivery system in a facility is complex yet critical to successful resident care outcomes. It is guided by both professional standards of practice and regulatory requirements. The basis of care delivery is the process of assessment and care planning. Documentation of this process (to ensure continuity of care) is also necessary.

The RAI (MDS and RAPs) is an integral part of this process. It ensures that facility staff collect minimum, standardized assessment data for each resident at regular intervals. The main intent is to drive the development of an individualized plan of care based on the identified needs, strengths and preferences of the resident.

It is helpful to think of the RAI as a package. The MDS identifies actual or potential problem areas. The RAPs provide further assessment of the "triggered" areas; they help staff to look for causal or confounding factors (some of which may be reversible). Use the RAPs to analyze assessment findings and then "chart your thinking". It is important that the RAP documentation include the causal or unique risk factors for decline or lack of improvement. The plan of care then addresses these factors with the goal of promoting the resident's highest practicable level of functioning: 1) improvement where possible, or 2) maintenance and prevention of avoidable declines.

RAPs function as decision facilitators, which means they lead to a more thorough understanding of possible problem situations by providing educational insight and structure to the assessment process. The RAPs will give the interdisciplinary team a sound basis for the development of the resident's care plan. After the comprehensive assessment process is completed, the interdisciplinary team will be able to decide if:

- The resident has a troubling condition that warrants intervention, and addressing this problem is a necessary condition for other functional problems to be successfully addressed;
- Improvement of the resident's functioning in one or more areas is possible;
- Improvement is not likely, but the present level of functioning should be preserved as long as possible, with rates of decline minimized over time;
- The resident is at risk of decline and efforts should emphasize slowing or minimizing decline, and avoiding functional complications (e.g., contractures, pain); or
- The central issues of care revolve around symptom relief and other palliative measures during the last months of life.

OBRA 1987 mandated that facilities provide necessary care and services to help each resident attain or maintain their highest practicable well-being. Facilities must ensure that residents improve when possible and do not deteriorate unless the resident's clinical condition demonstrates that the decline was unavoidable.

4.2 How are the RAPs Organized?

There are four parts to each RAP:

Section I - The Problem gives general information about how a condition affects the nursing home population. The Problem statement often describes the focus or objectives of the protocol. It is important when reviewing a "triggered" RAP not to overlook information in the Problem section. Although **Section III - The Guidelines** contain the "detail", the Problem section should be reviewed for information relevant to the assessment.

Section II - The Triggers identify one or a combination of MDS item responses specific to a resident that alert the assessor to the resident's possible problems, needs, or strengths. The specific MDS response indicates that clinical factors are present that may or may not represent a condition that should be addressed in the care plan. Triggers merely "flag" conditions necessary for the interdisciplinary team members to consider in making care planning decisions.

When the resident's status on a particular MDS item(s) matches one of the "triggers" for a RAP, the RAP is "triggered" and a review (with the possibility of additional data gathering and assessment) is required using the RAP Guidelines.

Section III - The Guidelines present comprehensive information for evaluating factors that may cause, contribute to, or exacerbate the triggered condition. The Guidelines help facility staff decide if a triggered condition actually does limit the resident's functional status or if the resident is at particular risk of developing the condition.

If the condition is found to be a problem for the resident, the Guidelines will assist the interdisciplinary team in determining if the problem can be eliminated or reversed, or if special care must be taken to maintain a resident at his or her current level of functioning.

In addition to identifying causes or risk factors that contribute to the resident's problem, the Guidelines may assist the interdisciplinary team to:

- Find associated causes and effects. Sometimes a problem condition (e.g., falls) is associated with just one specific cause (e.g., new drug that caused dizziness). More often, a problem (e.g., falls) stems from a combination of multiple factors (e.g., new drug; resident forgot walker; bed too high, etc.).
- Determine if multiple triggered conditions are related.
- Suggest a need to get more information about a resident's condition from the resident, resident's family, responsible party, attending physician, direct care staff, rehabilitative staff, laboratory and diagnostic tests, consulting psychiatrist, etc.
- Determine if a resident is a good candidate for rehabilitative interventions.
- Identify the need for a referral to an expert in an area of resident need.
- Begin to formulate care plan goals and approaches.

Section IV - The RAP Key has two parts. The first part is a review of the items on the MDS that triggered a review of the RAP. The second part is a summary, but sometimes also provides a clarification of the information in the Guidelines section of the RAP. The RAP Key should be used as a reference, but does not take the place of the main body of the RAP.

There are 18 RAPs in the Resident Assessment Instrument, Version 2.0¹:

- Delirium
- Cognitive Loss/Dementia
- Visual Function
- Communication
- ADL Function /Rehabilitation
- Urinary Incontinence and Indwelling Catheter
- Psychosocial Well-Being
- Mood State
- Behavior Symptoms
- Activities
- Falls
- Nutritional Status
- Feeding Tubes
- Dehydration/Fluid Maintenance
- Dental Care
- Pressure Ulcers
- Psychotropic Drug Use
- Physical Restraints

4.3 What does the RAP Process Involve?

There are various models for completing the RAP in-depth assessment process for a resident with a particular problem. Assessment of the resident in "triggered" RAP areas may be performed solely by the RN Coordinator (i.e., as the RAI must be completed or coordinated by an RN per the OBRA statute). Generally, the RAPs will be completed by various members of clinical disciplines as appropriate to the needs of individual residents. Facilities may also establish procedures in which certain RAPs are always reviewed by a particular discipline (e.g., the dietician completes the Nutritional Status and Feeding Tube RAPs, if triggered). The interdisciplinary team may also review RAP Guidelines in a joint manner and have the assessment process flow seamlessly into care planning. There are no mandates regarding the "process" of how facility staff use the RAPs. Rather, facility staff should be creative and experiment until they find "what works" most efficiently and effectively for them in achieving the desired outcome (i.e.,

¹ The names of the RAPs in Version 2.0 are unchanged from the original version, as are the RAP Guidelines. The triggers in almost all of the RAPs have been revised, however.

a sound and comprehensive assessment that is used to develop an individualized plan of care for each resident).

The RAP process includes the following steps:

1. Facility staff use the RAI triggering mechanism to determine which RAP problem areas require review and additional assessment. The triggered conditions are indicated in the appropriate column on the RAP Summary form.
2. Staff assess the resident in the areas that have been triggered and are guided by the RAPs and other assessment information as needed, to determine the nature of the problem and understand the causes specific to the resident.
3. Staff document key findings regarding the resident's status based on the RAP review. RAP assessment documentation should generally describe:
 - Nature of the condition (may include presence or lack of objective data and subjective complaints).
 - Complications and risk factors that affect the staff's decision to proceed to care planning.
 - Factors that must be considered in developing individualized care plan interventions.
 - Need for referrals or further evaluation by appropriate health professionals.

Documentation about the resident's condition should support clinical decision-making regarding whether to proceed with a care plan for a triggered condition and the type(s) of care plan interventions that are appropriate for a particular resident.

The decision to proceed to care planning should also be indicated in the appropriate column on the RAP Summary form.

4. Based on the review of assessment information, the interdisciplinary team decides whether or not the triggered condition affects the resident's functional status or well-being and warrants a care plan intervention.
5. The interdisciplinary team, in conjunction with the wishes of the resident, resident's family, and attending physician develop, revise, or continue the care plan based on this comprehensive assessment.

4.4 Identifying Need for Further Resident Assessment by Triggering RAP Conditions (RAP Process - Step 1)

A RAP may have several MDS items or sets of items that are defined as triggers. Only one of the trigger definitions must be present for a RAP to be triggered, although for many RAPs, each of the specific trigger items that are present must be investigated (e.g., address each of the potential side effects for the Psychotropic Drug Use RAP). Note that the concept of "automatic" and "potential" triggers used in the original version of the RAI has been eliminated. In Version 2.0, there are no "potential" triggers, or situations in which a symbol on the Trigger Legend does not require RAP review.

The trigger definitions can be found in:

- Section II of each RAP;
- The RAP Key found at the end of each RAP; and
- The RAP Trigger Legend.

The Trigger Legend is a 2 page form that summarizes all of the triggers for the 18 RAPs. It is not a required form that must be maintained in the resident's clinical record. Rather, it is a worksheet that may be used by the interdisciplinary team members to determine which RAPs are triggered from a completed MDS form.

Many facilities use automated systems instead of the Trigger Legend form to trigger RAPs. The resulting set of triggered RAPs that is generated by your home's software program should be matched against the trigger definitions to make sure that triggered RAPs have been correctly identified.² HCFA has also developed test files for facility validation of a software program's triggering logic. It is the facility's responsibility to ensure that the software is triggering correctly. At a minimum, ask whether the triggered RAPs are what you would have expected. Did the software miss some RAPs you thought should have been triggered (do some of the RAPs seem to be missing); are there others triggered that you did not expect?

To identify the triggered RAPs using the Trigger Legend:

1. Compare the completed MDS with the Trigger Legend to determine which RAPs are "triggered" for review. Begin by looking at the **KEY** in the upper left corner of the Trigger Legend form. Note that there are four possible ways for a RAP to trigger:

The first, indicated by a solid black circle, is the predominant method and requires only one MDS item to trigger a RAP.

²This process should be performed on a sample of assessment records any time changes have been made in the MDS software.

The second, indicated by a "2" within a solid circle, requires two MDS items to trigger a RAP.

The third, indicated by an asterisk (*), requires one of three types of psychotropic medications (antipsychotic, antianxiety or antidepressant), and one other item in the Psychotropic Drug Use column indicated by a solid black circle.

The fourth is indicated by a small case "a" within a circle. This is a special ADL trigger that will focus the RAP review on rehabilitation or on the maintenance of current function.

Find the ADL -Rehabilitation Trigger A and the ADL-Maintenance Trigger B columns by scanning the top of the Trigger Legend form. Notice each ADL column title is marked with a circled "a".

If there are solid circles in both ADL columns, the ADL Maintenance column will take precedence.

2. Look at the two left columns of the Trigger Legend. These columns list the letter and number codes as well as the name of the MDS items to be considered. The third column lists the specific resident codes that will trigger a RAP. The remaining columns list the individual RAP titles.

To identify a triggered RAP, match the resident's MDS item responses with the "Code" column. If there is a "match", follow horizontally to the right until a trigger is indicated by one of the key symbols. If, for example, there is a solid circle in the column, the RAP titled at the top of that column is "triggered". This means that further assessment using the RAP Guideline is required for that particular condition.

3. Note which RAPs are triggered by particular MDS items. If desired, circle or highlight the trigger indicator or the title of the column.

4. Continue down the left column of the Trigger Legend matching recorded MDS item responses with trigger definitions until all triggered RAPs have been identified.

5. When the Trigger Legend review is completed, document on the RAP Summary form which RAPs triggered by checking the boxes in the column titled "Check if Triggered".

EXAMPLES

When Mrs. D. returns to her room after eating breakfast, she cannot recall eating breakfast, and always asks the nurse when breakfast will be served. MDS item Short Term Memory, B2a, has been coded 1 (Memory Problem), and the Cognitive Loss/Dementia RAP is triggered for further assessment.

Mr. F. is independent in cognitive skills for daily decision-making. His transferring ability varies throughout each day. He receives no assistance at some times and heavy weight-bearing assistance of one person at other times. The MDS item Decision Making, B4, is coded 0 (Independent). The MDS item Transferring, G1bA, is coded 3 (Limited Assistance). The ADL-Rehabilitation RAP is triggered for further assessment, focusing on a possible rehabilitative intervention. Rationale for trigger: Mr. F. has good cognitive skills for learning new ways to function and realize his potential.

Mr. P. is receiving an antipsychotic medication two times per day. He has fallen within the last 30 days. The MDS item Antipsychotics, O4a, is coded 7 (Received 7 days a week). The MDS item Falls (in past 30 days), J4a, is checked. The Psychotropic Drug Use RAP is triggered for further assessment. (Note: Because J4a is checked, the Falls RAP will also be triggered.)

Mrs. T. is highly involved in activities of the facility. When structured activities are not scheduled, she keeps busy reading, crocheting and writing a journal. Mrs. T. awakens early in the morning and rarely takes a nap. MDS item Awake Mornings, N1a, is checked. MDS item Involved in Activities, N2, is coded 0 (most of time). Both of these MDS items are required to trigger the Activities RAP; these factors in combination suggest that the focus of the assessment should be on reviewing the current activities plan.

Mrs. C. is limited in bed mobility (MDS item G1aA), with a physical restraint used during part of the day. The presence of any of these items is sufficient to trigger the Pressure Ulcer RAP, focusing on issues of problem avoidance in the future. (Note: other RAPs triggered include ADLs and Physical Restraints.)

Different types of triggers can change the focus of the RAP review. There are four types of triggers:

1. **Potential Problems** - Those factors that suggest the presence of a problem that warrants additional assessment and consideration of a care plan intervention. These are usually "narrowly" defined as factors that warrant additional assessment. They include clinical factors commonly seen as indicative of possible underlying problems and consequently have generally been well understood by facility staff members. Examples include the

presence of a pressure ulcer or use of a trunk restraint, both of which indicate the need for further review to determine what type of intervention is appropriate or whether underlying behavioral symptoms can be minimized or eliminated by treatment of the underlying cause (e.g., agitated depression).

2. **Broad Screening Triggers** - These are factors that assist staff to identify hard to diagnose problems. Because some problems are often difficult to assess in the elderly nursing home population, certain triggers have been "broadly" defined and consequently may have a fair number of "false positives" (i.e., the resident may trigger a RAP which is not automatically representative of a problem for the resident). Examples include factors related to delirium or dehydration. At the same time, experience has shown that many residents who have these problems were not identified prior to having triggered for review. Thus careful consideration of these triggered conditions is warranted.
3. **Prevention of Problems** - Those factors that assist staff to identify residents at risk of developing particular problems. Examples include risk factors for falling or developing a pressure ulcer.
4. **Rehabilitation Potential** - Those factors that are aimed at identifying candidates with rehabilitation potential. Not all triggers identify deficits or problems. Some triggers indicate areas of resident strengths. In general, these factors suggest consideration of programs to improve a resident's functioning or minimize decline. For example, MDS item responses indicating "Resident believes he or she is capable of increased independence in at least some ADLs" (G8a) may focus the assessment and care plan on functional areas most important to the resident or on the area with the highest potential for improvement.

Facility staff who are assessing a resident whose condition "triggers" a RAP should know what item responses on the MDS triggered that RAP. This step is often missed, especially if someone other than the person(s) who completed the MDS reviews the Trigger Legend or the triggering is automated. Referring to the Triggers section of the RAP to identify relevant triggers can help to "steer" the assessment to factors particular to the individual resident. For example, if a staff member assigned to assess a resident who has fallen or is at risk for falls knows that the Falls RAP was triggered because the resident had been dizzy during the MDS assessment period (MDS item J1f - Dizziness was checked), the RAP review would include a focus on causal factors and interventions for dizziness. While reviewing the RAP, other factors may come to light regarding the resident's risk for falls, but knowing the trigger condition clarifies or possibly rules out certain avenues of approach to the resident's problem.

At the same time, there can also be a tendency to believe that the RAP review is limited to only those MDS items that triggered the RAP. Such a view is false and can lead to key causal factors being unnoticed and a less than appropriate plan of care being initiated. Many of the trigger conditions serve to initiate a more comprehensive review process including specific causal factors (as referenced in the Guidelines) that are to be considered relative to the resident's status.

4.5 Assessment of the Resident Whose Condition Triggered RAPs (RAP Process - Step 2)

“Reviewing” a triggered RAP means doing an in-depth assessment of a resident who has a particular clinical condition in terms of the potential need for care plan interventions. The RAP is used to organize or guide the assessment process so that information needed to fully understand the resident’s condition is not overlooked.

The triggered RAPs are used to glean information that pertains to the resident’s condition. While reviewing the RAP, facility staff consider what MDS items caused the RAP to trigger and what type of trigger it is (i.e., potential problem, broad screen, prevention of problem or rehabilitation potential). This focuses the review on information that will be helpful in deciding if a care plan intervention is necessary, and what type of intervention is appropriate.

The information in the RAP is used to supplement clinical judgment and stimulate creative thinking when attempting to understand or resolve difficult or confusing symptoms and their causes. The Guidelines are an aide, a tool, a starting point. It is the understanding and insight of members of the interdisciplinary team that will help integrate these factors into a meaningful resident assessment and care plan.

4.6 Decision-making and Documentation of the RAP Findings (RAP Process - Steps 3 and 4)

It is recommended that staff who have participated in the assessment and who have documented information about the resident’s status for triggered RAPs be a part of the interdisciplinary team that develops the resident’s care plan. The team, including the resident, family or resident representative, makes the final decision to proceed to address the “triggered” condition on the care plan.

In order to provide continuity of care for the resident and good communication to all persons involved in the resident’s care, it is important that information from the assessment that led the team to their care planning decision be clearly documented.

It is not necessary to record all of the items referred to in the RAP Guidelines, listing all factors that do and do not apply. Rather, documentation should focus on key issues, which may include:

- Why will you address or not address specific conditions in the care plan?
- What is it about the conditions that may affect the resident’s daily functioning?
- Why did you decide the resident is at risk, that improvement is possible, or that decline can be minimized?
- Why could the resident benefit from consultation with an expert in a particular area (e.g., gynecologist, psychologist, surgeon, speech pathologist)?

nursing care, ophthalmology evaluation to rule out visual field deficits, speech therapy referral. We will discuss Ms. E.'s care at nursing rounds tomorrow and develop a revised plan to address these issues.

EXAMPLE #2: This is an example of 1) documentation in the progress notes of the clinical record clarifying that a problem is present and has been discussed with the resident, and 2) another note that describes the beginning of a work-up to evaluate and treat causes of the problem.

8/21/95 PROBLEM: URINARY INCONTINENCE

Nursing note:

Mrs. D.'s clothing has been found wet during the night on 3 occasions in the past two weeks. Her nurse assistants have also found that she has been tucking washcloths in her underwear. I spoke with her this morning. She admitted that she has been having some urinary accidents for some time but was hiding them. She cried, saying, "I am so ashamed". I reassured her that although incontinence is not normal, it is common, and should be evaluated for possible treatments. I proceeded to review the type of step by step evaluation that could be done, some which could be done here at the home and, if necessary, she would see some specialists. Mrs. D. seemed relieved and asked me to call her daughter with the information. I spoke with Ms. D. who agreed with the evaluation. She said that she has been noticing a faint odor of urine when she visits, but her mother always denied any problems. Will contact physician.

G. Hope, RN

EXAMPLE #3: This is an example of a note in a clinical record that could be referenced on the RAP Summary form to substantiate a team's decision to proceed to care planning when a RAP is triggered.

8/30/95 PROBLEM: DELIRIUM

Physician Progress note:

Mr. F. has had new symptoms in the past week of altered perceptions (thinks someone keeps jumping through his window at night when the curtain moves and has hallucinations), restlessness (pacing) and agitation, and is more confused. A review of his medication sheet shows that his Digoxin dose was increased from 0.125 mg every other day to 0.25 mg. daily 2 weeks ago during an episode of congestive heart failure. His appetite has also decreased and he says food is making him sick. He is delusional in his thinking that his food is poisoned. Mr. F.'s exam is unremarkable for signs of an acute illness or other causes of delirium. His symptoms are consistent with probable digoxin toxicity. We will obtain a digoxin level in the morning. In the meantime, I have asked the nursing staff to hold the digoxin and encourage fluids until we reevaluate in the morning. I will temporarily put him on a low dose of Haldol 0.5 mg twice daily in order to reduce his delusions and distress. I will review his status daily with the goal of tapering him off the Haldol once his mental status returns to baseline.

Ben Todd, M.D.

8/30/95 PROBLEM: DELIRIUM

Nursing note:

Until the acute confusion subsides, Mr. F will receive close observation, monitoring of his intake with encouragement of fluids, cueing during ADLs to help him focus. He will be allowed to pace in the confines of the unit and restricted to the unit until his confusion resolves.

J. Doe, RN

EXAMPLE #4: This case illustrates summary documentation using RAP Guidelines to assess the resident's progress related to a previously noted condition, as well as the success of the care plan over time.

PROBLEM: PRESSURE ULCER OVER RIGHT TROCHANTER

Three months ago, Mr. H. developed a Stage III pressure ulcer over his right trochanter when he fell asleep on the spirals of a notebook while reading in bed (pressure). Mr. H. had been receiving Ambien 10mg at bedtime for sleep because he had difficulty falling asleep with a roommate who snores loudly. He was friendly with the roommate and did not want to switch rooms when the opportunity was offered. Deep sleep most likely contributed to his not responding to the spiral by shifting his weight. Mr. H. has since agreed to move in with a quieter roommate and discontinue the Ambien. We have been treating the ulcer with surgical debridement as necessary and wet to dry saline dressings three times daily, and the ulcer has cleared up nicely to a dime-size area with clean granulation tissue present. Dr. K. discontinued wet to dry dressings and it is being managed with a transparent dressing. Mr. H. is back to his usual activities and is adherent to his repositioning program when in bed. We will continue the current care plan.

EXAMPLE #5: This case illustrates documentation, using RAP Guidelines, to assess the progress of a long-stay resident who has chronic Urinary Incontinence AND Pressure Ulcer risk.

PROBLEM: LONG-STANDING URINARY INCONTINENCE AND PRESSURE ULCER RISK

Mr. F. is a severely demented gentleman who suffers from immobility secondary to dementia and disuse. He has tight contractures of his elbows, hips, knees, and ankles making toileting difficult. Mr. F. is frail, primarily bed- and recliner chair-bound. He is totally dependent on staff for care in ADLs, including eating. He has long-standing incontinence that has been managed for the past year with an external catheter to protect his skin (He has a history of rashes). When transferred he is always placed on pressure relieving devices. He receives a turning and positioning regimen. This regimen has been working and he is free of rashes and skin breakdown. We and his family are in agreement about continuing the current palliative approach to urinary incontinence and preventive approach to ulcer formation.

EXAMPLE #6: This example illustrates that it is not necessary to use the titles of the RAPs to document resident assessment information using RAP Guidelines. The most important goal of

documentation is to describe events in a way that everyone can understand what is happening to the resident.

PROBLEM: SIDE EFFECTS FROM MELLARIL

Mrs. L. has been disimpacted of hard, pasty stool twice during the last 6 days. Bowel elimination records show that she has been having infrequent movements. Staff say that she strains at stool. Mrs. L. has a long history of schizophrenia. Her psychosis has been managed with various antipsychotics over the years. Most recently (last 6 weeks) we switched her from Haldol to Mellaril 50 mg. TID daily for its sedative effects as she was agitated, wandering, and delusional. The Mellaril has calmed her down to the point that she is able to sit in on some unit activities without leaving them. The dose was then reduced but when symptoms recurred we went back to 50mg. TID. Her blood pressure has been stable at 138/86 - 146/90 and she has had no falls. The constipation is most likely related to the Mellaril. However, as her emotional state is currently stable and she is functioning better we will maintain the current dose, add Colace 100 mg. bid, assure adequate fluid intake, and consult with dietary for suggestions.

EXAMPLE #7: This is an example of a note that illustrates the assessment of multiple problems that were triggered by the MDS. The rationale for combining the assessment into one note is that the resident's risks, problems, causes, and treatments are all interrelated. On a RAP Summary form the following note could be referenced for several triggered RAPs: Falls, Psychotropic Drug Use, Cognitive Loss, Mood State.

PROBLEM: FALLS

Mrs. T.'s severely depressed mood has improved with Trazodone and involvement in a twice weekly expressive therapy group. She has been more attentive to her surroundings and has begun to socialize like her old self. She remains disoriented to time and continues to need many reminders for most tasks (her baseline). She has rejoined her baking group that meets every other day. Her appetite has picked up and she eats most meals that are offered. We are now concerned about 2 falling episodes this past week. She usually walks alone but is very slow. On Monday night she seemed to falter in the dining room but grabbed onto some chairs to steady herself. On Tuesday she was walking in the corridor with her daughter, faltered, and then her daughter caught her before she fell. Mrs. T. insisted that she felt O.K. She denied feeling dizzy or unsteady and said she just tripped over a chair. Yesterday, she fell to the floor in the dining room while getting up from a chair. She sustained no injuries but she was posturally hypotensive (See vital sign sheet). She was seen by Dr. R. who cut back on her Trazodone dose. We will monitor postural vital signs twice daily, and supervise all transfers and walking, and observe for changes in mood. She has been referred to PT for gait evaluation.

EXAMPLE #8: The following example illustrates how to document a situation when the resident functions at a consistent level over a long period of time. The MDS assessment always triggers the same RAP for the same reason, but the resident has shown neither improvement nor decline

4.7 Development or Revision of the Care Plan (RAP Process - Step 5)

Following the decision to address a "triggered" condition on the care plan, key staff or the interdisciplinary team should:

- Review the current care plan if the condition is already addressed and make changes, as needed, to reflect the new assessment; and
- Develop new care plan problems, goals and approaches as needed.

Staff may choose to combine related "triggered" conditions into a single care plan problem that will address the initial set of causal problems and related outcomes identified in the RAP review.

Chapter 5 will address the development of resident care plans in more detail.

4.8 Frequently Asked Questions on RAP Documentation

Q: "Is it necessary to complete a RAP review if a resident always triggers for the same RAP in the same way? For example, Mrs. Peterson always triggers for the Nutritional Status RAP because she often leaves 25% of her food uneaten at most meals. She is not a big eater, and prefers to snack throughout the day - not to mention the portions on the tray are quite large. Do we need to do the entire RAP each time?"

A: No, it is not necessary to always review and document RAP findings on subsequent assessments the way you would on the initial assessment. Triggers identify areas warranting further assessment. The RAP guides this assessment. In this example, further assessment may reveal a swallowing problem, chewing problem, delirium, activity endurance problem, or a healthy life time pattern. If Mrs. Peterson chooses to eat frequent snacks, and still is consuming a nutritionally adequate diet, then there is no reason to complete the RAP in its entirety at each full assessment. In this example, clearly document the initial nutritional assessment including: preferences, information that confirms her diet is sufficient, any supporting weights or any lab values that give insight into nutrition. If she continues to trigger this RAP for the same reasons, make a one line entry referring to the original nutritional assessment and indicate that the resident's status has not changed. On subsequent assessments, it is always necessary to assess the resident to validate that his or her status has not changed as compared to the original RAP assessment and documentation.

Q: "Is it required to write a summary note documenting all of the RAP information?"

A: The requirement is that you document information from the resident's assessment and staff's decision making about care. This should already be an easily accessible part of the medical record, in which case a summary note may be redundant. Ask yourself this question: "If I was a newly hired care giver for this resident, will I be able to find and understand the

assessment and decision making process?" If the answer is yes, then you should feel secure that your documentation is complete. If you answer no, consider pulling together key information or "filling in the gaps" in a short note.

Q: "I often hear different stories about what is required for RAP documentation. These stories seem to vary by nursing home, surveyors, care givers, books, software and even the day of the week! Why is that, and how can we find out what is expected in our written documentation?"

A: While interpretations of HCFA's requirements have varied, the RAP process was developed to reflect good clinical practice and RAP documentation expectations have never changed: RAPs guide further assessment of residents who have or are at risk of developing problems (triggered areas). This assessment is supposed to lend further insight into the problems identified by the MDS. RAP "documentation" involves only what should already be taking place: clearly written assessments, decision making by staff knowledge about the resident's condition, and care plans developed based on a comprehensive assessment of a resident's needs, strengths, and preferences.

Where staff often go astray is in the basics. What does clear documentation and decision making mean? The RAP guides the assessment piece and documentation should follow. Decision making is a written account of the team's clinical thought processes about the resident assessment findings. This seemingly simple process has left many people baffled and searching for "user friendly" alternatives to RAP documentation. As a result an industry of workbooks, flow sheets, check lists and software has been created. In some cases, these products may help staff by providing structure that facilitates the clinical assessment and decision-making process; in other cases, such products have tended to create a larger paper trail and made the process more complicated than necessary. Each facility should establish a documentation process that "works" for them and incorporate additional tools only if they are deemed of clear benefit in facilitating documentation and clinical decision-making.

Q: "I don't see how we can possibly do the Urinary Incontinence RAP in 14 days after admission. And, it seems everyone has a different idea about when these RAPs are due. Some say 7 days after admission, 14 days, 21 days, who is right?"

A: Statutory requirements dictate that the RAI be completed within 14 days after admission. As an integral part of the RAI, RAPs must be completed within 14 days, which means that the initial RAP Guideline review must be conducted and documented by the end of that time. However, the RAPs may point out the need for a more extensive evaluation which cannot be completed entirely within the time period. A good example is the Urinary Incontinence RAP. It is generally difficult to perform a complete work-up in 14 days. Even getting initial tests ordered and scheduled can take several weeks. Rather what is intended by "14 days after admission" is when the initial RAP assessment process and documentation must be completed. Certainly you do not wait several weeks to initiate the assessment and make care planning decisions. These initial plans should be outlined in the care plan along with the plan for further assessment.

Q: "Is the person who signs the 'Signature of RN Coordinator for RAP Assessment Process on the RAP Summary form, the same person as the MDS RN Coordinator? What dates are entered in #2 and #4 on the RAP Summary form, and whose name is placed in the 'Signature of Person Completing Care Planning Decision'?"

A: The "Signature of RN Coordinator for RAP Assessment Process" does not need to be the same RN as is on the MDS assessment. The date entered in VB2 on the RAP Summary form is the date the RN Coordinator of the RAP process (i.e., the person who oversaw completion of the RAPs), indicated the triggered RAPs and completed the Location and Date of RAP Assessment Documentation section. This must be completed no later than 14 days after admission. The (Signature of) Person Completing Care Planning Decision can be any person(s) who facilitates the care planning decision-making. It is an interdisciplinary process. The care plan must be done no later than 21 days after admission or 7 days after MDS and RAPs are completed. The care-planning information on the RAP Summary form would be completed at that time, with the date to enter in #4 the day that #3 is signed.

4.9 When is the Resident Assessment Instrument not Enough?

Federal requirements support a facility's ongoing responsibility to assess a resident. The Quality of Care regulation³ requires that "each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care". Services provided or arranged by the facility must also meet professional standards of quality. Compliance with these regulations requires that the facility monitor the resident's condition and respond with appropriate careplanning interventions.

The MDS is a screening instrument and does not include detailed descriptions of all factors necessary for careplanning and evaluation. When completing the MDS, the assessor simply indicates whether or not a factor is present. For certain clinical situations, if the MDS indicates the presence of a potential resident problem, need, or strength, the assessor may need to investigate and document the resident's condition in more detail. For example, if a resident is noted as having a contracture on the MDS, additional documentation in the record may include the number of contractures present, sites, and degree of restriction in each affected joint. RAPs also assist in gathering additional information for some clinical conditions.

In addition, completion of the MDS/RAPs does not necessarily fulfill a facility's obligation to perform a comprehensive assessment. Facilities are responsible for assessing areas that are relevant to individual residents regardless of whether or not the appropriate areas are included in the RAI. For example, the MDS includes a listing of those diagnoses that affect the resident's functioning or needs in the past 7 days. While the MDS may indicate the presence of medical

³ 42 CFR 483.25-(F 309)

Haldol to p.o. and will slowly decrease the dosage. Continue with Bactrim DS until course completed. Discontinue Zantac. It is unclear why he was started on it and it may be contributing to his confusion. Monitor Intake and Output for next 7 days. I will do a further exam of Mr. S. on Monday.

Day 4 (The following is an example of a dialogue between the nurse and the social worker about what was learned in admission examinations. It does not represent documentation but serves to illustrate the interdisciplinary assessment processes. Also included on this day are the follow-up nursing notes and a separate physical therapy note. Staff's awareness of the needs and treatments for the resident is expanding.)

SOCIAL WORKER (SW):

"I spoke with Mr. S., his wife Marion and oldest daughter, Susan, the first two days of admission. Throughout the conversation, Mr. S. was unable to answer simple questions. He was easily sidetracked and would become consumed with smoothing out his bedclothes. Marion and Susan said that normally he can't answer simple questions about his immediate needs, but he can talk endlessly about woodworking and opera."

NURSE (N):

"Mr. S. is much clearer today. Although he didn't remember meeting me before, he responded to his name, and stated that he was not in his home, but in an old person's home. His wife was present and he called her by her proper name."

SW: "Mary [the nurse on evenings] told me that his cognition will probably continue to improve once his delirium clears. I have shared this with the family who seemed relieved."

N: "She is probably right. The UTI, dehydration, morphine, Zantac and Haldol probably contributed to his acute confusion, but because he has Alzheimer's disease, it makes it difficult to assess his baseline."

SW: "Well, his family described a gregarious man, who enjoyed attending the Alzheimer's Day Care Program at the community center. He was diagnosed with Alzheimer's Disease five years ago although the daughter stated that she felt that he was having problems several years before the actual diagnosis. His wife also told me that Mr. S. was having increasing difficulties with his ADLs. She would have to break tasks down into sub-tasks. He required lots of cueing for dressing especially."

N: "He had his admission physical exam yesterday. Under the circumstances, everything seems O.K. His enlarged prostate probably causes some urinary retention which would have put him at greater risk for the urinary tract infection, but his surgical incision line was clean. He appears well hydrated, and the nurse assistants from the day and evening shift indicate that he is taking in ample fluids. He continues to manipulate bed clothes, which according to his wife is a new activity, but it is tapering off. This could represent

a resolution of his acute confusion. We will continue to monitor his intake and output, and cognition in light of his acute confusion. He is at risk for falling. He still has a few more days on his antibiotic for his UTI. The physical therapist will be seeing him today in fact. I'm going to write a brief note to document the areas we covered in these conversations."

NURSING NOTE

Discussed Mr. S.'s condition with Social Worker. Mr. S. seems to be "clearer today". He is oriented to person, able to identify wife by her correct name, and is aware that he is not in his home. He identifies his property that his wife brought in from home (picture and opera posters), and his fidgeting with the bedcloths has lessened. As his acute confusion improves we should see a returning to baseline. On exam Mr. S. appeared well hydrated, I/O adequate according to reports from nurse assistants. He appears in mild discomfort only when he ambulates, and is receiving Tylenol regularly. His dose of Haldol is being slowly tapered. He does not appear to have any negative effects from this. K. Phillips, R.N.

PHYSICAL THERAPY NOTE

On August 14, 1995, he sustained the fall and fractured his left hip. He underwent a successful replacement of the hip, and was cleared for light weight bearing status on 8/21/95. Because of his worsening cognition, and additional problems, he has not been ambulating except out of bed to the commode with nursing staff.

According to the daughter, who was involved with his care at home, his fall was an isolated event. Usually he ambulates around his home, Adult Day Care, and takes frequent walks without event. Orthostatic blood pressures and pulses from the end of his hospitalization and since admission here have been within normal limits, with orthostatic changes noted upon admission to the hospital.

His fall at home occurred at 2 am. The resident was very restless the entire day. He appeared to be having difficulty urinating. His wife was planning to take him into the doctor's office in the morning. Mr. S. got out of bed and was found wandering around the house. His wife tried to get him to return to bed, but he went into the bathroom, got into the shower - with his clothing on - and fell. Wife is not certain if he slipped or just fell.

Upon examination, he did not have orthostatic changes in his blood pressure or heart rate from a lying to upright position. He was able to get out of bed to a standing position with contact guard. Using his new walker, he was able to move to the hallways - safely. He did seem confused about the walker, but followed my commands appropriately.

This resident is ready to bear full weight. Staff should walk with him three times a day using contact guard and cueing for the walker. A sign that reads "Mr. S. remember your pusher" (his word for walker) was placed by his bed and by the inside of the door. According to notes from the Cognitive Impairment Clinic, he is able to read and follow simple written directions.

Assessment: Mr. S. is at risk for future falls due to his recent fracture and hip replacement, cognitive impairments, new required use of walker (which he may get to a point that he doesn't need), and residual acute confusion. Plan: Monitor closely, contact guarding with all ambulation. Ambulate in hallway at least three times a day. Slowly increase distance, over the next two weeks, from room to dining room. J. Smith, P.T.

Day 5 (Example of documentation of additional information gathered that would be relevant to comprehensive resident assessment using the MDS and RAPs)

NURSING NOTE

Resident incontinent of urine all three shifts since admission. His normal pattern at home was to toilet himself as needed, with additional reminders from his wife before leaving the house and at bed time. Resident with a past history of enlarged prostate and urinary retention. Resident is moving his bowels daily and passing moderate amounts of soft, formed stool. Digital exam is negative for feces in rectum. Mr. S. is receiving tapering doses of Haldol. We expect the incontinence to resolve with diminishing Haldol doses, full treatment of UTI, and resolution of delirium. The decision was made to document bowel and bladder activity, I/O of fluids, assess for bladder distention, discuss with wife regarding past patterns for bathroom cueing, and to continue to review medications: Haldol, Bactrim DS.

K. Phillips, R.N.

2. DRAWING INFORMATION TOGETHER

The above are examples of the types of activities and dialogue that occur as staff gather information and structure care during the first few days of a resident's stay in the home. Using this and other information, staff would next fill out the MDS. Each discipline would complete their assigned portion of the MDS, cross check the assessment across disciplines and shifts for accuracy, and then have it signed off by the RN.

A completed MDS for Mr. S. follows. Note that this completed MDS form includes information presented in the examples above, as well as other information not available to the reader. In reviewing Mr. S.'s MDS, note the information that it contains for use by staff in using the RAP Guidelines.

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

- Key:**
- = One item required to trigger
 - ② = Two items required to trigger
 - * = One of these three items, plus at least one other item required to trigger
 - ⓐ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

Delirium
 Cognitive Loss/Dementia
 Visual Function
 Communication
 ADL-Rehabilitation Trigger A ⓐ
 ADL-Maintenance Trigger B ⓐ
 Urinary Incontinence and Involving Catheter
 Psychosocial Well-Being
 Mood State
 Behavioral Symptoms
 Activities Trigger A
 Activities Trigger B
 Falls
 Nutritional Status
 Feeding Tubes
 Dehydration/Fluid Maintenance
 Dental Care
 Pressure Ulcers
 Psychotropic Drug Use
 Physical Restraints

| MDS ITEM | CODE | Delirium | Cognitive Loss/Dementia | Visual Function | Communication | ADL-Rehabilitation Trigger A ⓐ | ADL-Maintenance Trigger B ⓐ | Urinary Incontinence and Involving Catheter | Psychosocial Well-Being | Mood State | Behavioral Symptoms | Activities Trigger A | Activities Trigger B | Falls | Nutritional Status | Feeding Tubes | Dehydration/Fluid Maintenance | Dental Care | Pressure Ulcers | Psychotropic Drug Use | Physical Restraints | | |
|-------------|---|----------|-------------------------|-----------------|---------------|--------------------------------|-----------------------------|---|-------------------------|------------|---------------------|----------------------|----------------------|-------|--------------------|---------------|-------------------------------|-------------|-----------------|-----------------------|---------------------|-----|-------------|
| B2a | Short term memory | 1 | ● | | | | | | | | | | | | | | | | | | | B2a | |
| B2b | Long term memory | 1 | ● | | | | | | | | | | | | | | | | | | | | B2b |
| B4 | Decision making | 1,2,3 | ● | | | | | | | | | | | | | | | | | | | | B4 |
| B4 | Decision making | 3 | | | | ● | | | | | | | | | | | | | | | | | B4 |
| B5a to B5f | Indicators of delirium | 2 | ● | | | | | | | | | | | | | | | | ● | | | | B5a to B5f |
| B6 | Change in cognitive status | 2 | ● | | | | | | | | | | | | | | | | ● | | | | B6 |
| C1 | Hearing | 1,2,3 | | | ● | | | | | | | | | | | | | | | | | | C1 |
| C4 | Understanding others | 1,2,3 | | | ● | | | | | | | | | | | | | | | | | | C4 |
| C6 | Understand others | 1,2,3 | ● | | ● | | | | | | | | | | | | | | | | | | C6 |
| C7 | Change in communication | 2 | | | | | | | | | | | | | | | | | | ● | | | C7 |
| D1 | Vision | 1,2,3 | | ● | | | | | | | | | | | | | | | | | | | D1 |
| D2a | Side vision problem | 1,2,3 | | ● | | | | | | | | | | | | | | | | | | | D2a |
| E1a to E1p | Indicators of depression, anxiety, sad mood | 1,2 | | | | | | ● | | | | | | | | | | | | | | | E1a to E1p |
| E1o | Receptive aphasia | 1,2 | | | | | | | | | | | | | | | | | | ● | | | E1o |
| E1o | Withdrawal from activities | 1,2 | | | | | | ● | | | | | | | | | | | | | | | E1o |
| E2 | Mood persistence | 1,2 | | | | | | ● | | | | | | | | | | | | | | | E2 |
| E3 | Change in Mood | 2 | ● | | | | | | | | | | | | | | | | | ● | | | E3 |
| E4aA - E4eA | Behavioral symptoms | 1,2,3 | | | | | | | | ● | | | | | | | | | | | | | E4 |
| E5 | Change in behavioral symptoms | 1 | | | | | | | | ● | | | | | | | | | | | | | E5 |
| E5 | Change in behavioral symptoms | 2 | ● | | | | | | | | | | | | | | | | | ● | | | E5 |
| F1a | Establishes new goals | 1 | | | | | | ● | | | | | | | | | | | | | | | F1a |
| F2a to F2d | Unsettled relationships | ✓ | | | | | | ● | | | | | | | | | | | | | | | F2a to F2d |
| F3a | Struggle to adjust roles | ✓ | | | | | | ● | | | | | | | | | | | | | | | F3a |
| F3b | Lost roles | ✓ | | | | | | ● | | | | | | | | | | | | | | | F3b |
| F3c | Daily routine changes | ✓ | | | | | | ● | | | | | | | | | | | | | | | F3c |
| G1aA - G1jA | ADL self-performance | 1,2,3,4 | | | | ● | | | | | | | | | | | | | | | | | G1aA - G1jA |
| G1aA | Self mobility | 1,2,3,4 | | | | ● | | | | | | | | | | | | | | ● | | | G1aA |
| G2A | Bathing | 1,2,3,4 | | | | ● | | | | | | | | | | | | | | | | | G2A |
| G3a | Bathing while sitting | 1,2,3 | | | | | | | | | | | | | | | | | | ● | | | G3a |
| G6a | Bedfast | ✓ | | | | | | | | | | | | | | | | | | ● | | | G6a |
| G6aA | Resident staff believe transfer | ✓ | | | | | | | | | | | | | | | | | | ● | | | G6aA |
| H1a | Bowel incontinence | 1,2,3,4 | | | | | | | | | | | | | | | | | | ● | | | H1a |
| H1b | Stool incontinence | 1,2,3,4 | | | | | | | | | | | | | | | | | | ● | | | H1b |
| H2b | Constipation | ✓ | | | | | | | | | | | | | | | | | | ● | | | H2b |
| H2a | Fecal impaction | ✓ | | | | | | | | | | | | | | | | | | ● | | | H2a |
| H3c,d,e | Catheter use | ✓ | | | | | | ● | | | | | | | | | | | | | | | H3c,d,e |
| H3a | Use of catheters | ✓ | | | | | | ● | | | | | | | | | | | | | | | H3a |
| I1i | Hypotension | ✓ | | | | | | | | | | | | | | | | | | ● | | | I1i |
| I1 | Psychological distress | ✓ | | | | | | | | | | | | | | | | | | ● | | | I1 |
| I1ee | Depression | ✓ | | | | | | | | | | | | | | | | | | ● | | | I1ee |
| I1j | Cataracts | ✓ | | ● | | | | | | | | | | | | | | | | | | | I1j |
| I1ii | Glaucoma | ✓ | | ● | | | | | | | | | | | | | | | | | | | I1ii |
| I3 | UTI | ✓ | | | | | | | | | | | | | | | | | | ● | | | I3 |
| I3 | Dehydration diagnosis | 2,7,6,5 | | | | | | | | | | | | | | | | | | ● | | | I3 |
| J1a | Weight fluctuation | ✓ | | | | | | | | | | | | | | | | | | ● | | | J1a |
| J1c | Dehydrated | ✓ | | | | | | | | | | | | | | | | | | ● | | | J1c |
| J1d | Incontinent fluid | ✓ | | | | | | | | | | | | | | | | | | ● | | | J1d |
| J1f | Disziness | ✓ | | | | | | | | | | | ● | | | | | | | | | | J1f |
| J1g | Fever | ✓ | | | | | | | | | | | | | | | | | | ● | | | J1g |
| J1i | Hallucinations | ✓ | | | | | | | | | | | | | | | | | | ● | | | J1i |
| J1j | Urinary Infection | ✓ | | | | | | | | | | | | | | | | | | ● | | | J1j |
| J1k | Lung aspirations | ✓ | | | | | | | | | | | | | | | | | | ● | | | J1k |
| J1m | Syncope | ✓ | | | | | | | | | | | | | | | | | | ● | | | J1m |

SECTION D. VISION PATTERNS

| | | |
|------------------------------------|--|----------------|
| 1. VISION | (Ability to see in adequate light and with glasses if used) 0. ADEQUATE —sees fine detail, including regular print in newspapers/books 1. IMPAIRED —sees large print, but not regular print in newspapers/books 2. MODERATELY IMPAIRED —limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY IMPAIRED —object identification in question, but eyes appear to follow objects 4. SEVERELY IMPAIRED —no vision or sees only light, colors, or shapes; eyes do not appear to follow objects | |
| 2. VISUAL LIMITATIONS/DIFFICULTIES | Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes NONE OF ABOVE | a. b. c. |
| 3. VISUAL APPLIANCES | Glasses; contact lenses; magnifying glass 0. No 1. Yes | |

SECTION E. MOOD AND BEHAVIOR PATTERNS

| | | |
|--|--|---------|
| 1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD | (Code for indicators observed in last 30 days, irrespective of the assumed cause) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week) VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die" b. Repetitive questions—e.g., "Where do I go; What do I do?" c. Repetitive verbalizations—e.g., calling out for help, ("God help me") d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received e. Self deprecation—e.g., "I am nothing; I am of no use to anyone" f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues SLEEP-CYCLE ISSUES j. Unpleasant mood in morning k. Insomnia/change in usual sleep pattern SAD, APATHETIC, ANXIOUS APPEARANCE l. Sad, pained, worried facial expressions—e.g., furrowed brows m. Crying, tearfulness n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking LOSS OF INTEREST o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends p. Reduced social interaction | |
| 2. MOOD PERSISTENCE | One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered | |
| 3. CHANGE IN MOOD | Resident's mood status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated | |
| 4. BEHAVIORAL SYMPTOMS | (A) Behavioral symptom frequency in last 7 days 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) Behavioral symptom alterability in last 7 days 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety) b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at) c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused) d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/toes, hoarding, rummaged through others' belongings) e. RESISTS CARE (resisted taking medications/injections, ADL) | (A) (B) |

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

SECTION F. PSYCHOSOCIAL WELL-BEING

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

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

| | | |
|---|---|-------------------|
| 1. (A) ADL SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup) | 0. INDEPENDENT —No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days 1. SUPERVISION —Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided 1 or 2 times during last 7 days 2. LIMITED ASSISTANCE —Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days 3. EXTENSIVE ASSISTANCE —While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: — Weight-bearing support — Full staff performance during part (but not all) of last 7 days 4. TOTAL DEPENDENCE —Full staff performance of activity during entire 7 days 8. ACTIVITY DID NOT OCCUR during entire 7 days | (A) (B) |
| (B) ADL SUPPORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification) | 0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+ persons physical assist 8. ADL activity itself did not occur during entire 7 days | SELF-PERF SUPPORT |
| a. BED MOBILITY | How resident moves to and from lying position, turns side to side, and positions body while in bed | |
| b. TRANSFER | How resident moves between surfaces—to/from bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet) | |
| c. WALK IN ROOM | How resident walks between locations in his/her room | |
| d. WALK IN CORRIDOR | How resident walks in corridor on unit | |
| e. LOCOMOTION ON UNIT | How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair | |
| f. LOCOMOTION OFF UNIT | How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair | |
| g. DRESSING | How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis | |
| h. EATING | How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition) | |
| i. TOILET USE | How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes | |
| j. PERSONAL HYGIENE | How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers) | |

Resident _____

Numeric Identifier _____

| | | | | | |
|----|--|---|---|-----|-----|
| 2. | BATHING | How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) <i>Code for most dependent in self-performance and support.</i> (A) BATHING SELF-PERFORMANCE codes appear below 0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur during entire 7 days (Bathing support codes are as defined in Item 1, code B above) | (A) | (B) | |
| 3. | TEST FOR BALANCE (see training manual) | (Code for ability during test in the last 7 days) 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help a. Balance while standing b. Balance while sitting—position, trunk control | | | |
| 4. | FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual) | (Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury) (A) RANGE OF MOTION 0. No limitation 1. Limitation on one side 2. Limitation on both sides a. Neck b. Arm—including shoulder or elbow c. Hand—including wrist or fingers d. Leg—including hip or knee e. Foot—including ankle or toes f. Other limitation or loss | (B) VOLUNTARY MOVEMENT 0. No loss 1. Partial loss 2. Full loss | (A) | (B) |
| 5. | MODES OF LOCOMOTION | (Check all that apply during last 7 days) Cane/walker/crutch Wheeled self Other person wheeled | a. Wheelchair primary mode of locomotion b. NONE OF ABOVE | d. | e. |
| 6. | MODES OF TRANSFER | (Check all that apply during last 7 days) Bedfast all or most of time Bed rails used for bed mobility or transfer Lifted manually | a. Lifted mechanically b. Transfer aid (e.g., slide board, trapeza, cane, walker, brace) c. NONE OF ABOVE | d. | e. |
| 7. | TASK SEGMENTATION | Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them 0. No 1. Yes | | | |
| 8. | ADL FUNCTIONAL REHABILITATION POTENTIAL | Resident believes he/she is capable of increased independence in at least some ADLs Direct care staff believe resident is capable of increased independence in at least some ADLs Resident able to perform tasks/activity but is very slow Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings NONE OF ABOVE | | a. | b. |
| 9. | CHANGE IN ADL FUNCTION | Resident's ADL self-performance status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated | | | |

SECTION H. CONTINENCE IN LAST 14 DAYS

| | | |
|----|--|--|
| 1. | CONTINENCE SELF-CONTROL CATEGORIES (Code for resident's PERFORMANCE OVER ALL SHIFTS) | |
| 0. | CONTINENT —Complete control [includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool] | |
| 1. | USUALLY CONTINENT —BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly | |
| 2. | OCCASIONALLY INCONTINENT —BLADDER, 2 or more times a week but not daily; BOWEL, once a week | |
| 3. | FREQUENTLY INCONTINENT —BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week | |
| 4. | INCONTINENT —Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time | |
| a. | BOWEL CONTINENCE | Control of bowel movement, with appliance or bowel continence programs, if employed |
| | BLADDER CONTINENCE | Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., Foley) or continence programs, if employed |
| 2. | BOWEL ELIMINATION PATTERN | Bowel elimination pattern regular—at least one movement every three days a. Diarrhea b. Fecal impaction c. Constipation d. NONE OF ABOVE |

| | | | | | | | |
|----|-------------------------------------|--|---|----|----|----|----|
| 3. | APPLIANCES AND PROGRAMS | Any scheduled toileting plan Bladder retraining program External (condom) catheter Indwelling catheter Intermittent catheter | a. Did not use toilet room/commode/urinal b. Pads/briefs used c. Enemas/irrigation d. Ostomy present e. NONE OF ABOVE | f. | g. | h. | i. |
| 4. | CHANGE IN URINARY CONTINENCE | Resident's urinary continence has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated | | | | | |

SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

| | | | | | | | | | | | | | | | | | | | | | | | | | | |
|----|---|---|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|--|
| 1. | DISEASES (If none apply, CHECK the NONE OF ABOVE box) | <p>ENDOCRINE/METABOLIC/NUTRITIONAL</p> <p>Diabetes mellitus Hyperthyroidism Hypothyroidism</p> <p>HEART/CIRCULATION</p> <p>Arteriosclerotic heart disease (ASHD) Cardiac dysrhythmias Congestive heart failure Deep vein thrombosis Hypertension Hypotension Peripheral vascular disease Other cardiovascular disease</p> <p>MUSCULOSKELETAL</p> <p>Arthritis Hip fracture Missing limb (e.g., amputation) Osteoporosis Pathological bone fracture</p> <p>NEUROLOGICAL</p> <p>Alzheimer's disease Aphasia Cerebral palsy Cerebrovascular accident (stroke) Dementia other than Alzheimer's disease</p> <p>Hemiplegia/Hemiparesis Multiple sclerosis Paraplegia Parkinson's disease Quadriplegia Seizure disorder Transient ischemic attack (TIA) Traumatic brain injury</p> <p>PSYCHIATRIC/MOOD</p> <p>Anxiety disorder Depression Manic depression (bipolar disease) Schizophrenia</p> <p>PULMONARY</p> <p>Asthma Emphysema/COPD</p> <p>SENSORY</p> <p>Cataracts Diabetic retinopathy Glaucoma Macular degeneration</p> <p>OTHER</p> <p>Allergies Anemia Cancer Renal failure NONE OF ABOVE</p> | v. | w. | x. | y. | z. | aa. | bb. | cc. | dd. | ee. | ff. | gg. | hh. | ii. | jj. | kk. | ll. | mm. | nn. | oo. | pp. | qq. | rr. | |
| 2. | INFECTIONS (If none apply, CHECK the NONE OF ABOVE box) | <p>Antibiotic resistant infection (e.g., Methicillin resistant staph)</p> <p>Clostridium difficile (c. diff.)</p> <p>Conjunctivitis</p> <p>HIV infection</p> <p>Pneumonia</p> <p>Respiratory infection</p> <p>a. Septicemia b. Sexually transmitted diseases c. Tuberculosis d. Urinary tract infection in last 30 days e. Viral hepatitis f. Wound infection g. NONE OF ABOVE</p> | a. | b. | c. | d. | e. | f. | g. | h. | i. | j. | k. | l. | m. | | | | | | | | | | | |
| 3. | OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES | a. _____ b. _____ c. _____ d. _____ e. _____ | | | | | | | | | | | | | | | | | | | | | | | | |

SECTION J. HEALTH CONDITIONS

| | | | | | | | | | | | | |
|----|--|--|----|----|----|----|----|----|----|----|----|----|
| 1. | PROBLEM CONDITIONS (Check all problems present in last 7 days unless other time frame is indicated) | <p>INDICATORS OF FLUID STATUS</p> <p>Weight gain or loss of 3 or more pounds within a 7 day period</p> <p>Inability to lie flat due to shortness of breath</p> <p>Dehydrated; output exceeds input</p> <p>Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days</p> <p>a. Dizziness/Vertigo b. Edema c. Fever d. Hallucinations e. Internal bleeding f. Recurrent lung aspirations in last 90 days g. Shortness of breath h. Syncope (fainting) i. Unsteady gait j. Vomiting</p> | f. | g. | h. | i. | j. | k. | l. | m. | n. | o. |
|----|--|--|----|----|----|----|----|----|----|----|----|----|

Resident _____

Numeric Identifier _____

| | | | | |
|----|--|--|--|----|
| 2. | PAIN SYMPTOMS | (Code the highest level of pain present in the last 7 days) | | |
| | a. FREQUENCY with which resident complains or shows evidence of pain | | b. INTENSITY of pain | |
| | 0. No pain (skip to J4) | | 1. Mild pain | |
| | 1. Pain less than daily | | 2. Moderate pain | |
| | 2. Pain daily | | 3. Times when pain is horrible or excruciating | |
| 3. | PAIN SITE | (If pain present, check all sites that apply in last 7 days) | | |
| | Back pain | a. | Incisional pain | t. |
| | Bone pain | b. | Joint pain (other than hip) | g. |
| | Chest pain while doing usual activities | c. | Soft tissue pain (e.g., lesion, muscle) | h. |
| | Headache | d. | Stomach pain | l. |
| | Hip pain | e. | Other | j. |
| 4. | ACCIDENTS | (Check all that apply) | | |
| | Fell in past 30 days | a. | Hip fracture in last 180 days | c. |
| | Fell in past 31-180 days | b. | Other fracture in last 180 days | d. |
| | | | NONE OF ABOVE | e. |
| 5. | STABILITY OF CONDITIONS | Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating) | | a. |
| | | Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem | | b. |
| | | End-stage disease, 6 or fewer months to live | | c. |
| | | NONE OF ABOVE | | d. |

SECTION K. ORAL/NUTRITIONAL STATUS

| | | | |
|----|-------------------------------------|---|------------------------|
| 1. | ORAL PROBLEMS | Chewing problem | a. |
| | | Swallowing problem | b. |
| | | Mouth pain | c. |
| | | NONE OF ABOVE | d. |
| 2. | HEIGHT AND WEIGHT | Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes | |
| | | a. HT (in.) | b. WT (lb.) |
| 3. | WEIGHT CHANGE | a. Weight loss—5% or more in last 30 days; or 10% or more in last 180 days | |
| | | 0. No | 1. Yes |
| | | b. Weight gain—5% or more in last 30 days; or 10% or more in last 180 days | |
| | | 0. No | 1. Yes |
| 4. | NUTRITIONAL PROBLEMS | Complains about the taste of many foods | a. |
| | | Regular or repetitive complaints of hunger | b. |
| | | Leaves 25% or more of food uneaten at most meals | c. |
| | | NONE OF ABOVE | d. |
| 5. | NUTRITIONAL APPROACHES | (Check all that apply in last 7 days) | |
| | | Parenteral/IV | a. |
| | | Feeding tube | b. |
| | | Mechanically altered diet | c. |
| | | Syringes (oral feeding) | d. |
| | | Therapeutic diet | e. |
| | | Dietary supplement between meals | f. |
| | | Plate guard, stabilized built-up utensil, etc. | g. |
| | | On a planned weight change program | h. |
| | | NONE OF ABOVE | i. |
| 6. | PARENTERAL OR ENTERAL INTAKE | (Skip to Section L if neither 5a nor 5b is checked) | |
| | | a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days | |
| | | 0. None | 3. 51% to 75% |
| | | 1. 1% to 25% | 4. 76% to 100% |
| | | 2. 26% to 50% | |
| | | b. Code the average fluid intake per day by IV or tube in last 7 days | |
| | | 0. None | 3. 1001 to 1500 cc/day |
| | | 1. 1 to 500 cc/day | 4. 1501 to 2000 cc/day |
| | | 2. 501 to 1000 cc/day | 5. 2001 or more cc/day |

SECTION L. ORAL/DENTAL STATUS

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

SECTION M. SKIN CONDITION

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

SECTION N. ACTIVITY PURSUIT PATTERNS

| | | | |
|--|--|---|---------------------------------|
| 1. | TIME AWAKE | (Check appropriate time periods over last 7 days) | |
| | | Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: | |
| | | Morning | a. |
| | | Evening | b. |
| | | Afternoon | c. |
| | | NONE OF ABOVE | d. |
| (If resident is comatose, skip to Section O) | | | |
| 2. | AVERAGE TIME INVOLVED IN ACTIVITIES | (When awake and not receiving treatments or ADL care) | |
| | | 0. Most—more than 2/3 of time | 2. Little—less than 1/3 of time |
| | | 1. Some—from 1/3 to 2/3 of time | 3. None |
| 3. | PREFERRED ACTIVITY SETTINGS | (Check all settings in which activities are preferred) | |
| | | Own room | a. |
| | | Day/activity room | b. |
| | | Inside NH/Vol unit | c. |
| | | Outside facility | d. |
| | | NONE OF ABOVE | e. |
| 4. | GENERAL ACTIVITY PREFERENCES | (Check all PREFERENCES whether or not activity is currently available to resident) | |
| | | Cards/other games | a. |
| | | Crafts/arts | b. |
| | | Exercise/sports | c. |
| | | Music | d. |
| | | Reading/writing | e. |
| | | Spiritual/religious activities | f. |
| | | Trips/shopping | g. |
| | | Walking/wheeling outdoors | h. |
| | | Watching TV | i. |
| | | Gardening or plants | j. |
| | | Talking or conversing | k. |
| | | Helping others | l. |

| | |
|--|--|
| 5. PREFERENCES CHANGE IN DAILY ROUTINE | Code for resident preferences in daily routines 0. No change 1. Slight change 2. Major change |
| | a. Type of activities in which resident is currently involved b. Extent of resident involvement in activities |

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

SECTION O. MEDICATIONS

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

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

| | | | |
|---|---|---|---|
| 1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS | a. SPECIAL CARE—Check treatments or programs received during the last 14 days | | |
| | TREATMENTS | Ventilator or respirator | L |
| | Chemotherapy | a. PROGRAMS | |
| | Dialysis | b. Alcohol/drug treatment program | m |
| | IV medication | c. Alzheimer's/dementia special care unit | n |
| | Intake/output | d. Hospice care | o |
| | Monitoring acute medical condition | e. Pediatric unit | p |
| | Ostomy care | f. Respite care | q |
| | Oxygen therapy | g. Training in skills required to return to the community (e.g., talking medications, house work, shopping, transportation, ADLs) | r |
| | Radiation | h. NONE OF ABOVE | s |
| | Suctioning | | |
| | Tracheostomy care | | |
| | Transfusions | | |

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

| | |
|---------------------------------|--|
| 1. DISCHARGE POTENTIAL | a. Resident expresses/indicates preference to return to the community 0. No 1. Yes |
| | b. Resident has a support person who is positive towards discharge 0. No 1. Yes |
| | c. Stay projected to be of a short duration—discharge projected within 90 days (do not include expected discharge due to death) 0. No 1. Within 30 days 2. Within 31-90 days 3. Discharge status uncertain |
| 2. OVERALL CHANGE IN CARE NEEDS | Resident's overall self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support |

| | | | |
|---|---|----------|---------|
| b. THERAPIES - Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily) [Note—count only post admission therapies] | (A) = # of days administered for 15 minutes or more | DAYS (A) | MIN (B) |
| | (B) = total # of minutes provided in last 7 days | | |
| | a. Speech - language pathology and audiology services | | |
| | b. Occupational therapy | | |
| | c. Physical therapy | | |
| | d. Respiratory therapy | | |
| e. Psychological therapy (by any licensed mental health professional) | | | |

SECTION R. ASSESSMENT INFORMATION

| | |
|--|---|
| 1. PARTICIPATION IN ASSESSMENT | a. Resident: 0. No 1. Yes |
| | b. Family: 0. No 1. Yes 2. No family |
| | c. Significant other: 0. No 1. Yes 2. None |
| 2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT: | |
| a. Signature of RN Assessment Coordinator (sign on above line) | |
| b. Date RN Assessment Coordinator signed as complete | |
| c. Other Signatures Title Sections Date | |
| d. _____ Date | |
| e. _____ Date | |
| f. _____ Date | |
| g. _____ Date | |
| h. _____ Date | |

| | | |
|---|---|-------------------------------|
| 2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS | (Check all interventions or strategies used in last 7 days—no matter where received) | |
| | Special behavior symptom evaluation program | a. |
| | Evaluation by a licensed mental health specialist in last 90 days | b. |
| | Group therapy | c. |
| | Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage | d. |
| | Reorientation—e.g., cueing | e. |
| NONE OF ABOVE | f. | |
| 3. NURSING REHABILITATION/RESTORATIVE CARE | Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily) | |
| | a. Range of motion (passive) | f. Walking |
| | b. Range of motion (active) | g. Dressing or grooming |
| | c. Splint or brace assistance | h. Eating or swallowing |
| | TRAINING AND SKILL PRACTICE IN: | i. Amputation/prosthesis care |
| | d. Bed mobility | j. Communication |
| | e. Transfer | k. Other |
| | | |
| | | |
| | | |
| | | |

3. FURTHER ASSESSMENT USING RAP GUIDELINES

The RAP review and assessment process provides a time for staff to think about and discuss key areas of concern related to the resident. There are many ways to structure this assessment process, e.g. who leads the discussion or assessment, who participates, and how the resident, family and physician are involved. But in each case, staff should:

- Discuss the triggered problems and any current treatment goals and related approaches to care.
- Identify the key causal factors (i.e., why the problem is present).
- Review the associated and confounding factors referenced in the RAP Guidelines (i.e., things that contribute to the problem or add to the complexity of the situation).
- Ensure that information regarding the resident's status and clinical decision-making is documented, and that the RAP Summary form identifies where this documentation can be found.
- Proceed to Care Planning.

The following RAP Summary form indicates which RAPs were triggered for Mr. S., where documentation can be found, and whether a care plan has been developed. Before turning to the RAP Summary form, you may wish to review the MDS to determine which RAPs should be triggered. Using Delirium as an example, the following are examples of how staff might proceed.

1. As shown here, the Delirium RAP was used throughout the initial assessment period. It was clear from admission that Mr. S. had acute confusion. Predictably the Delirium RAP was triggered. Staff documentation throughout the first weeks of residency capture the key elements of the Delirium RAP assessment. The location and date of this documentation is entered on the RAP Summary form. The decision to care plan is indicated. As key information is clearly documented in this example and readily accessible to all staff, there is no additional documentation required beyond the RAP Summary form and referenced notations and care plan.
2. In some cases, a staff person may want to write a summary of the RAP assessment. This could be for several reasons: e.g., while the assessment documentation is in the record it is incomplete, unclear, too scattered or not focused. It may also be useful to have the information summarized for quick reference by staff. If this is the case, the summary note for Delirium could look like this:

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

Numeric Identifier _____

Resident's Name: _____ Medical Record No.: _____

1. Check if RAP is triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
 - Describe:
 - Nature of the condition (may include presence or lack of objective data and subjective complaints).
 - Complications and risk factors that affect your decision to proceed to care planning.
 - Factors that must be considered in developing individualized care plan interventions.
 - Need for referrals/further evaluation by appropriate health professionals.
 - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
 - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

| A. RAP PROBLEM AREA | (a) Check if triggered | Location and Date of RAP Assessment Documentation | (b) Care Planning Decision—check if addressed in care plan |
|---|--------------------------|---|--|
| 1. DELIRIUM | <input type="checkbox"/> | | <input type="checkbox"/> |
| 2. COGNITIVE LOSS | <input type="checkbox"/> | | <input type="checkbox"/> |
| 3. VISUAL FUNCTION | <input type="checkbox"/> | | <input type="checkbox"/> |
| 4. COMMUNICATION | <input type="checkbox"/> | | <input type="checkbox"/> |
| 5. ADL FUNCTIONAL/REHABILITATION POTENTIAL | <input type="checkbox"/> | | <input type="checkbox"/> |
| 6. URINARY INCONTINENCE AND INDWELLING CATHETER | <input type="checkbox"/> | | <input type="checkbox"/> |
| 7. PSYCHOSOCIAL WELL-BEING | <input type="checkbox"/> | | <input type="checkbox"/> |
| 8. MOOD STATE | <input type="checkbox"/> | | <input type="checkbox"/> |
| 9. BEHAVIORAL SYMPTOMS | <input type="checkbox"/> | | <input type="checkbox"/> |
| 10. ACTIVITIES | <input type="checkbox"/> | | <input type="checkbox"/> |
| 11. FALLS | <input type="checkbox"/> | | <input type="checkbox"/> |
| 12. NUTRITIONAL STATUS | <input type="checkbox"/> | | <input type="checkbox"/> |
| 13. FEEDING TUBES | <input type="checkbox"/> | | <input type="checkbox"/> |
| 14. DEHYDRATION/FLUID MAINTENANCE | <input type="checkbox"/> | | <input type="checkbox"/> |
| 15. DENTAL CARE | <input type="checkbox"/> | | <input type="checkbox"/> |
| 16. PRESSURE ULCERS | <input type="checkbox"/> | | <input type="checkbox"/> |
| 17. PSYCHOTROPIC DRUG USE | <input type="checkbox"/> | | <input type="checkbox"/> |
| 18. PHYSICAL RESTRAINTS | <input type="checkbox"/> | | <input type="checkbox"/> |

B. _____
 1. Signature of RN Coordinator for RAP Assessment Process

2. — —
 Month Day Year

3. Signature of Person Completing Care Planning Decision

4. — —
 Month Day Year

Delirium: RAP Summary Example 1

Mr. S. admitted from hospital with diagnosis of acute confusion. Since admission his cognition has steadily cleared. Indicators of delirium, such as being easily distracted, having altered perception or awareness of surroundings, and restlessness have lessened, but are not completely gone. Mr. S. has a history of Alzheimer's Disease, family have been very helpful in describing his baseline mentation. The team believes that delirium is related to his UTI, relocation, Haldol, Morphine, Zantac, and dehydration. To this end, his Haldol is being tapered with the goal of elimination (he was not on this drug prior to hospitalization), Morphine and Zantac have been discontinued, UTI has been treated with Bactrim DS - a follow up U/A C+S will be sent upon completion, I/O is being monitored and fluids being encouraged, and the family has been helping us simulate a homelike environment with Mr. S.'s possessions and routine.

Another example could look like this:

Delirium: RAP Summary Example 2

Mr. S. triggered for delirium. RAP was used as a guideline for assessment by team. (See nursing notes: 8/24/95, 8/28/95, MD note 8/25). Possible causal factors: UTI, Medication, Dehydration, Relocation have been identified and treatment plans are indicated. Refer to Delirium care plan.

4. CARE PLAN SPECIFICATION

The following is an example care plan for Delirium. It contains general points, rather than specific prescriptions. It is meant to show general culmination of the assessment process in the plan of care.

| Objective | Intervention | Evaluation |
|--|---|---|
| Mr. S. will remain safe and have no injuries in next 30 days | Keep night light on in room at night. Have family bring in familiar articles (bedspread, pictures). 15 minute checks while in room, encourage out of room activities. Involve in low stimulus activities. Keep pathways clear and free from clutter. Toilet q 2 hours while awake and q 4 hours during night. Offer frequent snacks including beverages. | Resident remained safe in last 30 days, with no evidence of injury. |

| | | |
|---|--|--|
| <p>Mr. S.'s cognitive function will return to baseline⁴ in 30 days</p> | <p>Taper Haldol as ordered. Continue to review all medications with physician. Assess for adequate hydration by monitoring daily fluid intake. Review requested notes from Adult Day Care to gain further insight into baseline. Continue with Tylenol for pain, give PRN dose before Physical Therapy and if resident appears agitated or withdrawn.</p> | <p>Resident's cognitive functioning appears similar to baseline⁴ according to: family, documentation from Adult Day Care and cognitive clinic at hospital. Resident received Tylenol as ordered, and did not appear to be in pain.</p> |
| <p>Mr. S. and family will be acclimated to the unit in 30 days as evidenced by recognizing his own room and participating in unit activities with minimal supervision</p> | <p>Primary team to meet with family to work on care plan and tour unit. Involve family in all aspects of care. Assess family's level of knowledge about Alzheimer's disease and acute confusion. Reorient Mr. S. to his room and surrounding unit. As acute confusion begins to clear, involve Mr. S. in more of unit activities.</p> | <p>Family met with primary care team and toured the unit. Mr. S. is able to recognize his room and attend unit activities with a staff prompt.</p> |
| <p>Resident will maintain adequate nutrition and hydration over next 30 days as evidenced by eating at least 3/4 of his meals and drinking 2 liters of fluid each day</p> | <p>See urinary incontinence care plan. Carefully assess fluid intake from meal trays. Offer supplemental fluids in between meals. Involve family in determining the best fluids, Mr. S likes chocolate milk and apple juice. Review monitored intake and output sheets from last 7 days. Continue if intake is not at least 2000 ml/day. Monitor skin turgor and mucous membranes.</p> | <p>Mr. S.'s intake was at least 2000. Resident received supplemental beverages in between meal. Skin turgor is intact and mucous membranes are moist.</p> |

⁴ Assumes description of baseline is documented elsewhere in the clinical record.

results from analysis of the resident by the interdisciplinary team based on communication about the resident that is reliable, consistent and understood by all team members. This benefits the resident by ensuring that the entire interdisciplinary team and all "hands on" caregivers are following the same process based upon a common knowledge base.

Properly executed, the assessment and care planning processes flow together into a seamless circular process that:

- Looks at each resident as a "whole" human being with unique characteristics and strengths.
- Breaks the resident into distinct functional areas for the purpose of gaining knowledge about the resident's functional status (MDS).
- Re-groups the information gathered to identify possible problems the resident may have (Triggers).
- Provides additional assessment of potential problems by looking at possible causes and risks, and how these causes and risks can be addressed to provide for a resident's highest practicable level of well-being (RAP Guidelines).
- Develops and implements an interdisciplinary care plan based on the complete assessment information gathered by the RAI process, with necessary monitoring and follow-up.
- Re-evaluates the resident's status at prescribed intervals (i.e., quarterly, annually, or if a significant change in status occurs) using the RAI and then modifies the resident's care plan as appropriate and necessary.

Care planning is a process that has several steps that may occur at the same time or in sequence. The following list of care planning components may help the interdisciplinary team finalize the care plan after completing the comprehensive assessment:

1. The RAI process (i.e., MDS and RAPs) is completed as the basis for care plan decision-making. By regulation, this process may be completed solely by the RN Coordinator, but ideally the RAI is completed as a cohesive effort by the members of the interdisciplinary team that will develop the resident's care plan.
2. The team may find during their discussions that several problem conditions have a related cause but appear as one problem for the resident. They may also find that they stand alone and are unique. Goals and approaches for each problem condition may be overlapping, and consequently the interdisciplinary team may decide to address the problem conditions in combination on the care plan.

CHAPTER 5: LINKING ASSESSMENT TO INDIVIDUALIZED CARE PLANS



5.1 Overview of the RAI and Care Planning

Throughout this manual the concept of linkages has been stressed. That is, good assessment forms the basis for a solid care plan, and the RAPs serve as the link between the MDS and care planning.

This chapter provides a discussion of how the care plan is driven not only by identified resident problems, but also by a resident's unique characteristics, strengths and needs. When the care plan is implemented in accordance with standards of good clinical practice, then the care plan becomes powerful, practical and represents the best approach to providing for the quality of care and quality of life needs of an individual resident.

The process of care planning is one of looking at a resident as a whole, building on the individual resident characteristics measured using standardized MDS items and definitions. The MDS was designed to allow the interdisciplinary team to observe and evaluate the resident's status with these detailed, consistently applied definitions. Once the separate items in the MDS have been reviewed, the RAP process provides guidance to the staff on how to use this information to assess triggered problems and ultimately to arrive at a holistic view of the person.

Once the resident has been assessed using triggered RAPs, the opportunity for development or modification of the care plan exists. The triggering of a RAP indicates the need for further review which is carried out utilizing the Guidelines that have been developed for each RAP. Staff use RAP Guidelines to determine whether a new care plan is needed or changes are needed in a resident's existing care plan. It is important to remember that even though a RAP may not have been "triggered" in the assessment process, the interdisciplinary team must address, in the care plan, a resident problem in that area if clinically warranted. (See Chapter 4 for additional information on the use and documentation of RAPs.)

The care-planning process in long term care facilities has been the subject of countless books, journal articles, conferences and discussions. Often this discussion has focused more on the structure or content of care plans than on the course of action needed to attain or maintain a resident's highest practicable level of well-being. It is not the intent of this chapter to specify a care plan structure or format. Rather the intent is to reinforce that the care plan is based on using fundamental information gathered by the MDS, further review and assessment "triggered" by the MDS, and distillation of all final assessment information, through the RAP Guidelines, into an appropriate blueprint for meeting the needs of the individual resident. An appropriate care plan

3. After using RAP Guidelines to assess the resident, staff may decide that a "triggered" condition does not affect the resident's functioning or well-being and therefore should not be addressed on the care plan.
4. The existence of a care planning issue (i.e., a resident problem, need or strength) should be documented as part of the RAP review documentation. Documentation may be done by individual staff members who have completed assessments using the RAP Guidelines or who participated in care planning, or as a joint note by members of the interdisciplinary team.
5. The resident, family or resident representative should be part of the team discussion or join the care planning process whenever they choose. The individual team members may have already discussed preliminary care plan ideas with the resident, family or resident representative in order to get suggestions, confirm agreement, or clarify reasons for developing specific goals and approaches.
6. In some cases a resident may refuse particular services or treatments that the interdisciplinary team believes may assist the resident to meet their highest practicable level of well-being. The resident's wishes should be documented in the clinical record.
7. When the interdisciplinary team has identified problems, conditions, limitations, maintenance levels or improvement possibilities, etc., they should be stated, to the extent possible, in functional or behavioral terms (e.g., how is the condition a problem for the resident; how does the condition limit or jeopardize the resident's ability to complete the tasks of daily life or affect the resident's well-being in some way).

EXAMPLES

- Mr. Smith cannot find his room independently.
- Mrs. Jones slaps at the faces of direct care staff while they are giving personal care.
- Mr. Brown is unable to walk more than 15 feet because of shortness of breath.

8. The interdisciplinary team agrees on intermediate goal(s) that will lead to an outcome objective.
9. The intermediate goal(s) should be measurable and have a time frame for completion or evaluation.
10. The parts of the goal statement should include:

The Subject — the Verb — Modifiers — the Time frame.

| EXAMPLE | | | | |
|----------------|-------------|-------------------------|--|--------------------------------|
| <u>Subject</u> | <u>Verb</u> | <u>Modifiers</u> | | <u>Time frame</u> |
| Mr. Jones | will walk | up and down 5 stairs | with the help of one nursing assistant | daily for the next 30 days. |

11. Depending upon the conclusions of the assessment, types of goals may include improvement goals, prevention goals, palliative goals or maintenance goals.
12. Specific, individualized steps or approaches that staff will take to assist the resident to achieve the goal(s) will be identified. These approaches serve as instructions for resident care and provide for continuity of care by all staff. Short and concise instructions, which can be understood by all staff, should be written.
13. The final care plan should be discussed with the resident or the resident's representative.
14. The goals and their accompanying approaches are to be communicated to all direct care staff who were not directly involved in the development of the care plan.
15. The effectiveness of the care plan must be evaluated from its initiation and modified as necessary.
16. Changes to the care plan should occur as needed in accordance with professional standards of practice and documentation (e.g., signing and dating entries to the care plan). Communication about care plan changes should be ongoing among interdisciplinary team members.

5.2 The Care-Planning Process

In order to provide a backdrop for understanding care planning, how it is supported by the RAI process, and what is required by the regulations, this section has been organized around a Question and Answer format based on the interpretive guideline probes for the care planning requirements at 42 CFR 483.20. The appropriate F Tags have been added to the end of each question to guide the reader back to the regulation. The regulatory language and associated probes may be found in Appendix P of the State Operations Manual (SOM).

42 CFR 483.20 (d)(1)**Is the care plan oriented toward preventing avoidable declines in functioning or functional levels? - F 279**

The care plan is a guide for all staff to ensure that decline is avoided, if possible. Not only is the resolution of clinical problems important (e.g., treatment of a pressure ulcer), so is the prevention of further decline. For example, for the resident with pressure ulcers, a program of bed mobility as well as efforts at improving the resident's mood to increase willingness to get out of bed, will improve chances for slowing decline. There must be a realistic, directed effort to provide quality care in addressing immediate concerns while, at the same time, attempting to ensure that functional decline does not occur. This is "proactive" involvement by the interdisciplinary team to make sure that declines in resident functioning are avoided if possible.

How does the care plan attempt to manage risk factors? - F 279

The RAPs are excellent identifiers of resident factors that may increase the chance of decline or for a problem to develop. Risk factors must not be overlooked when designing an effective care plan. Through the RAP review, the interdisciplinary team can identify certain resident characteristics that put the resident at risk for problems. For example, a resident may suddenly become at risk for falls when a change is made to certain medications. The team should identify this potential risk and identify the necessary precautions as part of the care plan (e.g. orthostatic blood pressure checks for a period of time).

Does the care plan build on resident strengths? - F 279

Care planning is usually thought of as a facility staff effort to solve or eliminate resident problems. While this view is often valid, it is also important for the interdisciplinary team to carefully look at the resident's strengths and use them to prevent decline or improve the resident's functional status. The RAI process not only identifies concerns but also pinpoints areas of resident vitality. These strengths or areas of vitality should be used in the care planning process to improve resident quality of care and quality of life through improved functional ability and self-esteem.

Does the care plan reflect standards of current professional practice? - F 279

It is important for all facility staff to be aware of and utilize current standards of professional practice. This can be accomplished through a routine, up-to-date in-house training program or through the use of qualified external training resources. New and more effective treatment modalities, resident activities, etc. are continually being identified which will benefit residents if built into their care plans.

Do treatment objectives have measurable outcomes? - F 279

Measurable outcomes require current knowledge about the resident to establish a baseline (e.g. how many times does a resident behavior or symptom occur in a certain time frame or how does a resident experience pain). Next, a target, goal or outcome is required (e.g., reduction of behaviors to a certain level or reduction of pain). Finally, some way of measuring if the care plan has moved the resident from the baseline to the target outcome is needed. Without measurable outcomes there is no way to truly identify that a care plan has been successful. The care plan is a dynamic document that needs to be continually evaluated and appropriately modified based on measurable outcomes. This continual evaluation takes into consideration resident change relative to the initial baseline—in other words, if the resident has declined, stayed the same, or improved at a lesser rate than expected, then a modification in the care plan may be necessary.

Has information regarding the resident's goals and wishes for treatment been obtained — especially if a resident wishes to refuse treatment? Has the resident been given sufficient information about his or her treatment so that an informed choice can be made? - F 279

Residents should, if possible, be involved in planning their treatment. This means that staff must talk to the resident about what goals the resident would like to achieve and whether they believe these goals can be achieved. Residents also have a right to refuse treatment. The interdisciplinary team should ensure that the resident has all of the necessary information about how a particular treatment will affect the care they receive and their general well-being so that the resident can make an informed choice about whether or not they wish to receive treatment.

If a resident refuses treatment, does the care plan reflect the facility's efforts to find alternative means to address the problem? - F 279

If a resident refuses treatment, the team should seek options with the help of the attending physician, resident and family. Often one method of treatment may not be acceptable to a resident, but another choice of treatment may. For example, a resident may refuse to take a prescribed anti-depressant medication for treatment of depression. Alternative courses of action could be explored with the resident that would use the expertise of mental health professionals. Consequently, rather than a care plan which indicates only that a resident refused treatment, the care plan would reflect other goals and methods of addressing the problem(s). Involve staff who have regular, first hand knowledge of the resident (e.g., nursing or activity assistants) in reviewing possible options. They can provide insights on why the resident may be refusing care and how to devise a better approach to the problem.

42 CFR 483.20 (d)(2)

Was interdisciplinary expertise utilized to develop a care plan to improve a resident's functional abilities? - F 280

It is of the utmost importance that the staff most knowledgeable about the resident, in coordination with staff having the most expertise in a given resident problem area, work with the resident and their family or other representative in the care planning process.

The medical model of care, while most common in the acute care setting, should not necessarily be the driving force in planning the resident's care unless the resident's medical condition is unstable and needs continuous clinical monitoring. The key is to identify those needs which affect the resident's day-to-day well-being. Such needs cover a broad range of areas and may vary among residents.

Although nursing staff are usually the "first responders" to resident problems and are responsible for the heaviest burden of documentation, each member of the interdisciplinary team brings a unique perspective and body of knowledge to the care planning process. As such, each members' contribution should be sought and valued.

In what ways do staff involve residents, families, and other resident representatives in care planning? - F 280

As emphasized in the Federal regulations as well as throughout this manual, the resident, resident's family or other resident representatives should be involved in the care planning process. The resident is the most appropriate individual to describe what is meaningful in his or her life. Family and friends may also contribute in a very meaningful way in describing what is important to a resident, especially for those residents who cannot speak for themselves. Although they may be knowledgeable about the resident and care practices, interdisciplinary team members do not know all of a resident's life history and experience which may affect his or her individual needs or dictate approaches.

It is important for the interdisciplinary team members to speak directly with the resident and the resident's family, friends and representatives during both the assessment and care planning process if an appropriate care plan is to be developed which will address all of the resident's individual quality of life and quality of care needs. If there is a legally designated proxy, staff should be aware of this fact and that individual should be given the opportunity to participate in the assessment and care planning process.

Is there evidence of assessment and care planning sufficient to meet the needs of newly admitted residents, prior to the completion of the first comprehensive assessment? - F 282

Some care planning needs to occur for immediate care of the resident after admission or after a significant change in status. Physician orders for immediate care (42 CFR 483.20 (a)/F 271) are the written orders facility staff need in order to provide essential care to the resident, consistent with the resident's physical and mental status at admission. These orders, at a minimum, should include dietary, medication (if necessary) and routine care instructions to maintain or improve the resident's functional abilities until facility staff can conduct a comprehensive resident assessment and develop an interdisciplinary care plan.

The interdisciplinary team may wish to conduct an initial RAP review for any identified problem or potential problem even before the MDS is completed. This review can be documented at the time, and a written update completed when the interdisciplinary team completes the RAI process and documents final care plan decisions.

For example, if a resident was re-admitted from the hospital with a physical restraint but the resident was not previously restrained, the interdisciplinary team should immediately assess the resident for the need for a restraint. Since the team would know that the Physical Restraint RAP would be triggered by the MDS, they would use the RAP to guide their assessment of the resident and make preliminary plans about how to handle the restraint issue. When the comprehensive assessment is completed, the interdisciplinary team would then make a final decision regarding the resident's current status and need for a restraint.

Similarly, if a resident is incontinent of urine at the first admission, or newly incontinent at re-admission, good practice would dictate that 14 days is too long to wait for completion of an initial assessment of the incontinence. Again, the Urinary Incontinence RAP can be used to guide the immediate care plan intervention. The documentation of the RAP review would then be updated following the completion of the comprehensive assessment.

Are direct care staff fully informed about the care, services and expected outcomes of the care they provide? Do direct care staff have general knowledge of the care and services provided by other staff and the relationship of those services to the resident's expected outcomes? - F 282

Direct care staff (e.g., nursing assistants, aides) must be directly involved in the care planning process. The importance of the communication between direct care staff and the interdisciplinary team cannot be overstated. Since direct care staff have the most frequent contact with residents, they may be the most knowledgeable about a resident's daily life, needs, problems and strengths.

Direct care staff who have not participated in the formal care plan decision-making process must be informed about how the care and services they provide is intended to improve, maintain or minimize decline in the resident's condition and well-being. Without knowing the reasons they are performing particular tasks, direct care staff may not understand the relationship between the care and services they provide for a resident and the expected outcomes for that resident. Similarly, for nursing staff to understand how the resident is responding to a plan of care, the input of direct care staff is crucial. In many ways, they are the best source of information on how the program has been implemented, how the resident has responded, and whether specific program variations might be useful.

What are some general care planning areas that could be considered in the Long Term Care setting? - F 280

The following are six general care planning areas that are useful in the long term care setting. This list is not prescriptive or all-inclusive. Ultimately the resident's status determines what should be addressed on the care plan.

Functional Status

Functional status limitations are identified using the MDS and triggers. All conditions determined to need care plan intervention, after using the RAPs to guide further assessment, must appear on

the care plan. The conditions identified by the RAI should be clearly linked to the problems addressed on the care plan.

Rehabilitation/Restorative Nursing

A resident's potential for physical, occupational, speech, psychological and other types of rehabilitation needs to be assessed and care planned. The risk of immobility, for example, should be assessed, and restorative nursing interventions planned accordingly. Complications of immobility, such as damage to the muscular system as indicated by weakness, difficulty walking, posture problems, foot drop, contractures, edema, constipation, calcium depletion, depression, agitation, etc., should be assessed as appropriate. These assessments may include causes, particular risk factors, clinical impressions and the need for referrals.

Health Maintenance

Health maintenance includes monitoring of disease processes that are currently being treated. These would include both stable and unstable conditions that need monitoring such as a history of cardiac problems, hypertension, CHF, pain, dehydration, mental illness, etc. If a resident is taking medications for conditions, regular monitoring of edema, vital signs, blood glucose, etc., may be appropriate.

The interdisciplinary team may also decide whether or not to list problems on the care plan that no longer affect the resident, are controlled or need no monitoring. This will depend on the team's decision about how a given problem affects the resident's overall functioning or well-being.

Other areas of health maintenance may include terminal care, and special treatments such as peritoneal dialysis or ventilator support.

Discharge Potential

Discharge potential for each resident needs to be assessed at admission, annually, and as needed. The assessment for discharge potential should focus on what needs to happen before the resident can safely be discharged. If the resident has discharge potential or if discharge is actively being pursued, documentation should appear in the resident's plan of care.

Medications

On at least a yearly basis, a comprehensive assessment of drug therapy should be completed (See 483.20 (b)(1)(2)(xiii)). This assessment can be documented anywhere in the resident's record and should include dose, frequency, existing and most likely side effects, relevant lab results, parameter comparisons, and justifications for use. Pharmacists review the drug regimen and discuss irregularities with appropriate facilities staff using Appendix N of the State Operations Manual on a monthly basis.

It is the interdisciplinary team's decision whether medications need to be addressed in the care plan. For example, consideration might be given to recent changes in medications, the use of multiple medications, or medications which may put the resident in jeopardy for a decline in functional status. The care plan should alert the staff to medication side effects for which the resident is at particular risk. The interdisciplinary team may decide to identify a drug(s) as an approach to meeting a goal. The interdisciplinary team should determine if any medications that the resident is taking are listed in a triggered RAP. If so, use of the medication needs to be assessed as a potential contributing cause to the RAP concern.

Daily Care Needs

Some facilities put all resident daily care needs and standard practice approaches on the care plan. Daily care needs that are specific to the resident and are out of the ordinary must be addressed on the care plan. Facility staff must use their professional judgment when making these decisions.

APPENDIX A

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