

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[Ⓢ]	— Month Day Year			
4.	RACE/Ⓢ ETHNICITY	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[Ⓢ] [C in 1 st box if non med. no.]	a. Social Security Number — b. Medicare number (or comparable railroad insurance number) 			
6.	FACILITY PROVIDER NO.[Ⓢ]	a. State No. b. Federal No.			
7.	MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient][Ⓢ]				
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 who Completed a Portion of the Accompanying Assessment or Tracking Form		
I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.		
Signature and Title	Sections	Date
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		
i.		
j.		
k.		
l.		

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 condition applies

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 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	
3. LIVED ALONE (PRIOR TO ENTRY)	0. No 1. Yes 2. In other facility	
4. ZIP CODE OF PRIOR PRIMARY RESIDENCE		
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 Stay in other nursing home Other residential facility—board and care home, assisted living, group home MH/psychiatric setting MR/DD setting NONE OF ABOVE	
6. LIFETIME OCCUPATION(S) [Put "I" between two occupations]		
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	
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) MR/DD with organic condition Down's syndrome Autism Epilepsy Other organic condition related to MR/DD MR/DD with no organic condition	
11. DATE BACKGROUND INFORMATION COMPLETED	Month Day Year	

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

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	— — MonthDayYear 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) — — MonthDayYear			
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 [Note—If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed]			
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 Hearing aid, present and not used regularly Other receptive comm. techniques used (e.g., lip reading) NONE OF ABOVE a. b. c. 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	

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 <i>NONE OF ABOVE</i>	a. b. c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

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

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

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			
(B) ADL SUPPORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance duration)		(A)	(B)
0. No setup or physical help from staff		SELF-PERF	SUPPORT
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			
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)	

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		(A)	(B)
		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)			
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		(B) VOLUNTARY MOVEMENT	
		0. No limitation		0. No loss	
		1. Limitation on one side		1. Partial loss	
		2. Limitation on both sides		2. Full loss	
		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			
5.	MODES OF LOCOMOTION	(Check all that apply during last 7 days)			
		Cane/walker/crutch	a.	Wheelchair primary mode of locomotion	d.
		Wheeled self	b.		
		Other person wheeled	c.	NONE OF ABOVE	e.
6.	MODES OF TRANSFER	(Check all that apply during last 7 days)			
		Bedfast all or most of time	a.	Lifted mechanically	d.
		Bed rails used for bed mobility or transfer	b.	Transfer aid (e.g., slide board, trapeze, cane, walker, brace)	e.
		Lifted manually	c.	NONE OF ABOVE	f.
7.	TASK SEGMENTATION	Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them			
		0. No 1. Yes			
8.	ADL FUNCTIONAL REHABILITATION POTENTIAL	Resident believes he/she is capable of increased independence in at least some ADLs			
		Direct care staff believe resident is capable of increased independence in at least some ADLs			
		Resident able to perform tasks/activity but is very slow			
		Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings			
		NONE OF ABOVE			
9.	CHANGE IN ADL FUNCTION	Resident's ADL self-performance status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days)			
		0. No change 1. Improved 2. Deteriorated			

SECTION H. CONTINENCE IN LAST 14 DAYS

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

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

SECTION J. HEALTH CONDITIONS

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

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.

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
		Regular or repetitive complaints of hunger	b. NONE OF ABOVE
5.	NUTRITIONAL APPROACHES	(Check all that apply in last 7 days)	
		Parenteral/IV	a. Dietary supplement between meals
		Feeding tube	b. Plate guard, stabilized built-up utensil, etc.
		Mechanically altered diet	c. On a planned weight change program
		Syringe (oral feeding)	d. NONE OF ABOVE
		Therapeutic diet	e. NONE OF ABOVE
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 M. SKIN CONDITION

1.	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.	
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, callouses, bunions, hammer toes, overlapping toes, pain, structural problems	a.
		Infection of the foot—e.g., cellulitis, purulent drainage	b.
		Open lesions on the foot	c.
		Nails/calluses trimmed during last 90 days	d.
		Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)	e.
		Application of dressings (with or without topical medications)	f.
		NONE OF ABOVE	g.

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	(Check appropriate time periods over last 7 days)	
		Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:	
		Morning	a. Evening
		Afternoon	b. NONE OF ABOVE
			c.
			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
		Inside NH/off unit	c. NONE OF ABOVE
			d.
			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
		Crafts/arts	b. Walking/wheeling outdoors
		Exercise/sports	c. Watching TV
		Music	d. Gardening or plants
		Reading/writing	e. Talking or conversing
		Spiritual/religious activities	f. Helping others
			g. NONE OF ABOVE
			h.
			i.
			j.
			k.
			l.
			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	

SECTION O. MEDICATIONS

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

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE —Check treatments or programs received during the last 14 days		
	TREATMENTS		
	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] (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			
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	a.	
	Evaluation by a licensed mental health specialist in last 90 days	b.	
	Group therapy	c.	
	Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage	d.	
	Reorientation—e.g., cueing	e.	
NONE OF ABOVE			f.
3. NURSING REHABILITATION/ RESTORATIVE CARE	Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.)		
	a. Range of motion (passive)		f. Walking
	b. Range of motion (active)		g. Dressing or grooming
	c. Splint or brace assistance		h. Eating or swallowing
	TRAINING AND SKILL PRACTICE IN:		i. Amputation/prosthesis care
	d. Bed mobility		j. Communication
	e. Transfer		k. Other

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 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 2. No family	
	c. Significant other:	0. No 1. Yes 2. None	
2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:			
a. Signature of RN Assessment Coordinator (sign on above line)			
b. Date RN Assessment Coordinator signed as complete			
— — Month Day Year			

SECTION T.THERAPY SUPPLEMENT FOR MEDICARE PPS

1.	SPECIAL TREATMENTS AND PROCEDURES	a. RECREATION THERAPY —Enter number of days and total minutes of recreation therapy administered (for at least 15 minutes a day) in the last 7 days (Enter 0 if none)	<table border="1"> <tr> <th colspan="2">DAYS</th> <th colspan="2">MIN</th> </tr> <tr> <th>(A)</th> <th>(B)</th> <th></th> <th></th> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>	DAYS		MIN		(A)	(B)						
		DAYS		MIN											
(A)	(B)														
(A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in last 7 days															
Skip unless this is a Medicare 5 day or Medicare readmission/return assessment.															
b. ORDERED THERAPIES —Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service? 0. No 1. Yes															
If not ordered, skip to item 2															
c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.															
d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?															
2.	WALKING WHEN MOST SELF SUFFICIENT	Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0,1,2, or 3 AND at least one of the following are present: • Resident received physical therapy involving gait training (P.1.b.c) • Physical therapy was ordered for the resident involving gait training (T.1.b) • Resident received nursing rehabilitation for walking (P.3.f) • Physical therapy involving walking has been discontinued within the past 180 days													
		Skip to item 3 if resident did not walk in last 7 days (FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)													
a. Furthest distance walked without sitting down during this episode.															
0. 150+ feet 3. 10-25 feet 1. 51-149 feet 4. Less than 10 feet 2. 26-50 feet															
b. Time walked without sitting down during this episode.															
0. 1-2 minutes 3. 11-15 minutes 1. 3-4 minutes 4. 16-30 minutes 2. 5-10 minutes 5. 31+ minutes															
c. Self-Performance in walking during this episode.															
0. INDEPENDENT —No help or oversight 1. SUPERVISION —Oversight, encouragement or cueing provided 2. LIMITED ASSISTANCE —Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3. EXTENSIVE ASSISTANCE —Resident received weight bearing assistance while walking															
d. Walking support provided associated with this episode (code regardless of resident's self-performance classification).															
0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+ persons physical assist															
e. Parallel bars used by resident in association with this episode.															
0. No 1. Yes															
3.	CASE MIX GROUP	Medicare <table border="1"><tr><td></td><td></td><td></td><td></td><td></td></tr></table>						State <table border="1"><tr><td></td><td></td><td></td><td></td><td></td></tr></table>							

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

Numeric Identifier _____

Resident's Name:	Medical Record No.:
1. Check if RAP is triggered. 2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status. • Describe: — Nature of the condition (may include presence or lack of objective data and subjective complaints). — Complications and risk factors that affect your decision to proceed to care planning. — Factors that must be considered in developing individualized care plan interventions. — Need for referrals/further evaluation by appropriate health professionals. • Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident. • Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.). 3. Indicate under the <u>Location of RAP Assessment Documentation</u> 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	☐		☐
2. COGNITIVE LOSS	☐		☐
3. VISUAL FUNCTION	☐		☐
4. COMMUNICATION	☐		☐
5. ADL FUNCTIONAL/REHABILITATION POTENTIAL	☐		☐
6. URINARY INCONTINENCE AND INDWELLING CATHETER	☐		☐
7. PSYCHOSOCIAL WELL-BEING	☐		☐
8. MOOD STATE	☐		☐
9. BEHAVIORAL SYMPTOMS	☐		☐
10. ACTIVITIES	☐		☐
11. FALLS	☐		☐
12. NUTRITIONAL STATUS	☐		☐
13. FEEDING TUBES	☐		☐
14. DEHYDRATION/FLUID MAINTENANCE	☐		☐
15. DENTAL CARE	☐		☐
16. PRESSURE ULCERS	☐		☐
17. PSYCHOTROPIC DRUG USE	☐		☐
18. PHYSICAL RESTRAINTS	☐		☐

B. _____

1. Signature of RN Coordinator for RAP Assessment Process

4. Signature of Person Completing Care Planning Decision

2. / /
 Month Day Year

4. / /
 Month Day Year

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

Key:

● = One item required to trigger

② = Two items required to trigger

* = One of these three items, plus at least one other item required to trigger

@ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

MDS ITEM		CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A @	ADL-Maintenance Trigger B @	Urinary Incontinence and Involving Catheter	Mood State	Behavioral Symptoms	Activities Trigger A	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints
B2a	Short term memory	1	●																	B2a
B2b	Long term memory	1	●																	B2b
B4	Decision making	1,2,3	●																	B4
B4	Decision making	3					●													B4
B5a to B5f	Indicators of delirium	2	●															●		B5a to B5f
B6	Change in cognitive status	2	●															●		B6
C1	Hearing	1,2,3				●														C1
C4	Understood by others	1,2,3				●														C4
C6	Understand others	1,2,3		●		●														C6
C7	Change in communication	2																●		C7
D1	Vision	1,2,3			●															D1
D2a	Side vision problem			●																D2a
E1a to E1p	Indicators of depression, anxiety, sad mood	1,2							●											E1a to E1p
E1n	Repetitive movement	1,2																●		E1n
E1o	Withdrawal from activities	1,2							●											E1o
E2	Mood persistence	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
F1d	Establishes own goals								●											F1d
F2a to F2d	Unsettled relationships	✓							●											F2a to F2d
F3a	Strong id. past 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	2,3,4,8															●			G1aA
G2A	Bathing	1,2,3,4				●														G2A
G3b	Balance while sitting	1,2,3																●		G3b
G6a	Bedfast	✓																●		G6a
G8a,b	Resident staff believe capable	✓				●														G8a,b
H1a	Bowel incontinence	1,2,3,4															●			H1a
H1b	Bladder incontinence	2,3,4							●											H1b
H2b	Constipation	✓																●		H2b
H2d	Fecal impaction	✓																●		H2d
H3c,d,e	Catheter use	✓							●											H3c,d,e
H3g	Use of pads/briefs	✓							●											H3g
I1i	Hypotension	✓																●		I1i
I1j	Peripheral vascular disease	✓																●		I1j
I1ee	Depression	✓																●		I1ee
I1j	Cataracts	✓			●															I1j
I1ll	Glaucoma	✓			●															I1ll
I2j	UTI	✓														●				I2j
I3	Dehydration diagnosis	276.5														●				I3
J1a	Weight fluctuation	✓														●				J1a
J1c	Dehydrated	✓														●				J1c
J1d	Insufficient fluid	✓														●				J1d
J1f	Dizziness	✓										●						●		J1f
J1h	Fever	✓														●				J1h
J1i	Hallucinations	✓																●		J1i
J1j	Internal bleeding	✓														●				J1j
J1k	Lung aspirations	✓																●		J1k
J1m	Syncope	✓																●		J1m

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

Key:

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

Proceed to RAP Review once triggered

Key:																						
● = One item required to trigger																						
② = Two items required to trigger																						
* = One of these three items, plus at least one other item required to trigger																						
@ = When both ADL triggers present, maintenance takes precedence																						
Proceed to RAP Review once triggered																						
MDS ITEM			CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A	ADL-Maintenance Trigger A @	Urinary Incontinence Trigger B @	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints
J1a	Unsteady gait	✓																		●		J1a
J4a,b	Fell	✓													●					●		J4a,b
J4c	Hip fracture	✓																		●		J4c
K1b	Swallowing problem	✓																		●		K1b
K1c	Mouth pain	✓																●				K1c
K3a	Weight loss	1														●						K3a
K4a	Taste alteration	✓														●						K4a
K4c	Leave 25% food	✓														●						K4c
K5a	Parenteral IV feeding	✓														●		●				K5a
K5b	Feeding tube	✓															●	●				K5b
K5c	Mechanically altered	✓														●						K5c
K5d	Syringe feeding	✓														●						K5d
K5e	Therapeutic diet	✓														●						K5e
L1a,c,d,e	Dental	✓																	●			L1a,c,d,e
L1f	Daily cleaning teeth	Not ✓																	●			L1f
M2a	Pressure ulcer	2,3,4														●						M2a
M2a	Pressure ulcer	1,2,3,4																	●			M2a
M3	Previous pressure ulcer	1																		●		M3
M4e	Impaired tactile sense	✓																		●		M4e
N1a	Awake morning	✓												②								N1a
N2	Involved in activities	0												②								N2
N2	Involved in activities	2,3											●									N2
N5a,b	Prefers change in daily routine	1,2											●									N5a,b
O4a	Antipsychotics	1-7																		*		O4a
O4b	Anxiolytics	1-7													●					*		O4b
O4c	Antidepressants	1-7													●					*		O4c
O4e	Durgals	1-7																●				O4e
P4c	Trunk restraint	1,2													●							P4c
P4c	Trunk restraint	2																	●			P4c
P4d	Limb restraint	1,2																			●	P4d
P4e	Chair prevents rising	1,2																			●	P4e
													</									

MDS QUARTERLY ASSESSMENT FORM

Numeric Identifier

A1.	RESIDENT NAME												
		a. (First)			b. (Middle Initial)			c. (Last)			d. (Jr/Sr)		
A2.	ROOM NUMBER												
A3.	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"											

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 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 8. 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 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	(A)
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 (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	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. e.
H3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan Bladder retraining program External (condom) catheter	a. b. c. d. i. j.
I2.	INFECTIONS	Urinary tract infection in last 30 days	j. 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) Dehydrated; output exceeds input Hallucinations	c. i. 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) Hip fracture in last 180 days Fell in past 30 days Fell in past 31-180 days	a. b. 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.
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. i.
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 awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Afternoon Evening NONE OF ABOVE	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 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. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:			
a. Signature of RN Assessment Coordinator (sign on above line)			
b. Date RN Assessment Coordinator signed as complete			
Month — Day — Year			

Numeric Identifier

E1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die" b. Repetitive questions—e.g., "Where do I go; What do I do?" c. Repetitive verbalizations—e.g., calling out for help, ("God help me") d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received e. Self deprecation—e.g., "I am nothing; I am of no use to anyone" f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack	h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues SLEEP-CYCLE ISSUES j. Unpleasant mood in morning k. Insomnia/change in usual sleep pattern SAD, APATHETIC, ANXIOUS APPEARANCE l. Sad, pained, worried facial expressions—e.g., furrowed brows m. Crying, tearfulness n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking LOSS OF INTEREST o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends p. Reduced social interaction	
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 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. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety) b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at) c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused) d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or drobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings) e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)	(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 8. ACTIVITY DID NOT OCCUR during entire 7 days (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		(A)	(B)
	a. BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed	SELF-PERF	SUPPORT
	b. TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		

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	(A)
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	(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	f.
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	
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	Diarrhea Fecal impaction	c. d. e.

H3. APPLIANCES AND PROGRAMS		Any scheduled toileting plan		a.	Indwelling catheter	d.
		Bladder retraining program		b.	Ostomy present	i.
		External (condom) catheter		c.	NONE OF ABOVE	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)				
		MUSCULOSKELETAL		m.	Multiple sclerosis	w.
		Hip fracture		n.	Quadruplegia	z.
		NEUROLOGICAL		r.	PSYCHIATRIC/MOOD	
		Aphasia		s.	Depression	ee.
		Cerebral palsy		t.	Manic depressive (bipolar disease)	ff.
		Cerebrovascular accident (stroke)		u.	OTHER	
		Hemiplegia/Hemiparesis		v.	NONE OF ABOVE	rr.
I2.	INFECTIONS	(If none apply, CHECK the NONE OF ABOVE box)				
		Antibiotic resistant infection (e.g., Methicillin resistant staph)		a.	Septicemia	g.
		Clostridium difficile (c. diff.)		b.	Sexually transmitted diseases	h.
		Conjunctivitis		c.	Tuberculosis	i.
		HIV infection		d.	Urinary tract infection in last 30 days	j.
		Pneumonia		e.	Viral hepatitis	k.
		Respiratory infection		f.	Wound infection	l.
					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)				
		a. _____				
		b. _____				
J1.	PROBLEM CONDITIONS	(Check all problems present in last 7 days unless other time frame is indicated)				
		INDICATORS OF FLUID STATUS		OTHER		
		Weight gain or loss of 3 or more pounds within a 7 day period		Delusions		
		Inability to lie flat due to shortness of breath		Edema		
		Dehydrated; output exceeds input		Fever		
		Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days		Hallucinations		
				Internal bleeding		
				Recurrent lung aspirations in last 90 days		
				Shortness of breath		
				Unsteady gait		
				Vomiting		
				NONE OF ABOVE		
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		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		
J4.	ACCIDENTS	(Check all that apply)				
		Fell in past 30 days		Hip fracture in last 180 days		
		Fell in past 31-180 days		Other fracture in last 180 days		
				NONE OF ABOVE		
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				
K1.	ORAL PROBLEMS	Chewing problem				
		Swallowing problem				
		NONE OF ABOVE				
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 Feeding tube	a. b.	On a planned weight change program NONE OF ABOVE	h. i.
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.		
M5.	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 Evening Afternoon 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 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)			
O3.	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 b. Antianxiety c. Antidepressant d. Hypnotic e. Diuretic			

P1.	SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE—Check treatments or programs received during the last 14 days			
		TREATMENTS Chemotherapy Dialysis IV medication Intake/output Monitoring acute medical condition Ostomy care Oxygen therapy Radiation Suctioning Tracheostomy care Transfusions	a. b. c. d. e. f. g. h. i. j. k.	Ventilator or respirator Alcohol/drug treatment program Alzheimer's/dementia special care unit Hospice care Pediatric unit Respite care Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) NONE OF ABOVE	l. m. n. o. p. q. r. 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 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) 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	
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. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:					
a. Signature of RN Assessment Coordinator (sign on above line)					
b. Date RN Assessment Coordinator signed as complete					
Month Day Year					

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

Numeric Identifier _____

A1.	RESIDENT NAME				
		a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)
A2.	ROOM NUMBER				
A3.	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			
B3.	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 Location of own room b. Staff names/faces c. NONE OF ABOVE are recalled			
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)			

E1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die" b. Repetitive questions—e.g., "Where do I go; What do I do?" c. Repetitive verbalizations—e.g., calling out for help, ("God help me") d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received e. Self deprecation—e.g., "I am nothing; I am of no use to anyone" f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack	h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues j. Unpleasant mood in morning k. Insomnia/change in usual sleep pattern 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 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 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)
		a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)			
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)			
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)			
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)			
		e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)			
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 8. ACTIVITY DID NOT OCCUR during entire 7 days			
	(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		(A)	(B)
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		SELF-PERF	SUPPORT
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)			

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	(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	
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 (A) (B)
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.	f.
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	
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	Diarrhea c. NONE OF ABOVE Fecal impaction d.	e.

H3. APPLIANCES AND PROGRAMS		Any scheduled toileting plan	a.	Indwelling catheter	d.
		Bladder retraining program	b.	Ostomy present	i.
		External (condom) catheter	c.	NONE OF ABOVE	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 a.		Hemiplegia/Hemiparesis	v.
	MUSCULOSKELETAL	Hip fracture m.		Multiple sclerosis	w.
	NEUROLOGICAL	Aphasia r.		Quadruplegia	z.
		Cerebral palsy s.		PSYCHIATRIC/MOOD	
		Cerebrovascular accident (stroke) t.		Depression	ee.
				Manic depressive (bipolar disease)	ff.
				OTHER	
				NONE OF ABOVE	rr.
I2.	INFECTIONS	(If none apply, CHECK the NONE OF ABOVE box)			
	Antibiotic resistant infection (e.g., Methicillin resistant staph) a.			Septicemia	g.
	Clostridium difficile (c. diff.) b.			Sexually transmitted diseases	h.
	Conjunctivitis c.			Tuberculosis	i.
	HIV infection d.			Urinary tract infection in last 30 days	j.
	Pneumonia e.			Viral hepatitis	k.
	Respiratory infection f.			Wound infection	l.
				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)			
	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 a.		OTHER	
	Inability to lie flat due to shortness of breath b.			Delusions	e.
	Dehydrated; output exceeds input c.			Edema	g.
	Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days d.			Fever	h.
				Hallucinations	i.
				Internal bleeding	j.
				Recurrent lung aspirations in last 90 days	k.
				Shortness of breath	l.
				Unsteady gait	n.
				Vomiting	o.
				NONE OF ABOVE	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			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	
J4.	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.
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				a.
	End-stage disease, 6 or fewer months to live				b.
	NONE OF ABOVE				c.
K1.	ORAL PROBLEMS	Chewing problem			d.
	Swallowing problem				a.
	NONE OF ABOVE				b.
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 Feeding tube	a. ☐ On a planned weight change program b. ☐ NONE OF ABOVE	h. ☐ i. ☐
K6.	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 1. 1% to 25% 2. 26% to 50% 3. 51% to 75% 4. 76% to 100% b. Code the average fluid intake per day by IV or tube in last 7 days 0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 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.] 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		
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. ☐	
M5.	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 Evening Afternoon 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 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)		
O3.	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 b. Antianxiety c. Antidepressant d. Hypnotic e. Diuretic		

P1.	SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE—Check treatments or programs received during the last 14 days TREATMENTS Chemotherapy Dialysis IV medication Intake/output Monitoring acute medical condition Ostomy care Oxygen therapy Radiation Suctioning Tracheostomy care Transfusions PROGRAMS Ventilator or respirator Alcohol/drug treatment program Alzheimer's/dementia special care unit Hospice care Pediatric unit Respite care Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) NONE OF ABOVE	a. ☐ b. ☐ c. ☐ d. ☐ e. ☐ f. ☐ g. ☐ h. ☐ i. ☐ j. ☐ k. ☐	l. ☐ m. ☐ n. ☐ o. ☐ p. ☐ q. ☐ r. ☐ 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 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) 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		
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. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:				
a. Signature of RN Assessment Coordinator (sign on above line)				
b. Date RN Assessment Coordinator signed as complete				
— —				

MDS 2.0 September, 2000

MINIMUM DATA SET (MDS) — VERSION 2.0

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

Correction Request Form

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

TO MODIFY A RECORD IN THE STATE DATABASE:

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

TO INACTIVATE A RECORD IN THE STATE DATABASE:

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

PRIOR RECORD SECTION.

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

Prior AA1	RESIDENT NAME			
		a. (First)	b. (Middle Initial)	c. (Last)
		d. (Jr/Sr)		
Prior AA2	GENDER	1. Male 2. Female		
Prior AA3	BIRTHDATE	— — Month Day Year		
Prior AA5	SOCIAL SECURITY	a. Social Security Number		
		— —		
Prior AA8	REASONS FOR ASSESSMENT	a. Primary reason for assessment ASSESSMENT (Complete Prior Date item Prior A3a ONLY) 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 DISCHARGE TRACKING (Complete Prior Date item Prior R4 ONLY) 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment REENTRY TRACKING (Complete Prior Date item Prior A4a ONLY) 9. Reentry 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		
	PRIOR DATE	(Complete one only) Complete Prior A3a if Primary Reason (Prior AA8a) equals 1, 2, 3, 4, 5, 10, or 0. Complete Prior R4 if Primary Reason (Prior AA8a) equals 6, 7, or 8. Complete Prior A4a if Primary Reason (Prior AA8a) equals 9.		
Prior A3.	ASSESSMENT REFERENCE DATE	a. Last day of MDS observation period		
		— — Month Day Year		
Prior R4.	DISCHARGE DATE	Date of discharge		
		— — Month Day Year		
Prior A4a.	DATE OF REENTRY	Date of reentry		
		— — Month Day Year		

AT3.	REASONS FOR MODIFICATION	(If AT2=1, check at least one of the following reasons; check all that apply, then skip to AT5) a. Transcription error b. Data entry error c. Software product error d. Item coding error e. Other error If "Other" checked, please specify: _____	
AT4.	REASONS FOR INACTIVATION	(If AT2=2, check at least one of the following reasons; check all that apply) a. Test record submitted as production record b. Event did not occur c. Inadvertent submission of inappropriate record d. Other reason requiring inactivation If "Other" checked, please specify: _____	

RN COORDINATOR ATTESTATION OF COMPLETION

AT5.	ATTESTING INDIVIDUAL NAME	a. (First) b. (Last) c. (Title)
	SIGNATURE	
AT6.	ATTESTATION DATE	— — Month Day Year
AT7.	ATTESTATION OF ACCURACY AND SIGNATURES OF PERSONS WHO CORRECT A PORTION OF ASSESSMENT OR TRACKING INFORMATION	
	I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.	
	Signature and Title	Attestation Date
	a.	
	b.	
	c.	
	d.	
	e.	
	f.	

CORRECTION ATTESTATION SECTION.

COMPLETE THIS SECTION TO EXPLAIN AND ATTEST TO THE CORRECT REQUEST

AT1.	ATTESTATION SEQUENCE NUMBER	(Enter total number of attestations for this record, including the present one)	
AT2.	ACTION REQUESTED	1. MODIFY record in error (Attach and submit a COMPLETE assessment or tracking form. Do NOT submit the corrected items ONLY. Proceed to item AT3 below.) 2. INACTIVE record in error. (Do NOT submit an assessment or tracking form. Submit the correction request only. Skip to item AT4.)	

SECTION U. MEDICATIONS—CASE MIX DEMO

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

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

1=by mouth (PO)	5=subcutaneous (SQ)	8=inhalation
2=sub lingual (SL)	6=rectal (R)	9=enteral tube
3=intramuscular (IM)	7=topical	10=other
4=intravenous (IV)		
3. **Frequency.** Code the number of times per day, week, or month the medication is administered using the following list:

PR=(PRN) as necessary	2D=(BID) two times daily	QO=every other day
1H=(QH) every hour	(includes every 12 hrs)	4W=4 times each week
2H=(Q2H) every two hours	3D=(TID) three times daily	5W=five times each week
3H=(Q3H) every three hours	4D=(QID) four times daily	6W=six times each week
4H=(Q4H) every four hours	5D=five times daily	1M=(Q month) once every month
6H=(Q6H) every six hours	1W=(Q week) once each wk	2M=twice every month
8H=(Q8H) every eight hours	2W=two times every week	C=continuous
1D=(QD or HS) once daily	3W=three times every week	O=other
4. **Amount Administered (AA).** Record the number of tablets, capsules, suppositories, or liquid (any route) **per dose** administered to the resident. Code 999 for topicals, eye drops, inhalants and oral medications that need to be dissolved in water..
5. **PRN-number of days (PRN-n).** If the frequency code for the medication is "PR", record the number of times during the last 7 days each PRN medication was given. Code STAT medications as PRNs given once.
6. **NDC Codes.** Enter the National Drug Code for each medication given. Be sure to enter the correct NDC code for the drug name, strength, and form. The NDC code must match the drug dispensed by the pharmacy.

[illegible]