

APPENDIX B

MDS and QUARTERLY REVIEW FORMS FOR VERSION 2.0

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MINIMUM DATA SET (MDS) — VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|-------|--|---|---------------------|---|------------|--|--|--|--|--|--|-------|-----|------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. | RESIDENT NAME [Ⓞ] | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | a. (First) | b. (Middle Initial) | c. (Last) | d. (Jr/Sr) | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. | GENDER [Ⓞ] | 1. Male | | 2. Female | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. | BIRTHDATE [Ⓞ] | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table> | | | | | | | | | | Month | Day | Year | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Month | Day | Year | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. | RACE/ETHNICITY [Ⓞ] | 1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin | | 4. Hispanic 5. White, not of Hispanic origin | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. | SOCIAL SECURITY AND MEDICARE NUMBERS [Ⓞ] [C in 1 st box if non med. no.] | a. Social Security Number <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> b. Medicare number (or comparable railroad insurance number) <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 6. | FACILITY PROVIDER NO. [Ⓞ] | a. State No. <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> b. Federal No. <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| 7. | MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] [Ⓞ] | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 8. | REASONS FOR ASSESSMENT | [Note—Other codes do not apply to this form] a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. NONE OF ABOVE b. Codes for assessments required for Medicare PPS or the State 1. Medicare 5 day assessment 2. Medicare 30 day assessment 3. Medicare 60 day assessment 4. Medicare 90 day assessment 5. Medicare readmission/return assessment 6. Other state required assessment 7. Medicare 14 day assessment 8. Other Medicare required assessment | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 9. | SIGNATURES OF PERSONS COMPLETING THESE ITEMS: | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | a. Signatures | Title | | | Date | | | | | | | | | | | | | | | | | | | | | | | | |
| | b. | | | | Date | | | | | | | | | | | | | | | | | | | | | | | | |

GENERAL INSTRUCTIONS

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

Ⓞ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter [a] = When letter in box, check if multiple entries

MINIMUM DATA SET (MDS) — VERSION 2.0

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

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

SECTION AC. CUSTOMARY ROUTINE

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

SECTION AD. FACE SHEET SIGNATURES

| | | | |
|--|-------|----------|------|
| SIGNATURES OF PERSONS COMPLETING FACE SHEET: | | | |
| a. Signature of RN Assessment Coordinator | | | Date |
| b. Signatures | Title | Sections | Date |
| c. | | | Date |
| d. | | | Date |
| e. | | | Date |
| f. | | | Date |
| g. | | | Date |

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

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

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

| | | | |
|---|---|--|--|
| 1. RESIDENT NAME | _____ a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr) | | |
| 2. ROOM NUMBER | [] [] [] [] [] [] [] [] [] [] | | |
| 3. ASSESSMENT REFERENCE DATE | a. Last day of MDS observation period [] [] — [] [] — [] [] [] [] [] [] Month Day Year b. Original (0) or corrected copy of form (enter number of correction) | | |
| 4a. DATE OF REENTRY | Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) [] [] — [] [] — [] [] [] [] [] [] Month Day Year | | |
| 5. MARITAL STATUS | 1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated | | |
| 6. MEDICAL RECORD NO. | [] | | |
| 7. CURRENT PAYMENT SOURCES FOR N.H. STAY | (Billing Office to indicate; check all that apply in last 30 days) Medicaid per diem a. VA per diem f. Medicare per diem b. Self or family pays for full per diem g. Medicare ancillary part A c. Medicaid resident liability or Medicare co-payment h. Medicare ancillary part B d. Private insurance per diem (including co-payment) i. CHAMPUS per diem e. Other per diem j. | | |
| 8. REASONS FOR ASSESSMENT | a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment 9. Reentry 10. Significant correction of prior quarterly assessment 0. NONE OF ABOVE b. Codes for assessments required for Medicare PPS or the State 1. Medicare 5 day assessment 2. Medicare 30 day assessment 3. Medicare 60 day assessment 4. Medicare 90 day assessment 5. Medicare readmission/return assessment 6. Other state required assessment 7. Medicare 14 day assessment 8. Other Medicare required assessment | | |
| 9. RESPONSIBILITY/LEGAL GUARDIAN | (Check all that apply) Legal guardian a. Durable power attorney/financial d. Other legal oversight b. Family member responsible e. Durable power of attorney/health care c. Patient responsible for self f. NONE OF ABOVE g. | | |
| 10. ADVANCED DIRECTIVES | (For those items with supporting documentation in the medical record, check all that apply) Living will a. Feeding restrictions f. Do not resuscitate b. Medication restrictions g. Do not hospitalize c. Other treatment restrictions h. Organ donation d. NONE OF ABOVE i. Autopsy request e. | | |

SECTION B. COGNITIVE PATTERNS

| | | | |
|--------------------|--|--|--|
| 1. COMATOSE | (Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (If yes, skip to Section G) | | |
| 2. MEMORY | (Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem | | |

| | | | |
|---|--|--|--|
| 3. MEMORY/RECALL ABILITY | (Check all that resident was normally able to recall during last 7 days) Current season a. That he/she is in a nursing home d. Location of own room b. NONE OF ABOVE are recalled e. Staff names/faces c. | | |
| 4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING | (Made decisions regarding tasks of daily life) 0. INDEPENDENT—decisions consistent/reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions | | |
| 5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/AWARENESS | (Code for behavior in the last 7 days.) (Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time). 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out) e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not) | | |
| 6. CHANGE IN COGNITIVE STATUS | Resident's cognitive status, skills, or abilities have 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 C. COMMUNICATION/HEARING PATTERNS

| | | | |
|--|---|--|--|
| 1. HEARING | (With hearing appliance, if used) 0. HEARS ADEQUATELY—normal talk, TV, phone 1. MINIMAL DIFFICULTY when not in quiet setting 2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly 3. HIGHLY IMPAIRED/absence of useful hearing | | |
| 2. COMMUNICATION DEVICES/TECHNIQUES | (Check all that apply during last 7 days) Hearing aid, present and used a. Hearing aid, present and not used regularly b. Other receptive comm. techniques used (e.g., lip reading) c. NONE OF ABOVE d. | | |
| 3. MODES OF EXPRESSION | (Check all used by resident to make needs known) Speech a. Signs/gestures/sounds d. Writing messages to express or clarify needs b. Communication board e. American sign language or Braille c. Other f. NONE OF ABOVE g. | | |
| 4. MAKING SELF UNDERSTOOD | (Expressing information content—however able) 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY/NEVER UNDERSTOOD | | |
| 5. SPEECH CLARITY | (Code for speech in the last 7 days) 0. CLEAR SPEECH—distinct, intelligible words 1. UNCLEAR SPEECH—slurred, mumbled words 2. NO SPEECH—absence of spoken words | | |
| 6. ABILITY TO UNDERSTAND OTHERS | (Understanding verbal information content—however able) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part/intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY/NEVER UNDERSTANDS | | |
| 7. CHANGE IN COMMUNICATION/HEARING | Resident's ability to express, understand, or hear information 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 | | |

[] = When box blank, must enter number or letter [] = When letter in box, check if condition exists

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) | |
| | <p>VERBAL EXPRESSIONS OF DISTRESS</p> <p>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"</p> <p>b. Repetitive questions—e.g., "Where do I go; What do I do?"</p> <p>c. Repetitive verbalizations—e.g., calling out for help, ("God help me")</p> <p>d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received</p> <p>e. Self deprecation—e.g., "I am nothing; I am of no use to anyone"</p> <p>f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others</p> <p>g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack</p> | |
| | <p>h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions</p> <p>i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues</p> <p>SLEEP-CYCLE ISSUES</p> <p>j. Unpleasant mood in morning</p> <p>k. Insomnia/change in usual sleep pattern</p> <p>SAD, APATHETIC, ANXIOUS APPEARANCE</p> <p>l. Sad, pained, worried facial expressions—e.g., furrowed brows</p> <p>m. Crying, tearfulness</p> <p>n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking</p> <p>LOSS OF INTEREST</p> <p>o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends</p> <p>p. Reduced social interaction</p> | |
| 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 | <p>(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</p> <p>(B) Behavioral symptom alterability in last 7 days 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered</p> <p>a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)</p> <p>b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)</p> <p>c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)</p> <p>d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/throw food/feces, hoarding, rummaged through others' belongings)</p> <p>e. RESISTS CARE (resisted taking medications/injections, ADL assistance, or eating)</p> | (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 into 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 only 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). Code for most dependent in self-performance and support. (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 (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. b. c. | 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. b. c. | d. e. f. |
| | 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. c. d. e. | |
| 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 | | |

| | | | | | |
|----|-------------------------------------|--|----------------------------|--|----------------------------|
| 3. | APPLIANCES AND PROGRAMS | Any scheduled toileting plan Bladder retraining program External (condom) catheter Indwelling catheter Intermittent catheter | a. b. c. d. e. | Did not use toilet room/commode/urinal Pads/briefs used Enemas/irrigation Ostomy present NONE OF ABOVE | f. g. h. i. j. |
| 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) | ENDOCRINE/METABOLIC/NUTRITIONAL Diabetes mellitus Hyperthyroidism Hypothyroidism HEART/CIRCULATION Arteriosclerotic heart disease (ASHD) Cardiac dysrhythmias Congestive heart failure Deep vein thrombosis Hypertension Hypotension Peripheral vascular disease Other cardiovascular disease MUSCULOSKELETAL Arthritis Hip fracture Missing limb (e.g., amputation) Osteoporosis Pathological bone fracture NEUROLOGICAL Alzheimer's disease Aphasia Cerebral palsy Cerebrovascular accident (stroke) Dementia other than Alzheimer's disease | a. b. c. d. e. f. g. h. i. j. k. l. m. n. o. p. q. r. s. t. u. | Hemiplegia/Hemiparesis Multiple sclerosis Paraplegia Parkinson's disease Quadriplegia Seizure disorder Transient ischemic attack (TIA) Traumatic brain injury PSYCHIATRIC/MOOD Anxiety disorder Depression Manic depression (bipolar disease) Schizophrenia PULMONARY Asthma Emphysema/COPD SENSORY Cataracts Diabetic retinopathy Glaucoma Macular degeneration OTHER Allergies Anemia Cancer Renal failure NONE OF ABOVE | 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) | Antibiotic resistant infection (e.g., Methicillin resistant staph) Clostridium difficile (c. diff.) Conjunctivitis HIV infection Pneumonia Respiratory infection | a. b. c. d. e. f. | Septicemia Sexually transmitted diseases Tuberculosis Urinary tract infection in last 30 days Viral hepatitis Wound infection NONE OF ABOVE | g. h. i. j. k. l. m. |
| 3. | OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES | a. _____ b. _____ c. _____ d. _____ e. _____ | | | |

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 | | |
| | URINARY 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 | 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) | INDICATORS OF FLUID STATUS Weight gain or loss of 3 or more pounds within a 7 day period Inability to lie flat due to shortness of breath Dehydrated; output exceeds input Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days OTHER | a. b. c. d. | Dizziness/Vertigo Edema Fever Hallucinations Internal bleeding Recurrent lung aspirations in last 90 days Shortness of breath Syncope (fainting) Unsteady gait Vomiting NONE OF ABOVE | f. g. h. i. j. k. l. m. n. o. p. |
|----|--|--|----------------------|---|--|

SECTION M. SKIN CONDITION

| | | | | |
|----|--|--|--|----|
| 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 | f. |
| | Bone pain | b. | Joint pain (other than hip) | g. |
| | Chest pain while doing usual activities | c. | Soft tissue pain (e.g., lesion, muscle) | h. |
| | Headache | d. | Stomach pain | i. |
| | Hip pain | e. | Other | j. |
| 4. | ACCIDENTS | (Check all that apply) | | |
| | Fell in past 30 days | a. | Hip fracture in last 180 days | c. |
| | Fell in past 31-180 days | b. | Other fracture in last 180 days | d. |
| | | | NONE OF ABOVE | e. |
| 5. | STABILITY OF CONDITIONS | 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. |

| | | | |
|----|--|--|-----------------|
| 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.] | Number at Stage |
| | (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 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. | |
| | | Leaves 25% or more of food uneaten at most meals | c. | |
| | | Regular or repetitive complaints of hunger | b. | |
| | | NONE OF ABOVE | d. | |
| 5. | NUTRITIONAL APPROACHES | (Check all that apply in last 7 days) | | |
| | Parenteral/IV | a. | Dietary supplement between meals | f. |
| | Feeding tube | b. | Plate guard, stabilized built-up utensil, etc. | g. |
| | Mechanically altered diet | c. | On a planned weight change program | h. |
| | Syringe (oral feeding) | d. | | i. |
| | Therapeutic diet | e. | | j. |
| | | | NONE OF ABOVE | k. |
| 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 (gingiva); 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 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. |
| | | Outside facility | c. |
| | | Inside NH/off unit | d. |
| | | NONE OF ABOVE | e. |
| 4. | GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities) | (Check all PREFERENCES whether or not activity is currently available to resident) | |
| | | Cards/other games | a. |
| | | Trips/shopping | b. |
| | | Crafts/arts | c. |
| | | Walking/wheeling outdoors | d. |
| | | Exercise/sports | e. |
| | | Watching TV | f. |
| | | Music | g. |
| | | Gardening or plants | h. |
| | | Reading/writing | i. |
| | | Talking or conversing | j. |
| | | Spiritual/religious activities | k. |
| | | Helping others | l. |
| | | NONE OF ABOVE | m. |

| | | |
|------------------------------------|--|--|
| 5. PREFERS 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 | a. Antipsychotic | |
| | b. Antianxiety | |
| | c. Antidepressant | |
| | d. Hypnotic | |
| | e. Diuretic | |

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 | PROGRAMS |
| | Chemotherapy | a. Ventilator or respirator |
| | Dialysis | b. Alcohol/drug treatment program |
| | IV medication | c. Alzheimer's/dementia special care unit |
| | Intake/output | d. Hospice care |
| | Monitoring acute medical condition | e. Pediatric unit |
| | Ostomy care | f. Respite care |
| | Oxygen therapy | g. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) |
| | Radiation | h. NONE OF ABOVE |
| | Suctioning | i. |
| | Tracheostomy care | j. |
| Transfusions | k. | |

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]

| | DAYS | | MIN | |
|---|------|-----|-----|-----|
| | (A) | (B) | (A) | (B) |
| a. Speech - language pathology and audiology services | | | | |
| b. Occupational therapy | | | | |
| c. Physical therapy | | | | |
| d. Respiratory therapy | | | | |
| e. Psychological therapy (by any licensed mental health professional) | | | | |

| | | |
|---|--|--|
| 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 | |
| | Evaluation by a licensed mental health specialist in last 90 days | |
| | Group therapy | |
| | Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage | |
| | Reorientation—e.g., cueing | |
| NONE OF ABOVE | | |

| | | |
|--|---|--|
| 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) | |
| | b. Range of motion (active) | |
| | c. Splint or brace assistance | |
| | d. Bed mobility | |
| | e. Transfer | |
| | f. Walking | |
| | g. Dressing or grooming | |
| | h. Eating or swallowing | |
| | i. Amputation/prosthesis care | |
| j. Communication | | |
| k. Other | | |

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 | |

SECTION R. ASSESSMENT INFORMATION

| | | | |
|--|-----------------------|-------|--------|
| 1. PARTICIPATION IN ASSESSMENT | a. Resident: | 0. No | 1. Yes |
| | b. Family: | 0. No | 1. Yes |
| | c. Significant other: | 0. No | 1. Yes |
| 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 | | | |
| d. | | | |
| e. | | | |
| f. | | | |
| g. | | | |
| h. | | | |

MDS QUARTERLY ASSESSMENT FORM

Numeric Identifier _____

| | | |
|-----|--|--|
| A1. | RESIDENT NAME | a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr) |
| A2. | ROOM NUMBER | |
| 7. | ASSESSMENT REFERENCE DATE | a. Last day of MDS observation period [] [] - [] [] - [] [] [] [] Month Day Year b. Original (0) or corrected copy of form (enter number of correction) |
| A4a | DATE OF REENTRY | Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) [] [] - [] [] - [] [] [] [] Month Day Year |
| A6. | MEDICAL RECORD NO. | |
| B1. | COMATOSE | (Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (Skip to Section G) |
| B2. | MEMORY | (Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem |
| B4. | COGNITIVE SKILLS FOR DAILY DECISION-MAKING | (Made decisions regarding tasks of daily life) 0. INDEPENDENT—decisions consistent/reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions |
| B5. | INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS | (Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time]. 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out) e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not) |
| C4. | MAKING SELF UNDERSTOOD | (Expressing information content—however able) 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY/NEVER UNDERSTOOD |
| C6. | ABILITY TO UNDERSTAND OTHERS | (Understanding verbal information content—however able) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part/intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY/NEVER UNDERSTANDS |
| E1. | 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" |

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| E1. | INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (cont.) | VERBAL EXPRESSIONS OF DISTRESS 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. |
| E2. | 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 easily altered 1. Indicators present, easily altered 2. Indicators present, not easily altered | |
| E4. | BEHAVIORAL SYMPTOMS | (A) Behavioral symptom frequency in last 7 days 0. Behavior not exhibited in last 7 days 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) (B) |
| G1. | (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 only 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 B. ACTIVITY DID NOT OCCUR during entire 7 days | (A) |
| a. | BED MOBILITY | How resident moves to and from lying position, turns side to side, and positions body while in bed | |
| b. | TRANSFER | How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet) | |
| c. | WALK IN ROOM | How resident walks between locations in his/her room. | |
| d. | WALK IN CORRIDOR | How resident walks in corridor on unit. | |
| e. | 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 prostheses | |
| h. | EATING | How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition). | |

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| 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) | | |
| | 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.</i> (A) BATHING SELF PERFORMANCE codes appear below | (A) | |
| | | 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 | | |
| G4. | FUNCTIONAL LIMITATION IN RANGE OF MOTION | (Code for limitations during last 7 days that interfered with daily functions or placed residents 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) | |
| G6. | 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 | a. NONE OF ABOVE f. | |
| H1. | 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 | | |
| b. | 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 | | |
| H2. | BOWEL ELIMINATION PATTERN | Fecal impaction | d. NONE OF ABOVE | e. |
| H3. | APPLIANCES AND PROGRAMS | Any scheduled toileting plan Bladder retraining program External (condom) catheter | a. Indwelling catheter b. Ostomy present c. NONE OF ABOVE | d. l. |
| I2. | INFECTIONS | Urinary tract infection in last 30 days | j. NONE OF ABOVE | m. |
| I3. | OTHER CURRENT DIAGNOSES AND ICD-9 CODES | (Include only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death) | | |
| J1. | PROBLEM CONDITIONS | (Check all problems present in last 7 days) Dehydrated; output exceeds input Hallucinations | c. NONE OF ABOVE | l. p. |
| J2. | 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 0. No pain (skip to J4) 1. Pain less than daily 2. Pain daily b. INTENSITY of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating | | |
| J4. | ACCIDENTS | (Check all that apply) Fell in past 30 days Fell in past 31-180 days | a. Other fracture in last 180 days b. NONE OF ABOVE | c. d. e. |

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| J5. | STABILITY OF CONDITIONS | Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating) Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem End-stage disease, 6 or fewer months to live NONE OF ABOVE | a. b. c. d. |
| K3. | 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 | |
| K5. | NUTRITIONAL APPROACHES | Feeding tube On a planned weight change program NONE OF ABOVE | b. h. l. |
| M1. | ULCERS (Due to any cause) | (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.] 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. | Number at Stage |
| M2. | TYPE OF ULCER | (For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4) a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities | |
| N1. | TIME AWAKE | (Check appropriate time periods over last 7 days) Resident awakes all or most of time (i.e., naps no more than one hour per time period) in the: Morning Evening Afternoon NONE OF ABOVE | c. d. |
| (If resident is comatose, skip to Section O) | | | |
| N2. | AVERAGE TIME INVOLVED IN ACTIVITIES | (When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 3. None | |
| O1. | NUMBER OF MEDICATIONS | (Record the number of different medications used in the last 7 days; enter "0" if none used) | |
| O4. | DAYS RECEIVED THE FOLLOWING MEDICATION | (Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly) a. Antipsychotic b. Antianxiety c. Antidepressant d. Hypnotic e. Diuretic | |
| P4. | 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 | |
| Q2. | OVERALL CHANGE IN CARE NEEDS | Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support | |
| R2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT: | | | |
| a. Signature of RN Assessment Coordinator (sign on above line) | | | |
| b. Date RN Assessment Coordinator signed as complete Month — Day — Year | | | |
| c. Other Signatures Title Sections Date | | | |
| d. Date | | | |
| e. Date | | | |
| f. Date | | | |
| g. Date | | | |

Resident _____

Numeric Identifier _____

| | | |
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| G1. | | (A) (B) |
| c. | WALK IN ROOM | How resident walks between locations in his/her room |
| d. | WALK IN CORRIDOR | How resident walks in corridor on unit |
| | 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 |
| | 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) |
| G2. | 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.</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 |
| G3. | 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 |
| G4. | FUNCTIONAL LIMITATION IN RANGE OF MOTION | (Code for limitations during last 7 days that interfered with daily functions or placed residents 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 |
| G6. | MODES OF TRANSFER | (Check all that apply during last 7 days) Bedfast all or most of time a. NONE OF ABOVE Bed rails used for bed mobility or transfer b. |
| G7. | 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 |
| H1. | 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 |
| H2. | BOWEL ELIMINATION PATTERN | Diarrhea c. NONE OF ABOVE Fecal impaction d. |

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| H3. | APPLIANCES AND PROGRAMS | Any scheduled toileting plan Bladder retraining program External (condom) catheter | a. b. c. | Indwelling catheter Ostomy present NONE OF ABOVE | d. e. f. |
| 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) | | | | | |
| I1. | DISEASES | (If none apply, CHECK the NONE OF ABOVE box) MUSCULOSKELETAL Hip fracture NEUROLOGICAL Aphasia Cerebral palsy Cerebrovascular accident (stroke) Hemiplegia/Hemiparesis | m. n. o. p. q. r. | Multiple sclerosis Quadriplegia PSYCHIATRIC/MOOD Depression Manic depressive (bipolar disease) OTHER NONE OF ABOVE | w. x. y. z. aa. bb. cc. |
| I2. | INFECTIONS | (If none apply, CHECK the NONE OF ABOVE box) Antibiotic resistant infection (e.g., Methicillin resistant staph) Clostridium difficile (c. diff.) Conjunctivitis HIV infection Pneumonia Respiratory infection | a. b. c. d. e. f. | Septicemia Sexually transmitted diseases Tuberculosis Urinary tract infection in last 30 days Viral hepatitis Wound infection NONE OF ABOVE | g. h. i. j. k. l. m. |
| I3. | OTHER CURRENT DIAGNOSES AND ICD-9 CODES | (Include only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death) | a. b. | | |
| J1. | PROBLEM CONDITIONS | (Check all problems present in last 7 days unless other time frame is indicated) INDICATORS OF FLUID STATUS Weight gain or loss of 3 or more pounds within a 7 day period Inability to lie flat due to shortness of breath Dehydrated; output exceeds input Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days | a. b. c. d. | OTHER Delusions Edema Fever Hallucinations Internal bleeding Recurrent lung aspirations in last 90 days Shortness of breath Unsteady gait Vomiting NONE OF ABOVE | e. f. g. h. i. j. k. l. m. n. o. p. |
| J2. | 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 0. No pain (skip to J4) 1. Pain less than daily 2. Pain daily b. INTENSITY of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating | | | |
| J4. | ACCIDENTS | (Check all that apply) Fell in past 30 days Fell in past 31-180 days | a. b. | Hip fracture in last 180 days Other fracture in last 180 days NONE OF ABOVE | c. d. e. |
| J5. | STABILITY OF CONDITIONS | Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating) Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem End-stage disease, 6 or fewer months to live NONE OF ABOVE | | | a. b. c. d. |
| K1. | ORAL PROBLEMS | Chewing problem Swallowing problem NONE OF ABOVE | | | a. b. c. |
| K2. | 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.) | |
| K3. | 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 | | | |

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| G1. | | (A) (B) |
| 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) |
| G2. | BATHING | How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair) Code for most dependent in self-performance. (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 |
| G3. | 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 |
| | FUNCTIONAL LIMITATION RANGE OF MOTION | (Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury) (A) RANGE OF MOTION 0. No limitation 1. Limitation on one side 2. Limitation on both sides (B) VOLUNTARY MOVEMENT 0. No loss 1. Partial loss 2. Full loss |
| G6. | 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 |
| G7. | 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 |
| H1. | 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., toley) or continence programs, if employed |
| H2. | BOWEL ELIMINATION PATTERN | Diarhea Fecal impaction |

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|--|---|---|----------------------------------|--|--|
| H3. | APPLIANCES AND PROGRAMS | Any scheduled toileting plan Bladder retraining program External (condom) catheter | a. b. c. | Indwelling catheter Ostomy present NONE OF ABOVE | d. l. j. |
| 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) | | | | | |
| I1. | DISEASES | (If none apply, CHECK the NONE OF ABOVE box) ENDOCRINE/METABOLIC/NUTRITIONAL Diabetes mellitus MUSCULOSKELETAL Hip fracture NEUROLOGICAL Aphasia Cerebral palsy Cerebrovascular accident (stroke) | a. m. t. s. t. | Hemiplegia/Hemiparesis Multiple sclerosis Quadriplegia PSYCHIATRIC/MOOD Depression Manic depressive (bipolar disease) OTHER NONE OF ABOVE | v. w. z. ea. ff. rr. |
| I2. | INFECTIONS | (If none apply, CHECK the NONE OF ABOVE box) Antibiotic resistant infection (e.g., Methicillin resistant staph) Clostridium difficile (c. diff.) Conjunctivitis HIV infection Pneumonia Respiratory infection | a. b. c. d. e. t. | Septicemia Sexually transmitted diseases Tuberculosis Urinary tract infection in last 30 days Viral hepatitis Wound infection NONE OF ABOVE | g. h. l. j. k. l. m. |
| I3. | OTHER CURRENT DIAGNOSES AND ICD-9 CODES | (Include only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death) | a. b. | | |
| J1. | PROBLEM CONDITIONS | (Check all problems present in last 7 days unless other time frame is indicated) INDICATORS OF FLUID STATUS Weight gain or loss of 3 or more pounds within a 7 day period Inability to lie flat due to shortness of breath Dehydrated; output exceeds input Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days | | OTHER Delusions Edema Fever Hallucinations Internal bleeding Recurrent lung aspirations in last 90 days Shortness of breath Unsteady gait Vomiting NONE OF ABOVE | e. g. h. l. j. k. l. n. o. p. |
| J2. | 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 0. No pain (skip to J4) 1. Pain less than daily 2. Pain daily b. INTENSITY of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating | | | |
| J4. | ACCIDENTS | (Check all that apply) Fell in past 30 days Fell in past 31-180 days | a. b. | Hip fracture in last 180 days Other fracture in last 180 days NONE OF ABOVE | c. d. e. |
| J5. | STABILITY OF CONDITIONS | Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating) Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem End-stage disease, 6 or fewer months to live NONE OF ABOVE | | | a. b. c. d. |
| K1. | ORAL PROBLEMS | Chewing problem Swallowing problem NONE OF ABOVE | | | a. b. d. |
| K2. | 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.) | | |
| K3. | 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 | | | |

| | | | | |
|--|--|---|--|----|
| K5. | NUTRITIONAL APPROACHES | (Check all that apply in last 7 days) | | |
| | | Parenteral/IV | a. <input type="checkbox"/> On a planned weight change program | h. |
| | | Feeding tube | b. <input type="checkbox"/> NONE OF ABOVE | i. |
| | PARENTERAL OR ENTERAL INTAKE | (Skip to Section M 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 | | |
| M1. | ULCERS (Due to any cause) | (Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.] | Number at Stage | |
| | | a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. | | |
| | | b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. | | |
| | | c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue. | | |
| | | d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. | | |
| M2. | TYPE OF 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 | | |
| M4. | OTHER SKIN PROBLEMS OR LESIONS PRESENT (Check all that apply during last 7 days) | Abrasions, bruises Burns (second or third degree) Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster Skin desensitized to pain or pressure Skin tears or cuts (other than surgery) Surgical wounds NONE OF ABOVE | a. b. c. d. e. f. g. h. | |
| | SKIN TREATMENTS (Check all that apply during last 7 days) | Pressure relieving device(s) for chair Pressure relieving device(s) for bed Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE | a. b. c. d. e. f. g. h. i. j. | |
| M6. | FOOT PROBLEMS AND CARE (Check all that apply during last 7 days) | Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE | a. b. c. d. e. f. g. | |
| N1. | 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 <input type="checkbox"/> Evening Afternoon <input type="checkbox"/> NONE OF ABOVE | a. b. c. d. | |
| (If resident is comatose, skip to Section O) | | | | |
| N2. | 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 | | |
| O1. | NUMBER OF MEDICATIONS | (Record the number of different medications used in the last 7 days; enter "0" if none used) | | |
| | INJECTIONS | (Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used) | | |
| O4. | 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 <input type="checkbox"/> d. Hypnotic <input type="checkbox"/> b. Antianxiety <input type="checkbox"/> e. Diuretic <input type="checkbox"/> c. Antidepressant <input type="checkbox"/> | | |

| | | | | |
|---|--|---|---|---------|
| P1. | SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS | a. SPECIAL CARE—Check treatments or programs received during the last 14 days | | |
| | | TREATMENTS | <input type="checkbox"/> Ventilator or respirator | |
| | | Chemotherapy | a. <input type="checkbox"/> PROGRAMS | |
| | | Dialysis | b. <input type="checkbox"/> Alcohol/drug treatment program | m. |
| | | IV medication | c. <input type="checkbox"/> | |
| | | Intake/output | d. <input type="checkbox"/> Alzheimer's/dementia special care unit | n. |
| | | Monitoring acute medical condition | e. <input type="checkbox"/> Hospice care | o. |
| | | Ostomy care | f. <input type="checkbox"/> Pediatric unit | p. |
| | | Oxygen therapy | g. <input type="checkbox"/> Respite care | q. |
| | | Radiation | h. <input type="checkbox"/> Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) | r. |
| | | Suctioning | i. <input type="checkbox"/> | |
| | | Tracheostomy care | j. <input type="checkbox"/> | |
| | | Transfusions | k. <input type="checkbox"/> NONE OF ABOVE | s. |
| | | 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 (B) = total # of minutes provided in last 7 days | | |
| | | a. Speech - language pathology and audiology services | DAYS (A) | MIN (B) |
| | | b. Occupational therapy | | |
| | | c. Physical therapy | | |
| | | d. Respiratory therapy | | |
| | | e. Psychological therapy (by any licensed mental health professional) | | |
| P3. | 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) | <input type="checkbox"/> | |
| | | b. Range of motion (active) | <input type="checkbox"/> | |
| | | c. Splint or brace assistance | <input type="checkbox"/> | |
| | | f. Walking | <input type="checkbox"/> | |
| | | g. Dressing or grooming | <input type="checkbox"/> | |
| | | h. Eating or swallowing | <input type="checkbox"/> | |
| | | i. Amputation/prosthesis care | <input type="checkbox"/> | |
| | | j. Communication | <input type="checkbox"/> | |
| | | k. Other | <input type="checkbox"/> | |
| P4. | 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 | | |
| P7. | 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) | | |
| P8. | 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) | | |
| Q2. | OVERALL CHANGE IN CARE NEEDS | Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support | | |
| R2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT: | | | | |
| a. Signature of RN Assessment Coordinator (sign on above line) | | | | |
| b. Date RN Assessment Coordinator signed as complete <input type="text"/> - <input type="text"/> - <input type="text"/> | | | | |
| Month Day Year | | | | |
| c. Other Signatures Title Sections Date | | | | |
| d. _____ Date | | | | |
| e. _____ Date | | | | |
| f. _____ Date | | | | |
| g. _____ Date | | | | |
| h. _____ Date | | | | |

MINIMUM DATA SET (MDS) — VERSION 2.0

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

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

SECTION AA. IDENTIFICATION INFORMATION

| | | | | | | | | | | | | | | | | | | | | |
|---|--|---------------------|-----------|------------|-----------------------------------|-------------|---------------------------|----------------------------------|----------------------------------|--|--|--|--|-----|--|--|--|--|------|--|
| 1. RESIDENT NAME <small>Ⓞ</small> | | | | | | | | | | | | | | | | | | | | |
| | a. (First) | b. (Middle Initial) | c. (Last) | d. (Jr/Sr) | | | | | | | | | | | | | | | | |
| 2. GENDER <small>Ⓞ</small> | 1. Male 2. Female | | | | | | | | | | | | | | | | | | | |
| 3. BIRTHDATE <small>Ⓞ</small> | <table style="margin: auto; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td colspan="4"></td> <td style="text-align: center;">Year</td> </tr> </table> | | | | | | | | | | | | Month | Day | | | | | Year | |
| | | | | | | | | | | | | | | | | | | | | |
| Month | Day | | | | | Year | | | | | | | | | | | | | | |
| 4. RACE/ETHNICITY <small>Ⓞ</small> | <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1. American Indian/Alaskan Native</td> <td style="width: 50%;">4. Hispanic</td> </tr> <tr> <td>2. Asian/Pacific Islander</td> <td>5. White, not of Hispanic origin</td> </tr> <tr> <td>3. Black, not of Hispanic origin</td> <td></td> </tr> </table> | | | | 1. American Indian/Alaskan Native | 4. Hispanic | 2. Asian/Pacific Islander | 5. White, not of Hispanic origin | 3. Black, not of Hispanic origin | | | | | | | | | | | |
| 1. American Indian/Alaskan Native | 4. Hispanic | | | | | | | | | | | | | | | | | | | |
| 2. Asian/Pacific Islander | 5. White, not of Hispanic origin | | | | | | | | | | | | | | | | | | | |
| 3. Black, not of Hispanic origin | | | | | | | | | | | | | | | | | | | | |
| 5. SOCIAL SECURITY AND MEDICARE NUMBERS <small>Ⓞ</small> <small>[C in 1st box if non med. no.]</small> | <table style="width: 100%; border: none;"> <tr> <td colspan="4">a. Social Security Number</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="4">b. Medicare number (or comparable railroad insurance number)</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> | | | | a. Social Security Number | | | | | | | | b. Medicare number (or comparable railroad insurance number) | | | | | | | |
| a. Social Security Number | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| b. Medicare number (or comparable railroad insurance number) | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| 6. FACILITY PROVIDER NO. <small>Ⓞ</small> | <table style="width: 100%; border: none;"> <tr> <td colspan="4">a. State No.</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="4">b. Federal No.</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> | | | | a. State No. | | | | | | | | b. Federal No. | | | | | | | |
| a. State No. | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| b. Federal No. | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| 7. MEDICAID NO. <small>Ⓞ</small> <small>["+" if pending, "N" if not a Medicaid recipient]</small> | <table style="margin: auto; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | |
| 8. REASONS FOR ASSESSMENT | <small>(Note—Other codes do not apply to this form)</small> a. Primary reason for assessment 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment | | | | | | | | | | | | | | | | | | | |

SECTION R. ASSESSMENT/DISCHARGE INFORMATION

| | | | | | | | | | | | | |
|----------------------------|--|--|--|------|--|--|--|-------|-----|--|--|------|
| 3. DISCHARGE STATUS | a. Code for resident disposition upon discharge 1. Private home/apartment with no home health services 2. Private home/apartment with home health services 3. Board and care/assisted living 4. Another nursing facility 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Deceased 9. Other b. Optional State Code | | | | | | | | | | | |
| 4. DISCHARGE DATE | Date of death or discharge <table style="margin: auto; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td colspan="2"></td> <td style="text-align: center;">Year</td> </tr> </table> | | | | | | | Month | Day | | | Year |
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| Month | Day | | | Year | | | | | | | | |

SECTION AA. SIGNATURES OF STAFF COMPLETING FORM

| | | | |
|---------------|-------|----------|------|
| a. Signatures | Title | Sections | Date |
| | | | |
| b. | | | Date |
| c. | | | Date |

SECTION AB. DEMOGRAPHIC INFORMATION

[Complete only for stays less than 14 days] (AA8a=8)

| | | | | | | | | | | | | |
|------------------------------------|--|--|--|------|--|--|--|-------|-----|--|--|------|
| 1. DATE OF ENTRY | Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date <table style="margin: auto; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td colspan="2"></td> <td style="text-align: center;">Year</td> </tr> </table> | | | | | | | Month | Day | | | Year |
| | | | | | | | | | | | | |
| Month | Day | | | Year | | | | | | | | |
| 2. ADMITTED FROM (AT ENTRY) | 1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other | | | | | | | | | | | |

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

| | | | | | | | | | |
|------------------------------|---|--|--|--|--|--|--|--|--|
| 6. MEDICAL RECORD NO. | <table style="margin: auto; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> | | | | | | | | |
| | | | | | | | | | |

Ⓞ = Key items for computerized resident tracking

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

MINIMUM DATA SET (MDS) — VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

REENTRY TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

| | | | | | | | | | | | | | | | | | |
|-------|---|--|----------|---|------|--|--|--|--|--|--|-------|-----|------|--|--|--|
| 1. | RESIDENT NAME [⊗] | a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr) | | | | | | | | | | | | | | | |
| 2. | GENDER [⊗] | 1. Male 2. Female | | | | | | | | | | | | | | | |
| 3. | BIRTHDATE [⊗] | <table style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> </tr> <tr> <td>Month</td> <td>Day</td> <td colspan="4">Year</td> </tr> </table> | | | | | | | | | | Month | Day | Year | | | |
| | | | | | | | | | | | | | | | | | |
| Month | Day | Year | | | | | | | | | | | | | | | |
| 4. | RACE/ ETHNICITY [⊗] | 1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin | | 4. Hispanic 5. White, not of Hispanic origin | | | | | | | | | | | | | |
| 5. | SOCIAL SECURITY AND MEDICARE NUMBERS [⊗] [C in 1 st box if non med. no.] | <table style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> </tr> </table> | | | | | | | | | | | | | | | |
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| 6. | FACILITY PROVIDER NO. [⊗] | <table style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> </tr> </table> | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 7. | MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] [⊗] | <table style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> </tr> </table> | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |
| 8. | REASONS FOR ASSESSMENT | Note—Other codes do not apply to this form a. Primary reason for assessment 9. Reentry | | | | | | | | | | | | | | | |
| 9. | SIGNATURES OF PERSONS COMPLETING FORM | | | | | | | | | | | | | | | | |
| | Signatures | Title | Sections | Date | | | | | | | | | | | | | |
| | b. | | | | Date | | | | | | | | | | | | |
| | c. | | | | Date | | | | | | | | | | | | |

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

| | | | | | | | | | | | | | | | | | |
|-------|----------------------------|--|--|--|--|--|--|--|--|--|--|-------|-----|------|--|--|--|
| 4a. | DATE OF REENTRY | Date of reentry | | | | | | | | | | | | | | | |
| | | <table style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> </tr> <tr> <td>Month</td> <td>Day</td> <td colspan="4">Year</td> </tr> </table> | | | | | | | | | | Month | Day | Year | | | |
| | | | | | | | | | | | | | | | | | |
| Month | Day | Year | | | | | | | | | | | | | | | |
| 4b. | ADMITTED FROM (AT REENTRY) | 1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other | | | | | | | | | | | | | | | |
| 6. | MEDICAL RECORD NO. | <table style="width: 100%; text-align: center; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> <td style="border: 1px solid black; width: 20px; height: 20px;"> </td> </tr> </table> | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | |

⊗ = Key items for computerized resident tracking

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

APPENDIX C

Resident Assessment Protocols

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

- Key:**
- = One item required to trigger
 - ⊙ = 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

| MDS ITEM | CODE | Delirium | | | | | | | | | | | | | | B2a | | | | | | | |
|-------------|---|-------------------------|-----------------|---------------|--------------------------------|-----------------------------|--|-------------------------|------------|---------------------|----------------------|----------------------|-------|--------------------|---------------|-----|-------------------------------|-------------|-----------------|-----------------------|---------------------|-----|-------------|
| | | Cognitive Loss/Dementia | Visual Function | Communication | ADL-Rehabilitation Trigger A ⊙ | ADL-Maintenance Trigger B ⊙ | Urinary Incontinence and Indwelling 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 |
| B5 | Decision making | 3 | | | | | ● | | | | | | | | | | | | | | | | B5 |
| B5a to B5f | Indicators of delirium | 2 | ● | | | | | | | | | | | | | | | ● | | | | | B5a to B5f |
| B6 | Change in cognitive status | 2 | ● | | | | | | | | | | | | | | | ● | | | | | B6 |
| C1 | Hearing | 1,2,3 | | | ● | | | | | | | | | | | | | | | | | | C1 |
| C2 | Understood by others | 1,2,3 | | | ● | | | | | | | | | | | | | | | | | | C2 |
| 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 | Repetitive movements | 1,2 | | | | | | | | | | | | | | | | | ● | | | | E1o |
| E1o | Withdrawal from activities | 1,2 | | | | | | | | ● | | | | | | | | | | | | | E1o |
| E2 | Mood persists | 1,2 | | | | | | | | ● | | | | | | | | | | | | | E2 |
| E3 | Change in Mood | 2 | ● | | | | | | | | | | | | | | | | ● | | | | E3 |
| E4aA | Wandering | 1,2,3 | | | | | | | | | | | | | | | | | | | | | E4aA |
| E4aA - E4eA | Behavioral symptoms | 1,2,3 | | | | | | | | ● | | | | | | | | | | | | | E4aA - E4eA |
| E5 | Change in behavioral symptoms | 1 | | | | | | | | ● | | | | | | | | | | | | | E5 |
| E5 | Change in behavioral symptoms | 2 | ● | | | | | | | | | | | | | | | | | ● | | | E5 |
| E5 | Establishes own goals | 1 | | | | | | | | ● | | | | | | | | | | | | | E5 |
| F2a to F2d | Unsettled relationships | ✓ | | | | | | | | ● | | | | | | | | | | | | | F2a to F2d |
| F3a | Strong or poor roles | ✓ | | | | | | | | ● | | | | | | | | | | | | | F3a |
| F3b | Lost roles | ✓ | | | | | | | | ● | | | | | | | | | | | | | F3b |
| F3c | Daily routine different | ✓ | | | | | | | | ● | | | | | | | | | | | | | F3c |
| G1aA - G1jA | ADL self-performance | 1,2,3,4 | | | | ● | | | | | | | | | | | | | | | | | G1aA - G1jA |
| G1aA | Bed mobility | 2,3,4 | | | | | | | | | | | | | | | | | ● | | | | G1aA |
| G2A | Bathing | 1,2,3,4 | | | | ● | | | | | | | | | | | | | | | | | G2A |
| G2b | Balances while sitting | 1,2,3 | | | | | | | | | | | | | | | | | | | | | G2b |
| G6a | Bedfast | ✓ | | | | | | | | | | | | | | | | | | ● | | | G6a |
| G6aA | Resident staff believe responsible | ✓ | | | | | | | | ● | | | | | | | | | | | | | G6aA |
| H1a | Bowel incontinence | 1,2,3,4 | | | | | | | | | | | | | | | | | | ● | | | H1a |
| H1b | Diaper incontinence | 2,3,4 | | | | | | | | ● | | | | | | | | | | | | | H1b |
| H2b | Constipation | ✓ | | | | | | | | | | | | | | | | | | | ● | | H2b |
| H2d | Fecal impaction | ✓ | | | | | | | | | | | | | | | | | | | ● | | H2d |
| H3c,d,e | Catheter use | ✓ | | | | | | | | ● | | | | | | | | | | | | | H3c,d,e |
| H3d | Use of restraints | ✓ | | | | | | | | ● | | | | | | | | | | | | | H3d |
| I1i | Hypotension | ✓ | | | | | | | | | | | | | | | | | | ● | | | I1i |
| I1e | Peripheral vascular disease | ✓ | | | | | | | | | | | | | | | | | | ● | | | I1e |
| I1ee | Depression | ✓ | | | | | | | | | | | | | | | | | | | ● | | I1ee |
| I1f | Cataracts | ✓ | | | | ● | | | | | | | | | | | | | | | | | I1f |
| I1f | Glaucoma | ✓ | | | | ● | | | | | | | | | | | | | | | | | I1f |
| I2 | UTI | ✓ | | | | | | | | | | | | | | | | | | | | | I2 |
| I3 | Dehydration diagnosis | 2,7,6,5 | | | | | | | | | | | | | | | | | | ● | | | I3 |
| I3a | Weight fluctuation | ✓ | | | | | | | | | | | | | | | | | | ● | | | I3a |
| I3c | Dehydrated | ✓ | | | | | | | | | | | | | | | | | | ● | | | I3c |
| I3d | Insufficient fluid | ✓ | | | | | | | | | | | | | | | | | | ● | | | I3d |
| I3f | Dizziness | ✓ | | | | | | | | | | | | | | | | | | | ● | | I3f |
| I3f | Fever | ✓ | | | | | | | | | ● | | | | | | | | | | | | I3f |
| I3f | Hallucinations | ✓ | | | | | | | | | | | | | | | | | | | ● | | I3f |
| I3f | Internal bleeding | ✓ | | | | | | | | | | | | | | | | | | | ● | | I3f |
| I3k | Lung aspirations | ✓ | | | | | | | | | | | | | | | | | | | ● | | I3k |
| I3k | Syncope | ✓ | | | | | | | | | | | | | | | | | | | ● | | I3k |

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

- Key:
- = One item required to trigger
 - ⊖ = 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

| MDS ITEM | CODE | Delirium | Cognitive Loss/Dementia | Visual Function | Communication | ADL-Rehabilitation Trigger A ⊗ | ADL-Maintenance Trigger B ⊗ | Urinary Incontinence and Indwelling Catheter | 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 |
|-----------|-----------------------------------|----------|-------------------------|-----------------|---------------|--------------------------------|-----------------------------|--|------------|---------------------|----------------------|----------------------|-------|--------------------|---------------|-------------------------------|-------------|-----------------|-----------------------|---------------------|
| J1b | Unstable gait | | | | | | | | | | | | | | | | | | | |
| J4a,b | Fel | | | | | | | | | | | ● | | | | | | ● | | J4a,b |
| J4c | Wid fractures | | | | | | | | | | | | | | | | | ● | | J4c |
| K1b | Swallowing problem | | | | | | | | | | | | | | | | | ● | | K1b |
| K1c | Mouth pain | | | | | | | | | | | | | | | | ● | | | K1c |
| K3a | Weight loss | | | | | | | | | | | | | | | | | | | K3a |
| K4a | Taste sensation | | | | | | | | | | | | ● | | | | | | | K4a |
| K4c | Leave 25% food | | | | | | | | | | | | ● | | | | | | | K4c |
| K5a | Parenteral feeding | | | | | | | | | | | | ● | | ● | | | | | K5a |
| K5b | Feeding tube | | | | | | | | | | | | ● | | ● | | | | | K5b |
| K5c | Mechanical assist | | | | | | | | | | | | ● | | | | | | | K5c |
| K5d | Syringe feeding | | | | | | | | | | | | ● | | | | | | | K5d |
| K5e | Therapeutic diet | | | | | | | | | | | | ● | | | | | | | K5e |
| L1a,c,d,e | Dental | | | | | | | | | | | | | | | | ● | | | L1a,c,d,e |
| L1f | Day cleaning teeth | | | | | | | | | | | | | | | | ● | | | L1f |
| M2a | Pressure ulcer | | | | | | | | | | | | | ● | | | | | | M2a |
| M2b | Pressure ulcer | | | | | | | | | | | | | | | | | ● | | M2b |
| M3 | Previous pressure ulcer | | | | | | | | | | | | | | | | | ● | | M3 |
| M4c | Inoperable fecal stoma | | | | | | | | | | | | | | | | | ● | | M4c |
| N1a | Awake morning | | | | | | | | | | | | | | | | | | | N1a |
| N1b | Involved in activities | | | | | | | | | | | ⊖ | | | | | | | | N1b |
| N1c | Involved in activities | | | | | | | | | | | ⊖ | | | | | | | | N1c |
| N2 | Profess changes in daily routines | | | | | | | | | | | ● | | | | | | | | N2 |
| O4a | Antipsychotics | | | | | | | | | | | | | | | | | | * | O4a |
| O4b | Anxiolytics | | | | | | | | | | | | | | | | | | ** | O4b |
| O4c | Antidepressants | | | | | | | | | | | | | | | | | | * | O4c |
| O4d | Diuretics | | | | | | | | | | | | | | | | | | | O4d |
| P4c | Trunk restraint | | | | | | | | | | | | ● | | | | | | | P4c |
| P4b | Trunk restraint | | | | | | | | | | | | | | | | | | ● | P4b |
| P4d | Limb restraint | | | | | | | | | | | | | | | | | | ● | P4d |
| P4e | Chair prevents rising | | | | | | | | | | | | | | | | | | ● | P4e |

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

Numeric Identifier _____

| | |
|------------------|---------------------|
| Resident's Name: | Medical Record No.: |
|------------------|---------------------|

1. Check if RAP is triggered.
- 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"/> |

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

RESIDENT ASSESSMENT PROTOCOL: DELIRIUM

I. PROBLEM

Delirium (acute confusional state) is a common indicator or nonspecific symptom of a variety of acute, treatable illnesses. It is a serious problem, with high rates of morbidity and mortality, unless it is recognized and treated appropriately. Delirium is never a part of normal aging. Some of the classic signs of delirium may be difficult to recognize and may be mistaken for the natural progression of dementia, particularly in the late stages of dementia when delirium has high mortality. Thus careful observation of the resident and review of potential causes is essential.

Delirium is characterized by fluctuating states of consciousness, disorientation, decreased environmental awareness, and behavioral changes. The onset of delirium may vary, depending on severity of the cause(s) and the resident's health status; however, it usually develops rapidly, over a few days or even hours. Even with successful treatment of cause(s) and associated symptoms, it may take several weeks before cognitive abilities return to pre-delirium status.

Successful management depends on accurate identification of the clinical picture, correct diagnosis of specific cause(s), and prompt nursing and medical intervention. Delirium is often caused and aggravated by multiple factors. Thus, if you identify and address one cause, but delirium continues, you should continue to review the other major causes of delirium and treat any that are found.

II. TRIGGERS

Delirium problem suggested if one or more of following present:

- Easily Distracted^(a)
[B5a = 2]
- Periods of Altered Perception or Awareness of Surroundings^(a)
[B5b = 2]
- Episodes of Disorganized Speech^(a)
[B5c = 2]
- Periods of Restlessness^(a)
[B5d = 2]
- Periods of Lethargy ^(a)
[B5e = 2]
- Mental Function Varies Over the Course of the Day ^(a)
[B5f = 2]
- Cognitive decline^(a)
[B6 = 2]
- Mood decline^(a)
[E3 = 2]
- Behavior decline^(a)
[E5 = 2]

^(a) Note: All of these items also trigger on the Psychotropic Drug Use RAP (when psychotropic drug use present).

III. GUIDELINES

Detecting signs and symptoms of delirium requires careful observation. Knowledge of a person's baseline cognitive abilities facilitates evaluation.

- Staff should become familiar with resident's cognitive function by regularly observing the resident in a variety of situations so that even subtle but important changes can be recognized.

When observed in this manner, the presence of any trigger signs/symptoms may be seen as a potential marker for acute, treatable illness.

An approach to detection and treatment of the problem can be selected by reviewing the items that follow in the order presented. Also refer to the RAP KEY for guidance on the MDS items that are relevant.

DIAGNOSES AND CONDITIONS

By correctly identifying the underlying cause(s) of delirium, you may prevent a cycle of worsening symptoms (e.g., an infection-fever-dehydration-confusion syndrome) or a drug regimen for a suspected cause that worsens the condition. The most common causes of delirium are associated with circulatory, respiratory, infectious, and metabolic disorders. However, finding one cause or disorder does not rule out the possibility of additional contributing causes and/or multiple interrelated factors.

MEDICATIONS

Many medications given alone or in combination can cause delirium.

- If necessary, check doctor's order against med sheet and drug labels to avoid the common problem of medication error.
- Review the resident's drug profile with a physician.
- Review all medications (regularly prescribed, PRN, and "over-the-counter" drugs).

Number of medications. The greater the number, the greater the possibility of adverse drug reaction/toxicity.

- Review meds to determine need and benefit (ask if resident is receiving more than one class of a drug to treat a condition).
- Check to determine whether nonpharmacological interventions have been considered (e.g., a behavior management program rather than antipsychotics to address the needs of a resident who has physically or verbally abusive behavioral symptoms).

New medications.

- Review to determine whether there is a temporal relationship between onset or worsening of delirium and start of new medication.

Drugs that cause delirium.

1. **PSYCHOTROPIC**
 Antipsychotics
 Antianxiety/hypnotics
 Antidepressants
2. **CARDIAC**
 Digitalis glycosides (Digoxin),
 Antiarrhythmics, such as quinidine, procainamide (Pronestyl), disopyrime (Norpace)
 Calcium channel blockers, such as verapamil (Isoptin),
 nifedipine (Procardia), and diltiazem (Cardizem)
 Antihypertensives, such as methyldopa (Aldomet), propranolol (Inderal)
3. **GASTROINTESTINAL**
 H2 antagonists such as cimetidine (Tagamet) and ranitidine (Zantac)
4. **ANALGESICS** such as Darvon, narcotics (e.g., morphine, dilaudid)
5. **ANTI-INFLAMMATORY**
 Corticosteroids such as prednisone
 Nonsteroidal anti-inflammatory agents such as ibuprofen (Motrin)
6. **OVER-THE-COUNTER DRUGS**, especially those with anticholinergic properties
 Cold remedies (antihistamines, pseudoephedrine)
 Sedatives (antihistamines, e.g., Benadryl)
 Stay-awakes (caffeine)
 Antinauseants
 Alcohol

PSYCHOSOCIAL

After serious illness and drug toxicity are ruled out as causes of delirium, consider the possibility that the resident is experiencing psychosocial distress that may produce signs of delirium.

Isolation.

- Has the resident been away from people, objects and situations?
- Is resident confused about time, place, and meaning?
- Has the resident been in bed or in an isolated area while recuperating from an illness or receiving a treatment?

Recent loss of family/friend. Loss of someone close can precipitate a grief reaction that presents as acute confusion, especially if the person provided safety and structure for a demented resident.

- Review the MDS to determine whether the resident has experienced a recent loss of a close family member/friend.

Depression/sad or anxious mood. Mood states can lead to confusional states that resolve with appropriate treatment.

- Review the MDS to determine whether the resident exhibits any signs or symptoms of sad or anxious mood or has a diagnosis of a psychiatric illness.

Restraints. Restraints often aggravate the conditions staff are trying to treat (e.g., confusion, agitation, wandering).

- Did the resident become more agitated and confused with their use?

Recent relocation.

- Has the resident recently been admitted to a new environment (new room, unit, facility)?
- Was there an orientation program that provided a calm, gentle approach with reminders and structure to help the new resident settle into the environment?

SENSORY LOSSES

Sensory impairments often produce signs of confusion and disorientation, as well as behavior changes. This is especially true of residents with early signs of dementia. They can also aggravate a confusional state by impairing the resident's ability to accurately perceive or cope with environmental stimuli (e.g., loud noises; onset of evening). This can lead to the resident experiencing hallucinations/delusions and misinterpreting noises and images.

Hearing.

- Is hearing deficit related to easily remedied situations -- impacted ear wax or hearing aid dysfunction?
- Has sensory deprivation led to confusion?
- Has physician input been sought?

Vision.

- Has vision loss created sensory deprivation resulting in confusion?
- Have major changes occurred in visual function without the resident's being referred to a physician?

CLARIFYING INFORMATION

- Does the resident have a recent sleep disturbance?
- Does the resident have Alzheimer's or other dementia?
- Has the time of onset of the resident's cognitive and behavioral function been within the last few hours to days?

ENVIRONMENT

- Is the resident's environment conducive to reducing symptoms (e.g., quiet, well-lit, calm, familiar objects present)?
- Is the resident's daily routine broken down into smaller tasks (task segmentation) to help him/her cope?

DELIRIUM RAP KEY (For MDS Version 2.0)

TRIGGER — REVISION

Delirium problem suggested if one or more of following present:

- Easily Distracted^(a)
[B5a = 2]
- Periods of Altered Perception or Awareness of Surroundings^(a)
[B5b = 2]
- Episodes of Disorganized Speech^(a)
[B5c = 2]
- Periods of Restlessness^(a)
[B5d = 2]
- Periods of Lethargy^(a)
[B5e = 2]
- Mental Function Varies Over the Course of the Day^(a)
[B5f = 2]
- Deterioration in Cognitive Status^(a)
[B6 = 2]
- Deterioration in Mood^(a)
[E3 = 2]
- Deterioration in Behavioral Symptoms^(a)
[E5 = 2]

GUIDELINES

Factors that may be associated with signs and symptoms of delirium:

- **Diagnoses and Conditions.** Diabetes [I1a], Hyperthyroidism [I1b], Hypothyroidism [I1c], Cardiac dysrhythmias [I1e], CHF [I1f], CVA [I1t], TIA [I1bb], Asthma [I1hh], Emphysema/COPD [I1ii], Anemia [I1oo], Cancer [I1pp], Dehydration [J1c] or Fever [J1h], Myocardial infarction [I3], any viral or bacterial infection [I2], Surgical abdomen [I3], Head trauma [I3], Hypothermia [I3], Hypoglycemia [I3].
- **Medications.** Number of meds [O1], New meds [O2], Antipsychotics [O4a], Antianxiety [O4b], Hypnotics [O4d], Analgesics (Pain meds), Cardiac meds, GI meds, Anti-inflammatory, Anticholinergics, [from med charts].
- **Psychosocial.** Sad or anxious mood [E1, E2, E3], Isolation [F2e; from record], Recent loss [F2f], Depression [I1ee], Restraints [P4c,d,e], Recent relocation [AB1; A4a].
- **Sensory impairment.** Hearing [C1], Vision [D1].

Clarifying information to be considered in establishing a diagnosis: Sleep disturbance [E1k], Alzheimer's [I1q], Other Dementia [I1u], Time of symptom onset within hours to days [from record or observation];

Environment conducive to reducing symptoms: Quiet, well-lit, calm, familiar objects [from observation]; Task segmentation [G7].

^(a) Note: All of these items also trigger on the Psychotropic Drug Use RAP (when psychotropic drug use is present)

RESIDENT ASSESSMENT PROTOCOL: COGNITIVE LOSS/DEMENTIA**I. PROBLEM**

Approximately 60% of residents in nursing facilities exhibit signs and symptoms of decline in intellectual functioning. Recovery will be possible for less than 10% of these residents -- those with a reversible condition such as an acute confusional state (delirium). For most residents, however, the syndrome of cognitive loss or dementia is chronic and progressive, and appropriate care focuses on enhancing quality of life, sustaining functional capacities, minimizing decline, and preserving dignity.

Confusion and/or behavioral disturbances present the primary complicating care factors. Identifying and treating acute confusion and behavior problems can facilitate assessment of how chronic cognitive deficits affect the life of the resident.

For residents with chronic cognitive deficits, a therapeutic environment is supportive rather than curative and is an environment in which licensed and nonlicensed care staff are encouraged (and trained) to comprehend a resident's experience of cognitive loss. With this insight, staff can develop care plans focused on three main goals: (1) to provide positive experiences for the resident (e.g., enjoyable activities) that do not involve overly demanding tasks and stress; (2) to define appropriate support roles for each staff member involved in a resident's care; and (3) to lay the foundation for reasonable staff and family expectations concerning a resident's capacities and needs.

II. TRIGGERS

A cognitive loss/dementia problem suggested if one or more of following are present:

- Short-term Memory Problem
[B2a = 1]
- Long-term Memory Problem
[B2b = 1]
- Impaired Decision-making^a
[B4 = 1, 2, 3]
- Problem Understanding Others^b
[C6 = 1, 2, or 3]

^(a) Note: These codes also trigger on the Communication RAP.

^(b) Note: Code 3 also triggers on the ADL (Maintenance) RAP.

III. GUIDELINES

Review the following MDS items to investigate possible links between these factors and the resident's cognitive loss and quality of life. The four triggers identify residents with differing levels of cognitive loss. Even for those who are most highly impaired, the RAP seeks to help identify areas in which staff intervention might be useful. Refer to the RAP KEY for specific MDS and other specific issues to consider.

NEUROLOGICAL

Fluctuating Cognitive Signs and Symptoms/Neurological Status. Co-existing delirium and progressive cognitive loss can result in erroneous impressions concerning the nature of the resident's chronic limitations. Only when acute confusion and behavioral disturbances are treated, or when the treatment effort is judged to be as effective as possible, can a true measure of chronic cognitive deficits be obtained.

Recent Changes in the Signs/Symptoms of the Dementia Process. Identifying these changes can heighten staff awareness of the nature of the resident's cognitive and functional limitations. This knowledge can assist staff in developing reasonable expectations of the resident's capabilities and in designing programs to enhance the resident's quality of life. This knowledge can also challenge staff to identify potentially reversible causes for recent losses in cognitive status.

Mental Retardation, Alzheimer's Disease, and Other Adult-Onset Dementias. The most prevalent neurological diagnoses for cognitively impaired residents are Alzheimer's disease and multi-infarct dementia. But increasing numbers of mentally retarded residents are in nursing facilities, and many adults suffering from Down's syndrome appear to develop dementia as they age. The diagnostic distinctions among these groups can be useful in reminding staff of the types of long-term intellectual reserves that are available to these residents.

MOOD/BEHAVIOR

Specific treatments for behavioral distress as well as treatments for delirium, can lessen and even cure the behavioral problem. At the same time, however, some behavior problems will not be reversible, and staff should be prepared (and encouraged) to learn to live with their manifestations. In some situations where problem/distressed behavior continues, staff may feel that the behavior poses no threat to the resident's safety, health, or activity pattern and is not disruptive to other residents. For the resident with declining cognitive functions and a behavioral problem, you may wish to consider the following issues:

- Have cognitive skills declined subsequent to initiation of a behavior control program (e.g., psychotropic drugs or physical restraints)?
- Is decline due to the treatment program (e.g., drug toxicity or negative reaction to physical restraints)?
- Have cognitive skills improved subsequent to initiation of a behavior control program?
- Has staff assistance enhanced resident self-performance patterns?

CONCURRENT MEDICAL PROBLEMS

Major Concurrent Medical Problems. Identifying and treating health problems can positively affect cognitive functioning and the resident's quality of life. Effective therapy for congestive heart failure, chronic obstructive pulmonary disease, and constipation can lead, for example, to functional and cognitive improvement. Comfort (pain avoidance) is a paramount goal in controlling both acute and chronic conditions for cognitively impaired residents. Verbal reports from residents should be one (but not the only) source of information. Some residents will be unable to communicate sufficiently to pinpoint their pain.

FAILURE TO THRIVE

Cognitively impaired residents can reach the point where their accumulated health/neurological problems place them at risk of clinical complications (e.g., pressure ulcers) and death. As this level of disability approaches, staff can review the following:

- Do emotional, social, and/or environmental factors play a key role?
- If a resident is not eating, is this due to a reversible mood problem, a basic personality problem, a negative reaction to the physical and interactive environment in which eating activity occurs; or a neurological deficit such as deficiency in swallowing or loss of hand coordination?
- Could an identified problem be remedied through improved staff education – trying an antidepressant medication, referral to OT for training or an innovative counseling program?
- If causes cannot be identified, what reversible clinical complication can be expected as death approaches (e.g., fecal impaction, UTI, diarrhea, fever, pain, pressure ulcers)?
- What interventions are or could be in place to decrease complications?

FUNCTIONAL LIMITATIONS

Extent and Rate of Change of Resident Functional Abilities. Functional changes are often the first concrete indicators of cognitive decline and suggest the need to identify reversible causes. You may find it helpful to determine the following:

- To what extent is resident dependent for locomotion, dressing and eating?
- Could the resident be more independent?
- Is resident going downhill (e.g., experiencing declines in bladder continence, locomotion, dressing, vision, time involved in activities)?

SENSORY IMPAIRMENTS

Perceptual Difficulties. Many cognitively impaired residents have difficulty identifying small objects, positioning a plate to eat, or positioning the body to sit in a chair. Such difficulties can cause a resident to become cautious and ultimately cease to carry out everyday activities. If problems are vision-based, corrective programs may be effective. Unfortunately, many residents have difficulty indicating that the source of their problem is visual. Thus, the cognitively impaired can often benefit if tested for possible visual deficits.

Ability to Communicate. Many individuals suffering from cognitive deficits seem incapable of meaningful communication. However, many of the seemingly incomprehensible behaviors (e.g., screaming, aggressive behavior) in which these individuals engage may constitute their only form of communication. By observing the behavior and the pattern of its occurrence, one can frequently come to some understanding of the needs of individuals with dementia. For example, residents who are restrained for their own safety may become noisy due to bladder or bowel urgency.

- Is resident willing/able to engage in meaningful communication?
- Does staff use non-verbal communication techniques (e.g., touch, gesture) to encourage resident to respond?

MEDICATIONS

Psychoactive and other medications can be a factor in cognitive decline. If necessary, review Psychotropic Drug Use RAP.

INVOLVEMENT FACTORS

Opportunities for Independent Activity. Staff can encourage residents to participate in the many available activities, and staff can guard against assuming an overly protective attitude toward residents. *Decline in one functional area does not indicate the need for staff to assume full responsibility in that area nor should it be interpreted as an indication of inevitable decline in other areas.* Review information in the MDS when considering the following issues:

- Are there factors that suggest that the resident can be more involved in his/her care (e.g., instances of greater self-performance; desire to do more independently; retained ability to learn; retained control over trunk, limbs, and/or hands)?
- Can resident participate more extensively in decisions about daily life?
- Does resident retain any cognitive ability that permits some decision making?
- Is resident passive?
- Does resident resist care?
- Are activities broken into manageable subtasks?

Extent of Involvement in Activities of Daily Life. Programs focused on physical aspects of the resident's life can lessen the disruptive symptoms of cognitive decline for some residents. Consider the following:

- Are residents with some cognitive skills and without major behavioral problems involved in the life of the facility and the world around them?
- Can modifying task demands, or the environmental circumstances under which tasks are carried out, be beneficial?
- Are small group programs encouraged?
- Are special environmental stimuli present (e.g., directional markers, special lighting)?
- Do staff regularly assist residents in ways that permit them to maintain or attain their highest predictable level of functioning (e.g., verbal reminders, physical cues and supervision regularly provided to aid in carrying out ADLs; ADL tasks presented in segments to give residents enough time to respond to cues; pleasant, supportive interaction)?
- Has the resident experienced a recent loss of someone close (e.g., death of spouse, change in key direct care staff, recent move to the nursing facility, decreased visiting by family and friends)?

COGNITIVE LOSS/DEMENTIA RAP KEY *(For MDS Version 2.0)*

TRIGGER — REVISION

A cognitive loss/dementia problem suggested if one or more of following are present:

- Short-term Memory Problem
[B2a = 1]
- Long-term Memory Problem
[B2b = 1]
- Impaired Decision-making^(a)
[B4 = 1, 2, 3]
- Problem Understanding Others^(b)
[C6 = 1, 2, or 3]

GUIDELINES

Factors to review for relationship to cognitive loss:

- Neurological. MR/DD status [AB10], Delirium [B5], Cognitive decline [B6], Alzheimer's or other dementias [I1q,I1u],

Confounding Problems that may require resolution or suggest reversible causes:

- Mood/behavior. Depression, Anxiety, Sad mood or Mood decline [E1, E2, E3], Behavioral symptoms or behavioral decline [E4, E5], Anxiety disorder [I1dd], Depression [I1ee], Manic depressive disorder [I1ff], Other psychiatric disorders [I1gg, J1e, J1i].
- Concurrent medical problems. Constipation [H2b], Diarrhea [H2c], Fecal impaction [H2d], Diabetes [I1a], Hypothyroidism [I1c], CHF [I1f], Other cardiovascular disease [I1k], Asthma [I1hh], Emphysema/COPD [I1ii], Cancer [I1pp], UTI [I2j], Pain [J2].
- Failure to thrive. Terminal prognosis [J5c], Low weight for height [K2a,b], Weight Loss [K3a], Resident status deteriorated since last assessment [Q2].
- Functional limitations. ADL impairment [G1], ADL task segmentation [G7], Decline in ADL [G9], Decline in continence [H4].
- Sensory impairment. Hearing problems [C1], Speech unclear [C5], Rarely/never understands [C6], Visual problems [D1], Skin desensitized to pain/pressure [M4e].
- Medications. Antipsychotics [O4a], Antianxiety [O4b], Antidepressants [O4c], Diuretics [O4e].
- Involvement factors. New admission [AB1], Withdrawal from activities [E1o], Participates in small group activities [F1f, N3b, record], Staff/resident believe resident can do more [G8a,b], Trunk, limb or chair restraint [P4c,d,e].

^(a) Note: Code B4=3 also triggers on the ADL (Maintenance) RAP

^(b) Note: These codes also trigger on the Communication RAP.

RESIDENT ASSESSMENT PROTOCOL: VISUAL FUNCTION

I. PROBLEM

The aging process leads to a gradual decline in visual acuity: a decreased ability to focus on close objects or to see small print, a reduced capacity to adjust to changes in light and dark, and diminished ability to discriminate color. The aged eye requires about 3-4 times more light in order to see well than the young eye.

The leading causes of visual impairment in the elderly are macular degeneration, cataracts, glaucoma, and diabetic retinopathy. In addition, visual perceptual deficits (impaired perceptions of the relationship of objects in the environment) are common in the nursing home population. Such deficits are common consequence of cerebrovascular events and are often seen in the late stages of Alzheimer's disease and other dementias. The incidence of all these problems increases with age.

In 1974, 49% of all nursing home residents were described as being unable to see well enough to read a newspaper with or without glasses. In 1985, over 100,000 nursing home residents were estimated to have severe visual impairment or no vision at all. Thus vision loss is one the most prevalent losses of residents in nursing facilities. A significant number of residents in any facility may be expected to have difficulty performing tasks dependent on vision as well as problems adjusting to vision loss.

The consequences of vision loss are wide-ranging and can seriously affect physical safety, self-image, and participation in social, personal, self-care, and rehabilitation activities. This RAP is primarily concerned with identifying two types of residents: 1) Those who have treatable conditions that place them at risk of permanent blindness (e.g., Glaucoma: Diabetes, retinal hemorrhage); and 2) those who have impaired vision whose quality of life could be improved through use of appropriate visual appliances. Further, the assumption is made that residents with new acute conditions will have been referred to follow-up as the conditions were identified (e.g., sudden loss of vision; recent red eye; shingles; etc). To the extent that this did not occur, the RAP KEY follow-up questions will cause staff to ask whether such a referral should be considered.

II. TRIGGERS

An acute, reversible (R) visual function problem or the potential for visual improvement (I) suggested if one or more of following present:

- *Side Vision Problem (Reverse)*
[D2a = checked]
- *Cataracts (Reverse)*
[I1jj = checked]
- *Glaucoma (Reverse)*
[I1ll = checked]
- *Vision Impaired (Improve)*
[D1 = 1, 2, 3]

III. GUIDELINES

Visual impairment may be related to many causes, and one purpose of this section is to screen for the presence of major risk factors and to review the resident's recent treatment history. This section also includes items that ask whether the visually impaired resident desires or has a need for increased functional use of eyes.

Eye medications: Of greatest importance is the review of medications related to glaucoma (phospholine iodide, pilocarpine, propine, epinephrine, Timoptic or other Beta-Blockers, diamox, or Neptazane).

- Is the residents receiving his/her eye medication as ordered?
- Does the resident experience any side effects?

Diabetes, Cataracts, Glaucoma, or Macular Degeneration: Diabetes may affect the eye by causing blood vessels in the retina to hemorrhage (retinopathy). All these conditions are associated with decreased visual acuity and visual field deficits. If resident is able to cooperate it is very possible to test for glaucoma and retinal problems.

Exam by ophthalmologist or optometrist since problem noted:

- Has the resident been seen by a consultant?
- Have the recommendations been followed (e.g. medications, refraction [new glasses], surgery)?
- Is the recommendation compatible with the resident's wishes (e.g., medical rehab. vs. surgery)?

If neurological diagnosis or dementia exam by physician since problem noted: Check the medical record to see if a physician has examined the resident for visual/perceptual difficulties. Some residents with diseases such as myethenia gravis, stroke, and dementia will have such difficulties associated with central nervous system in the absence of diseases of the eye.

Sad or anxious mood: Some residents, especially those in a new environment, will complain of visual difficulties. Visual disorganization may improve with treatment of the sad or anxious mood.

Appropriate use of visual appliances: Residents may have more severe visual impairment when they do not use their eyeglasses. Residents who wear reading glasses when walking, for example, may misperceive their environment and bump into objects or fall.

- Are glasses labelled or color coded in a fashion that enables the resident/staff to determine when they should be used?
- Are the lenses of glasses clean and free of scratches?
- Were glasses recently lost? Were they being recently used, and now they are missing?

Functional need for eye exam/new glasses: Many residents with limited vision will be able to use the environment with little or no difficulty, and neither the resident nor staff will perceive the need for new visual appliances. In other circumstances, needs will be identified, and for residents who are capable of participating in a visual exam, new appliances, surgery to remove cataracts, etc., can be considered.

- Does resident have peripheral vision or other visual problem that impedes his/her ability to eat food, walk on the unit, or interact with others?
- Is residents's ability to recognize staff limited by a visual problem?
- If resident is having difficulty negotiating his environment or participating in self-care activities because of visual impairment has he/she been referred to low vision services?
- Does resident report difficulty seeing TV/reading material of interest?
- Does resident express interest in improved vision?
- Has resident refused to have eyes examined? How long ago did this occur? Has it occurred more than once?

Environmental modifications: Residents whose vision cannot be improved by refraction, or medical and/or surgical intervention may benefit from environmental modifications.

- Does the resident's environment enable maximum visual function (e.g., low-glare floors and table surfaces, night lights)?
- Has the environment been adapted to resident's individual needs (e.g., large print signs marking room, color coded tape on dresser drawers, large numbers on telephone, reading lamp with 300 watt bulb)? Could the resident be more independent with different visual cues (e.g., labeling items, task segmentation) or other sensory cues (e.g., cane for recognizing there are objects in path)?

Acute Problems that may have been missed: Eye pain, blurry vision, double vision, sudden loss of vision: These symptoms are usually associated with acute eye problems.

- Has resident been evaluated by a physician or ophthalmologist?

Residents with communication impairments may be very difficult to assess. Residents who are unable to understand others may have problems following the directions necessary to test visual acuity.

VISUAL FUNCTION RAP KEY (For MDS Version 2.0)

TRIGGER — REVISION

GUIDELINES

An acute, reversible visual function problem or the potential for visual improvement suggested if one or more of following present:

Issues and problems to be reviewed that may suggest need for intervention:

- Side Vision Problem (*Reverse*)
[D2a = checked]
- Cataracts (*Reverse*)
[I1jj = checked]
- Glaucoma (*Reverse*)
[I1ll = checked]
- Vision Impaired (*Improve*)
[D1 = 1, 2, 3]

- Eye medications [from record].
- Diabetes [I1a], Cataracts [I1jj], Glaucoma [I1ll], Macular Degeneration [I1mm].
- Exam by ophthalmologist since problem noted [from record].
- Neurological diagnosis or dementia [I1q to I1cc].
- Indicators of Depression, Anxiety, Sad Mood [E1].
- Appropriate use of visual appliances [D3; from record, observation].
- Functional need for eye exam/new glasses [from observation].
- Environmental modifications [from record, observation].
- Other acute problems: Eye pain, blurry vision, double vision, sudden loss of vision [from record, observation].

RESIDENT ASSESSMENT PROTOCOL: COMMUNICATION**I. PROBLEM**

Good communication enables residents to express emotion, listen to others, and share information. It also eases adjustment to a strange environment and lessens social isolation and depression.

EXPRESSIVE communication problems include changes/difficulties in: speech and voice production, finding appropriate words, transmitting coherent statements, describing objects and events, using nonverbal symbols (e.g., gestures), and writing. RECEPTIVE communication problems include changes/difficulties in: hearing, speech discrimination in quiet and noisy situations, vocabulary comprehension, vision, reading, and interpreting facial expressions.

When communication is limited, assessment focuses on reviewing several factors: underlying causes of the deficit, the success of attempted remedial actions, the resident's ability to compensate with nonverbal strategies (e.g., ability to visually observe nonverbal signs and signals), and the willingness and ability of staff to engage with residents to ensure effective communication. As language use recedes with dementia, both the staff and the resident must expand their nonverbal communication skills – one of the most basic and automatic of human abilities. Touch, facial expression, eye contact, tone of voice, and posture all are powerful means of communicating with the demented resident, and recognizing and using all practical means is the key to effective communication.

II. TRIGGERS

Potential for improved communication suggested if one or more of following present:

- Hearing problem
[C1 = 1, 2, 3]
- Problem making self understood
[C4 = 1, 2, 3]
- Problem understanding others*
[C6 = 1, 2, 3]

* Note: These codes also trigger on the Cognitive Loss/Dementia RAP.

III. GUIDELINES

The communication trigger suggests residents for whom a corrective communication treatment program may be beneficial. Specify those residents with potentially correctable problems. An effective review requires a special effort by staff to overcome any preconceived notions or fixed perceptions they may have about the resident's probable responsiveness to treatment. These perceptions may be based on the failure of prior treatment programs, as well as on assumptions that may not have been recently tested about the resident's unwillingness to begin a corrective program.

Review items listed on the RAP KEY as follows:

Confounding Problems.

As these confounding problems lessen or further decline is prevented, the resident's communication abilities should be reviewed .

Components of Communication.

Details of resident strengths and weaknesses in understanding, hearing, and expression are the direct or indirect focus of any treatment program.

Factors to be Reviewed for Possible Relationship to Communication Problems:

- For chronic conditions that are unlikely to improve, consider communication treatments or interventions that might compensate for losses (e.g., for moderately impaired residents with Alzheimer's, the use of short, direct phrases and tactile approaches to communication can be effective).
- Are there acute or transitory conditions which if successfully resolved may result in improved ability to communicate?
- Are medications in use that could cause or complicate communication deficits, where titration or substitution may result in improved ability to communicate?
- Are opportunities to communicate limited in ways that could be remedied – e.g., availability of partners?

Clarifying Issues:

Treatment/Evaluation History.

- Has resident received an evaluation by an audiologist or speech-language pathologist? How recently?
- Has the resident's condition deteriorated since the most recent evaluation?
- If such an evaluation resulted in a plan of care, has it been followed as specified?

COMMUNICATION RAP KEY (For MDS Version 2.0)

TRIGGER — REVISION

Potential for improved communication suggested if one or more of following present:

- Hearing problem
[C1 = 1, 2, 3]
- Problem making self understood
[C4 = 1, 2, 3]
- Problem understanding others*
[C6 = 1, 2, 3]

GUIDELINES

Confounding problems that may require resolution:

- Decline in cognitive status [B6]
- Increased mood problems [E3]
- Decline in ADL status [G9]

Components of communication to be considered:

- Hearing [C1]
- Communication devices/Modes of expression [C2, C3]
- Decline in communication/hearing [C7]
- Medical status of ear — discharges, cerumen accumulation, hearing changes [from record or exam]
- Vision [D1]

Factors to be reviewed for possible relationship to communication problems:

- **Chronic Conditions.** Alzheimer's or Other dementia [I1q, I1u], Aphasia [I1r], CVA [I1t], Parkinson's [I1y], Psychiatric disorders [I1dd to I1gg], Asthma [I1hh], Emphysema/COPD [I1ii], Cancer [I1pp],
- **Transitory Conditions.** Delirium [B5], Infections [I2], Acute episode [J5b]
- **Medications.** Psychotropic [04a-d], Narcotics, Parkinson's meds, Gentamycin, Tobramycin, Aspirin toxicity [from record]
- **Opportunities to Communicate.** Quality/quantity of communication is (or is not) commensurate with apparent ability to communicate [staff judgement]

Clarifying issues to be considered:

- Memory [B2, B3]
- Recent audiology/language pathology evaluation [P1ba; from record]
- Resident's condition deteriorated since last assessment [Q2]

* Note: These codes also trigger on the Cognitive Loss/Dementia RAP.

**RESIDENT ASSESSMENT PROTOCOL:
ACTIVITIES OF DAILY LIVING — FUNCTIONAL REHABILITATION POTENTIAL**

I. PROBLEM

Personal mastery of ADL and mobility are as crucial to human existence in the nursing home as they are in the community. The nursing home is unique only in that most residents require help with self-care functions. ADL dependence can lead to intense personal distress -- invalidism, isolation, diminished self-worth, and a loss of control over one's destiny. As inactivity increases, complications such as pressure ulcers, falls, contractures, and muscle-wasting can be expected.

The ADL RAP assists staff in setting positive and realistic goals, weighing the advantages of independence against risks to safety and self-identity. In promoting independence staff must be willing to accept a reasonable degree of risk and active resident participation in setting treatment objectives.

Rehabilitative goals of several types can be considered:

- To restore function to maximum self-sufficiency in the area indicated;
- To replace hands-on assistance with a program of task segmentation and verbal cueing;
- To restore abilities to a level that allows the resident to function with fewer supports;
- To shorten the time required for providing assistance;
- To expand the amount of space in which self-sufficiency can be practiced;
- To avoid or delay additional loss of independence; and
- To support the resident who is certain to decline in order to lessen the likelihood of complications (e.g., pressure ulcers and contractures).

II. TRIGGERS

The two MDS trigger categories (A and B) suggest the types of residents for whom special care interventions may be most important. Such residents may have either the need and potential to improve (Rehabilitation) or the need for services to prevent decline (Maintenance).

ADL TRIGGER A (Rehabilitation)

Rehabilitation/restorative plans suggested if one or more of following present:

- Bed Mobility — not independent
[G1aA = 1-4]^(a)
- Transfer — not independent
[G1bA = 1-4]
- Walk in room — not independent
[G1cA = 1-4]
- Walk in corridor — not independent
[G1dA = 1-4]
- Locomotion on unit — not independent
[G1eA = 1-4]
- Locomotion off unit — not independent
[G1fA = 1-4]

- Dressing — not independent
[G1gA = 1-4]
- Eating - not independent
[G1hA = 1-4]
- Toilet Use — not independent
[G1iA = 1-4]
- Personal Hygiene — not independent
[G1jA = 1-4]
- Bathing — not independent
[G2aA = 1-4]
- Resident believes he/she capable of increased independence in at least some ADLs
[G8a = checked]
- Staff believe resident capable of increased independence in at least some ADLs
[G8b = checked]

ADL TRIGGER B (Maintenance)

Maintenance/complication avoidance plan suggested if: [Note — when both triggers present (A & B), B takes precedence in the RAP Review]

- No ability to make decisions
[B4 = 3]^(b)

^(a) Note: Codes 2,3, and 4 also trigger on the Pressure Ulcer RAP

^(b) Note: This code also triggers on the Cognitive Loss/Dementia RAP

III. GUIDELINES

Base an approach to a resident's ADL difficulty on clinical knowledge of:

- The causes of dependence;
- The expected course of the problem(s); and
- Which services work or do not work.

The MDS goal is to assist the clinician in identifying residents for whom rehabilitative/restorative goals can be reasonably established. Many ADL-restricted residents can regain partial ability for self-care. Certain types of disease-generated losses will respond to therapy. In addition, the removal of inappropriate restraints and the close monitoring of potentially toxic medications can often result in increased functioning.

Use the items in the ADL RAP KEY to consider the resident's risk of decline and chance of rehabilitation. Responses to these items permit a focused approach to specific ADL deficits (i.e., selecting and describing the specific ADL areas where decline has been observed or improvement is possible). The first thing that needs to be considered is the possible presence of *confounding problems* that may require resolution before rehabilitation goals can be reasonably attempted.

The second task is to clarify the resident's potential for improved functioning. The clinician might find the following sequence of questions useful in initiating an evaluation:

- Does the resident have the ability to learn? To what extent can the resident call on past memory to assist in current problem-solving situations?
- What is the resident's general functional status? How disabled is the resident, and does status vary?
- Is mobility severely impaired?
- Is trunk, leg, arm and/or hand use severely impaired?
- Are there distinct behavioral problems?

- Are there distinct mood problems?
- Is the resident motivated to work at a rehabilitative program?

Where rehabilitation goals are envisioned, use of the *ADL Supplement* will help care planners to focus on those areas that might be improved, allowing them to choose from among a number of basic tasks in designated areas. Part 1 of the Supplement can assist in the evaluation of all residents triggered into the RAP. Part 2 of the Supplement can be helpful for residents with rehabilitation potential (ADL Trigger A), to help plan a treatment program.

ADL Supplement (Attaining maximum possible independence).

ADL SUPPLEMENT
(Attaining maximum possible Independence)

| | | | | | | |
|--|---|----------------|------------------|-------------------|-----------------|---------------|
| PART 1: ADL Problem Evaluation INSTRUCTIONS: For those triggered— In areas physical help provided, indicate reason(s) for this help. | DRESSING | BATHING | TOILETING | LOCOMOTION | TRANSFER | EATING |
| | Mental Errors: Sequencing problems, incomplete performance, anxiety limitations, etc. | | | | | |
| Physical Limitations: Weakness, limited range of motion, poor coordination, visual impairment, pain, etc. | | | | | | |
| Facility Conditions: Policies, rules, physical layout, etc. | | | | | | |

PART 2: Possible ADL Goals If wheelchair check:

| | | | | | | |
|--|-----------------------------------|-------------------------------------|---|--|--|---|
| INSTRUCTIONS: For those considered for rehabilitation or decline prevention treatment— Indicate specific type of ADL activity that might require: 1. Maintenance to prevent decline. 2. Treatment to achieve highest practical self sufficiency (selecting ADL abilities that are just above those the resident can now perform or participate in). | Locates/ selects/ obtains clothes | Goes to tub/ shower | Goes to toilet (include commode/ urinal at night) | Walks in room/ nearby <input type="checkbox"/> | Positions self in preparation | Opens/ pours/ unwraps/ cuts etc. |
| | Grasps/puts on upper/ lower body | Turns on water/ adjusts temperature | Removes/ opens clothes in preparation | Walks on unit <input type="checkbox"/> | Approaches chair/bed | Grasps utensils and cups |
| | Manages snaps, zippers, etc. | Lathers body (except back) | Transfers/ positions self | Walks throughout building (uses elevator) <input type="checkbox"/> | Prepares chair/bed (locks pad, moves covers) | Scoops/ spears food (uses fingers when necessary) |
| | Puts on in correct order | Rinses body | Eliminates into toilet | Walks outdoors <input type="checkbox"/> | Transfers (stands/sits/ lifts/turns) | Chews, drinks, swallows |
| | Grasps, removes each item | Dries with towel | Tears/uses paper to clean self | Walks on uneven surfaces <input type="checkbox"/> | Repositions/ arranges self | Repeats until food consumed |
| | Replaces clothes properly | Other | Flushes | Other <input type="checkbox"/> | Other | Uses napkins, cleans self |
| | Other | | Adjusts clothes, washes hands | | | Other |