

MDS 3.0: Recommended Content from National Evaluation Study

January 15, 2008 Draft

This draft MDS 3.0 Nursing Home Assessment Record dated January 15, 2008 is based on the results of a national clinical validation study that included testing of MDS 3.0 items for clinical efficiency, validity and reliability in 71 nursing homes in 8 states. CMS now plans further evaluation, which will include analysis of the impact of this assessment instrument on the resident classification system, Resource Utilization Group (RUG-III), used in the Medicare payment structure. Accordingly, items that will appear in the final MDS 3.0 that CMS will release in the future may not appear in this current draft or may change from the version currently in this draft. Look back periods may also change. Some items recommended by the national clinical validation study, but which are conditional on further CMS analyses are noted on the form. *Therefore, this document is a draft basic assessment record that may not include all items or versions thereof needed for tracking or non-nursing home providers and should not be used for staff training or when completing MDS 2.0.*

A1. Facility Provider Numbers

a. **National Provider Identifier (NPI)**

b. **CMS Certification Number (CCN)**

c. **State Provider Number**

A2. Legal Name of Resident

a. (First)

b. (Middle Initial)

c. (Last)

d. (Suffix)

A3. Social Security and Medicare Numbers

a. **Social Security Number**

__ __ __ __ -- __ __ -- __ __

b. **Medicare number** (or comparable railroad insurance number)

A4. Medicaid Number (enter "+" if pending, "N" if not a Medicaid recipient)

A5. Gender

Enter

Code

1. **Male**

2. **Female**

A6. Birthdate

__ __ __ __ -- __ __ __ __ -- __ __ __ __

month

day

year

A7. Marital Status

Enter

Code

1. **Never married**

2. **Married**

3. **Widowed**

4. **Separated**

5. **Divorced**

Complete A8 only on Admission, Annual, and Significant Change Assessment

A8. Language

Enter

Code

Does the resident need or want an interpreter to communicate with a doctor or health care staff?

0. **No**

1. **Yes** → If yes, specify preferred language: _____

9. **Unable to determine**

A9. Type of Assessment/Tracking

Enter <input type="text"/> Code	<p>a. Federal OBRA Reason for Assessment/Tracking</p> <p>01. Admission assessment (required by day 14)</p> <p>02. Quarterly review assessment</p> <p>03. Annual assessment</p> <p>04. Significant change in status assessment</p> <p>05. Significant correction to prior full assessment</p> <p>06. Significant correction to prior quarterly assessment</p> <p>99. Not OBRA required assessment/tracking</p>
Enter <input type="text"/> Code	<p>b. PPS Assessments</p> <p>PPS Scheduled Assessments for a Medicare Part A Stay</p> <p>1. 5-day scheduled assessment</p> <p>2. 14-day scheduled assessment</p> <p>3. 30-day scheduled assessment</p> <p>4. 60-day scheduled assessment</p> <p>5. 90-day scheduled assessment</p> <p>6. Readmission/return assessment</p> <p>PPS Unscheduled Assessments for a Medicare Part A Stay</p> <p>7. Unscheduled assessment used for PPS (OMRA, significant change, or significant correction assessment)</p> <p>9. Not PPS assessment</p>
Enter <input type="text"/> Code	<p>c. PPS Other Medicare Required Assessment – OMRA (required when all rehabilitation therapy discontinued)</p> <p>0. No</p> <p>1. Yes</p>

A10. Submission Requirement

Enter <input type="text"/> Code	<p>a. Federal required submission</p> <p>0. No</p> <p>1. Yes</p>
Enter <input type="text"/> Code	<p>b. State required submission</p> <p>0. No</p> <p>1. Yes</p>
Enter <input type="text"/> Code	<p>c. Submission only required for other reasons (e.g. HMO, other insurance, etc.)</p> <p>0. No</p> <p>1. Yes</p>

A11. Preadmission Screening and Resident Review (PASRR) (Complete only if A9a = 01, 03, or 04)

Enter <input type="text"/> Code	<p>Has the resident been evaluated by Level II PASRR, and determined to have a serious mental illness and/or mental retardation or a related condition?</p> <p>0. No</p> <p>1. Yes</p> <p>9. Not a Medicaid certified unit</p>
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A12. Medicare Stay

Enter <input type="text"/> Code	<p>a. Is the resident currently in a Medicare-covered stay?</p> <p>0. No → Skip to A13, State Case Mix Group</p> <p>1. Yes → Continue to A12b</p>
	<p>b. Start date of current Medicare stay</p> <p>____ -- ____ -- ____</p> <p>month day year</p>
	<p>c. Medicare Part A HIPPS code for billing</p> <p>____ _</p> <p>(RUG-III group followed by HIPPS modifier based on type of assessment)</p>

A13. State Case Mix Group (If required by the state)

A14. Optional Facility Items

a. Medical Record Number

b. Room number

A15. Assessment Reference Date

Observation end date

____ -- ____ -- ____
month day year

A16. Place holder: Entry Record Items a-d (entry date, type of entry, entered from, race/ethnicity) to be completed on entry only

A17. Place holder: Discharge Record Items a-b (discharge date, discharge location) to be completed on discharge only

A18. Signature of Persons Completing the Assessment

I certify that the accompanying information accurately reflects resident assessment 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.

a. Signature of RN Assessment Coordinator

b. Date RN Assessment Coordinator signed as complete

____ -- ____ -- ____
month day year

Other Signatures	Title	Sections	Date
c.			
d.			
e.			
f.			
g.			
h.			
i.			
j.			
k.			
l.			
m.			
n.			

Section B Hearing, Speech, and Vision

B1. Comatose

Enter

Code

Persistent vegetative state/no discernible consciousness in last 5 days.

0. **No** → Continue to B2, Hearing
1. **Yes** → Skip to Section G, Functional Status

B2. Hearing

Enter

Code

Ability to hear (with hearing aid or hearing appliances if normally used) in last 5 days.

0. **Adequate**—no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty**—difficulty in some environments (e.g. when person speaks softly or setting is noisy)
2. **Moderate difficulty**—speaker has to increase volume and speak distinctly
3. **Highly impaired**—absence of useful hearing

B3. Hearing Aid

Enter

Code

Hearing aid or other hearing appliance used in above 5-day assessment.

0. **No**
1. **Yes**

B4. Speech Clarity

Enter

Code

Select best description of speech pattern in last 5 days.

0. **Clear speech**—distinct intelligible words
1. **Unclear speech**—slurred or mumbled words
2. **No speech**—absence of spoken words

B5. Makes Self Understood

Enter

Code

Ability to express ideas and wants, consider both verbal and non-verbal expression in last 5 days.

0. **Understood**
1. **Usually understood**—difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood**—ability is limited to making concrete requests
3. **Rarely/never understood**

B6. Ability to Understand Others

Enter

Code

Understanding verbal content, however able (with hearing aid or device if used) in last 5 days.

0. **Understands**—clear comprehension
1. **Usually understands**—misses some part/intent of message **but** comprehends most conversation
2. **Sometimes understands**—responds adequately to simple, direct communication only
3. **Rarely/never understands**

B7. Vision

Enter

Code

Ability to see in adequate light (with glasses or other visual appliances) in last 5 days.

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

B8. Corrective Lenses

Enter

Code

Corrective lenses (contacts, glasses, or magnifying glass) used in above 5-day assessment.

0. **No**
1. **Yes**

Section C Cognitive Patterns

C1. Should Brief Interview for Mental Status be Conducted?—Attempt to conduct interview with all residents

Enter

 Code

- 0. **No** (resident is rarely/never understood) → Skip to C7, Staff Assessment for Mental Status
- 1. **Yes** → Continue to C2, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C2. Repetition of Three Words

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: **sock, blue, and bed.** Now tell me the three words."*

Enter

 Code

Number of words repeated after first attempt

- 0. **None**
- 1. **One**
- 2. **Two**
- 3. **Three**

After the resident's first attempt, repeat the words using cues (*"sock, something to wear; blue, a color; bed, a piece of furniture"*). You may repeat the words up to two more times.

C3. Temporal Orientation (orientation to year, month, and day)

Enter

 Code

Ask resident: *"Please tell me what year it is right now."*

- a. **Able to report correct year**
 - 3. **Correct**
 - 2. **Missed by 1 year**
 - 1. **Missed by 2–5 years**
 - 0. **Missed by > 5 years** or no answer

Enter

 Code

Ask resident: *"What month are we in right now?"*

- b. **Able to report correct month**
 - 2. **Accurate within 5 days**
 - 1. **Missed by 6 days to 1 month**
 - 0. **Missed by >1 month** or no answer

Enter

 Code

Ask resident: *"What day of the week is today?"*

- c. **Able to report correct day of the week**
 - 1. **Correct**
 - 0. **Incorrect** or no answer

C4. Recall

Ask resident: *"Let's go back to the first question. What were those three words that I asked you to repeat?"*
 If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

Enter

 Code

a. Able to recall "sock"

- 2. **Yes, no cue required**
 - 1. **Yes, after cueing** ("something to wear")
 - 0. **No**—could not recall

Enter

 Code

b. Able to recall "blue"

- 2. **Yes, no cue required**
 - 1. **Yes, after cueing** ("a color")
 - 0. **No**—could not recall

Enter

 Code

c. Able to recall "bed"

- 2. **Yes, no cue required**
 - 1. **Yes, after cueing** ("a piece of furniture")
 - 0. **No**—could not recall

C5. Summary Score

Enter Numbers

Add scores for questions C2–C4 and fill in total score (00–15)
Enter 99 if unable to complete interview

C6. Should the Staff Assessment for Mental Status (C7-C10) be Conducted?

Enter

 Code

- 0. **No** (resident was able to complete interview) → Skip to C11, Signs and Symptoms of Delirium
- 1. **Yes** (resident was unable to complete interview) → Continue to C7, Short-term Memory OK



Section C Cognitive Patterns

Staff Assessment for Mental Status—Do not conduct if Brief Interview for Mental Status (C2-C5) was completed

C7. Short-term Memory OK

Enter <input type="text"/> Code	Seems or appears to recall after 5 minutes.
	0. Memory OK
	1. Memory problem

C8. Long-term Memory OK

Enter <input type="text"/> Code	Seems or appears to recall long past.
	0. Memory OK
	1. Memory problem

C9. Memory/Recall Ability

Check all that the resident was normally able to recall during the last 5 days:

Check all that apply.	<input type="checkbox"/>	a. Current season
	<input type="checkbox"/>	b. Location of own room
	<input type="checkbox"/>	c. Staff names and faces
	<input type="checkbox"/>	d. That he or she is in a nursing home
	<input type="checkbox"/>	e. None of the above were recalled

C10. Cognitive Skills for Daily Decision Making

Enter <input type="text"/> Code	<p>Made decisions regarding tasks of daily life.</p> <p>0. Independent—decisions consistent/reasonable</p> <p>1. Modified independence—some difficulty in new situations only</p> <p>2. Moderately impaired—decisions poor; cues/supervision required</p> <p>3. Severely impaired—never/rarely made decisions</p>
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Delirium – complete on all residents

C11. Signs and Symptoms of Delirium (from CAM)

After completing Brief Interview for Mental Status or Staff Assessment and reviewing medical record, code a-d for the last 5 days.

<p>Coding:</p> <p>0. Behavior not present</p> <p>1. Behavior continuously present, does not fluctuate</p> <p>2. Behavior present, fluctuates (comes and goes, changes in severity)</p>	→ Enter Codes in Boxes →	Enter <input type="text"/> Code	a. Inattention —Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?
		Enter <input type="text"/> Code	b. Disorganized thinking —Was the resident’s thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?
		Enter <input type="text"/> Code	c. Altered level of consciousness —Did the resident have altered level of consciousness? (e.g., vigilant —startles easily to any sound or touch; lethargic —repeatedly dozes off when being asked questions, but responds to voice or touch; stuporous — very difficult to arouse and keep aroused for the interview; comatose —cannot be aroused)
		Enter <input type="text"/> Code	d. Psychomotor retardation —Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly?

C12. Acute Onset Mental Status Change

Enter <input type="text"/> Code	<p>Is there evidence of an acute change in mental status from the resident’s baseline in last 5 days?</p> <p>0. No</p> <p>1. Yes</p>
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Section D Mood

D1. Should Resident Mood Interview be Conducted?—Attempt to conduct interview with all residents

Enter

 Code

0. **No** (resident is rarely/never understood) → Skip to D5, Staff Assessment of Mood
 1. **Yes** → Continue to D2, Resident Mood Interview

D2. Resident Mood Interview (PHQ-9®)

	I. Symptom Presence Enter 0, 1, or 2 in box. If yes (1), then circle Symptom Frequency in column II.	II. Symptom Frequency If yes in column I, Symptom Presence, circle frequency.			
		0–1 Day (Not at all)	2–6 Days (Several days)	7–11 Days (More than half the days)	12–14 Days (Nearly every day)
Say to resident: “Over the last 2 weeks, have you been bothered by any of the following problems?”					
a. Little interest or pleasure in doing things	Enter <input type="text"/> Code 0. No 1. Yes → 9. No response	0	1	2	3
b. Feeling down, depressed, or hopeless	Enter <input type="text"/> Code 0. No 1. Yes → 9. No response	0	1	2	3
c. Trouble falling or staying asleep, or sleeping too much	Enter <input type="text"/> Code 0. No 1. Yes → 9. No response	0	1	2	3
d. Feeling tired or having little energy	Enter <input type="text"/> Code 0. No 1. Yes → 9. No response	0	1	2	3
e. Poor appetite or overeating	Enter <input type="text"/> Code 0. No 1. Yes → 9. No response	0	1	2	3
f. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	Enter <input type="text"/> Code 0. No 1. Yes → 9. No response	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching television	Enter <input type="text"/> Code 0. No 1. Yes → 9. No response	0	1	2	3
h. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	Enter <input type="text"/> Code 0. No 1. Yes → 9. No response	0	1	2	3
i. Thoughts that you would be better off dead, or of hurting yourself in some way If “Yes”, check here to indicate that responsible staff or provider has been informed: <input type="checkbox"/>	Enter <input type="text"/> Code 0. No 1. Yes → 9. No response	0	1	2	3

D3. Total Severity Score

Enter Numbers

Add scores for all circled responses in Column II, Symptom Frequency. Score may be between 00 and 27.
 Enter 99 if unable to complete interview (“No response” to 3 or more items).

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Section D Mood

D4. Should the Staff Assessment of Mood be Conducted?

Enter

Code

0. **No** (because Resident Mood Interview was completed) → Skip to Section E, Behavior
 1. **Yes** (because 3 or more items in Resident Mood Interview not completed) → Continue to D5, Staff Assessment of Mood

D5. Staff Assessment of Mood (PHQ-9-OV)—Do not conduct if Resident Mood Interview (D2-D3) was completed

	I. Symptom Presence Enter 0, 1, or 9 in box. If yes (1), then circle Symptom Frequency in column II.	II. Symptom Frequency If yes in column I, Symptom Presence, circle frequency.				
		0–1 Day (Not at all)	2–6 Days (Several days)	7–11 Days (More than half the days)	12–14 Days (Nearly every day)	
Say to staff: "Over the last 2 weeks, did the resident have any of the following problems or behaviors?"						
a. Little interest or pleasure in doing things	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
b. Feeling or appearing down, depressed, or hopeless	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
c. Trouble falling or staying asleep, or sleeping too much	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
d. Feeling tired or having little energy	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
e. Poor appetite or overeating	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
f. Indicating that s/he feels bad about self, is a failure, or has let self or family down	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching television	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
h. Moving or speaking so slowly that other people have noticed. Or the opposite—being so fidgety or restless that s/he has been moving around a lot more than usual	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
i. States that life isn't worth living, wishes for death, or attempts to harm self. If "Yes", check here to indicate that responsible staff or provider has been informed: <input type="checkbox"/>	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
j. Being short-tempered, easily annoyed	Enter <input type="text"/> Code	0. No 1. Yes → 9. No response	0	1	2	3

D6. Total Severity Score

Enter Numbers

Add scores for all circled responses in column II, Symptom Frequency. Score may be between 00 and 30.

Section E Behavior

E1. Psychosis

Check all that apply.	Check if problem condition was present at any time in last 5 days:	
	<input type="checkbox"/>	a. Hallucinations (perceptual experiences in the <i>absence</i> of real external sensory stimuli) or illusions (misperceptions in the <i>presence</i> of real external sensory stimuli)
	<input type="checkbox"/>	b. Delusions (misconceptions or beliefs that are firmly held, contrary to reality)
<input type="checkbox"/>	c. None of the above	

Behavioral Symptoms

* Conditional on RUGs analysis *

E2. Behavioral Symptom—Presence & Frequency

Note presence of symptoms and their frequency in the last 5 days:

Coding: 0. Not present in last 5 days 1. Present 1–2 days 2. Present 3 or more days	Enter Codes in Boxes	→ <input type="text" value="Enter Code"/>	a. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
		→ <input type="text" value="Enter Code"/>	b. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others)
		→ <input type="text" value="Enter Code"/>	c. Other behavioral symptoms not directed toward others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

E3. Overall Presence of Behavioral Symptoms in the last 5 days

Enter <input type="text"/> Code	Were any behavioral symptoms in questions E2 coded 1 or 2? 0. No → Skip to E6, Rejection of Care 1. Yes → Considering all of E2, Behavioral Symptoms, answer E4 and E5 below
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E4. Impact on Resident

Did any of the identified symptom(s):

Enter <input type="text"/> Code	a. Put the resident at significant risk for physical illness or injury? 0. No 1. Yes
Enter <input type="text"/> Code	b. Significantly interfere with the resident's care? 0. No 1. Yes
Enter <input type="text"/> Code	c. Significantly interfere with the resident's participation in activities or social interactions? 0. No 1. Yes

E5. Impact on Others

Did any of the identified symptom(s):

Enter <input type="text"/> Code	a. Put others at significant risk for physical injury? 0. No 1. Yes
Enter <input type="text"/> Code	b. Significantly intrude on the privacy or activity of others? 0. No 1. Yes
Enter <input type="text"/> Code	c. Significantly disrupt care or living environment? 0. No 1. Yes

Section E Behavior

*** Conditional on RUGs analysis ***

E6. Rejection of Care—Presence & Frequency

Enter

 Code

In the last 5 days, **did the resident reject evaluation or care** (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident’s goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and/or determined to be consistent with resident values, preferences, or goals.

- 0. **No**
- 1. **Yes, present 1-2 days**
- 2. **Yes, present 3 or more days**

*** Conditional on RUGs analysis ***

E7. Wandering—Presence & Frequency

Enter

 Code

In the last 5 days, **has the resident wandered?**

- 0. **No** → Skip to E9, Change in Behavioral Symptoms
- 1. **Yes, present 1-2 days**
- 2. **Yes, present 3 or more days**

E8. Wandering—Impact

Enter

 Code

a. Does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g., stairs, outside of the facility)?

- 0. **No**
- 1. **Yes**

Enter

 Code

b. Does the wandering significantly intrude on the privacy or activities of others?

- 0. **No**
- 1. **Yes**

Complete E9 only on Follow-up Assessment

E9. Change in Behavioral or Other Symptoms—Consider all of the symptoms assessed in items E1 through E8.

Enter

 Code

How does resident’s current behavior status, care rejection, or wandering **compare to prior assessment?**

- 0. **Same**
- 1. **Improved**
- 2. **Worse**

Section F

Preferences for Customary Routine and Activities

F1. Should Interview for Daily and Activity Preferences be Conducted? — Attempt to interview all residents able to communicate. If resident unable to complete, attempt to complete interview with family member or significant other.

Enter

Code

- 0. **No** (resident is rarely/never understood and family not available) → Skip to F6, Staff Assessment of Daily and Activity Preferences
- 1. **Yes** → Continue to F2, Interview for Daily Preferences

F2. Interview for Daily Preferences

Say to resident: "While you are in this facility..."

<p>Coding:</p> <ul style="list-style-type: none"> 1. Very important 2. Somewhat important 3. Not very important 4. Not important at all 5. Important, but can't do or no choice 9. No response or non-responsive 	<p>↓</p> <p>Enter Codes in Boxes</p> <p>↓</p>	Enter Code <input type="checkbox"/>	a. how important is it to you to choose what clothes to wear?
		Enter Code <input type="checkbox"/>	b. how important is it to you to take care of your personal belongings or things?
		Enter Code <input type="checkbox"/>	c. how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath?
		Enter Code <input type="checkbox"/>	d. how important is it to you to have snacks available between meals?
		Enter Code <input type="checkbox"/>	e. if you could go to bed whenever you wanted, how important would it be to you to stay up past 8:00 p.m.?
		Enter Code <input type="checkbox"/>	f. how important is it to you to have your family or a close friend involved in discussions about your care?
		Enter Code <input type="checkbox"/>	g. how important is it to you to be able to use the phone in private?
		Enter Code <input type="checkbox"/>	h. how important is it to you to have a place to lock your things to keep them safe?

F3. Interview for Activity Preferences

Say to resident: "While you are in this facility..."

<p>Coding:</p> <ul style="list-style-type: none"> 1. Very important 2. Somewhat important 3. Not very important 4. Not important at all 5. Important, but can't do or no Choice 9. No response or non-responsive 	<p>↓</p> <p>Enter Codes in Boxes</p> <p>↓</p>	Enter Code <input type="checkbox"/>	a. how important is it to you to have books, newspapers, and magazines to read?
		Enter Code <input type="checkbox"/>	b. how important is it to you to listen to music you like?
		Enter Code <input type="checkbox"/>	c. how important is it to you to be around animals such as pets?
		Enter Code <input type="checkbox"/>	d. how important is it to you to keep up with the news?
		Enter Code <input type="checkbox"/>	e. how important is it to you to do things with groups of people?
		Enter Code <input type="checkbox"/>	f. how important is it to you to do your favorite activities?
		Enter Code <input type="checkbox"/>	g. how important is it to you to go outside to get fresh air when the weather is good?
		Enter Code <input type="checkbox"/>	h. how important is it to you to participate in religious services or practices?



Section F

Preferences for Customary Routine and Activities

F4. Daily and Activity Preferences Primary Respondent

Enter

Code

Indicate primary respondent for Daily and Activity Preferences (F2 and F3).

1. **Resident**
2. **Family or significant other** (close friend or other representative)
9. **Interview could not be completed** by resident or family/significant other ("No Response" to 3 or more items)

F5. Should the Staff Assessment of Daily and Activity Preferences be Conducted?

Enter

Code

0. **No** (because Interview for Daily and Activity Preferences (F2 and F3) was completed by resident or family/significant other) → Skip to Section G, Functional Status
1. **Yes** (because 3 or more items in Interview for Daily and Activity Preferences (F2 and F3) were not completed by resident or family/significant other) → Continue to F6, Staff Assessment of Daily and Activity Preferences

Staff Assessment of Daily and Activity Preferences

F6. Resident Prefers:

Check all that apply.	<input type="checkbox"/>	a. Choosing clothes to wear	Check all that apply.	<input type="checkbox"/>	k. Place to lock personal belongings
	<input type="checkbox"/>	b. Caring for personal belongings		<input type="checkbox"/>	l. Reading books, newspapers, or magazines
	<input type="checkbox"/>	c. Receiving tub bath		<input type="checkbox"/>	m. Listening to music
	<input type="checkbox"/>	d. Receiving shower		<input type="checkbox"/>	n. Being around animals such as pets
	<input type="checkbox"/>	e. Receiving bed bath		<input type="checkbox"/>	o. Keeping up with the news
	<input type="checkbox"/>	f. Receiving sponge bath		<input type="checkbox"/>	p. Doing things with groups of people
	<input type="checkbox"/>	g. Snacks between meals		<input type="checkbox"/>	q. Participating in favorite activities
	<input type="checkbox"/>	h. Staying up past 8:00 p.m.		<input type="checkbox"/>	r. Spending time away from the nursing home
	<input type="checkbox"/>	i. Family or significant other involvement in care discussions		<input type="checkbox"/>	s. Spending time outdoors
	<input type="checkbox"/>	j. Use of phone in private		<input type="checkbox"/>	t. Participating in religious activities or practices
			<input type="checkbox"/>	u. None of the above	

Section G Functional Status

* Conditional on RUGs analysis *

G1. Activities of Daily Living (ADL) Assistance

Code for most dependent episode in last 5 days:

Coding:

- 0. **Independent**—resident completes activity with no help or oversight
- 1. **Set up assistance**
- 2. **Supervision**—oversight, encouragement or cueing provided throughout the activity
- 3. **Limited assistance**—guided maneuvering of limbs or other non-weight bearing assistance provided at least once
- 4. **Extensive assistance, 1 person assist**—resident performed part of the activity while one staff member provided weight-bearing support or completed part of the activity at least once
- 5. **Extensive assistance, 2 + person assist**—resident performed part of the activity while two or more staff members provided weight-bearing support or completed part of the activity at least once
- 6. **Total dependence, 1 person assist**—full staff performance of activity (requiring only 1 person assistance) at least once. The resident must be unable or unwilling to perform any part of the activity.
- 7. **Total dependence, 2 + person assist**—full staff performance of activity (requiring 2 or more person assistance) at least once. The resident must be unable or unwilling to perform any part of the activity.
- 8. **Activity did not occur** during entire period

Enter Codes in Boxes

Enter Code

Enter Code

Enter Code

Enter Code

Enter Code

Enter Code

Enter Code

Enter Code

Enter Code

Enter Code

Enter Code

Enter Code

- a. **Bed mobility**—moving to and from lying position, turning side to side and positioning body while in bed.
- b. **Transfer**—moving between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet).
- c. **Toilet transfer**—how resident gets to and moves on and off toilet or commode.
- d. **Toileting**—using the toilet room (or commode, bedpan, urinal); cleaning self after toileting or incontinent episode(s), changing pad, managing ostomy or catheter, adjusting clothes (**excludes** toilet transfer).
- e. **Walk in room**—walking between locations in his/her room.
- f. **Walk in facility**—walking in corridor or other places in facility.
- g. **Locomotion**—moving about facility, with wheelchair if used.
- h. **Dressing upper body**—dressing and undressing above the waist, includes prostheses, orthotics, fasteners, pullovers.
- i. **Dressing lower body**—dressing and undressing from the waist down, includes prostheses, orthotics, fasteners, pullovers.
- j. **Eating**—includes eating, drinking (regardless of skill) or intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids for hydration).
- k. **Grooming/personal hygiene**—includes combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** bath and shower).
- l. **Bathing**—how resident takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (**excludes** washing of back and hair).

Complete G2 only on Admission Assessment

G2. Mobility Prior to Admission

- | | |
|---|--|
| Enter
<input type="checkbox"/>
Code | <ul style="list-style-type: none"> a. Did resident have a hip fracture, hip replacement, or knee replacement in the 30 days prior to this admission? <ul style="list-style-type: none"> 0. No → Skip to G3, Balance During Transitions and Walking 1. Yes → Continue to G2b |
| Check all that apply.
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/> | <ul style="list-style-type: none"> b. If yes, check all that apply for tasks in which the resident was independent prior to fracture/replacement. <ul style="list-style-type: none"> 1. Transfer 2. Walk across room 3. Walk 1 block on a level surface 4. Resident was not independent in any of these activities 9. Unable to determine |

Section G Functional Status

G3. Balance During Transitions and Walking

After observing the resident, code the following **walking and transition items for most dependent** over the last 5 days:

Coding: 0. Steady at all times 1. Not steady, but <u>able</u> to stabilize without human assistance 2. Not steady, <u>only able</u> to stabilize with human assistance 8. Activity did not occur	Enter Codes in Boxes → ↓	Enter <input type="text"/> Code	a. Moving from seated to standing position
		Enter <input type="text"/> Code	b. Walking (with assistive device if used)
		Enter <input type="text"/> Code	c. Turning around and facing the opposite direction while walking
		Enter <input type="text"/> Code	d. Moving on and off toilet
		Enter <input type="text"/> Code	e. Surface-to-surface transfer (transfer between bed and chair or wheelchair)

G4. Functional Limitation in Range of Motion

Code for limitation during last 5 days that interfered with daily functions or placed resident at risk of injury.

Coding: 0. No impairment 1. Impairment on one side 2. Impairment on both sides	Enter Codes in Boxes ↓	Enter <input type="text"/> Code	a. Upper extremity (shoulder, elbow, wrist, hand)
		Enter <input type="text"/> Code	b. Lower extremity (hip, knee, ankle, foot)

G5. Mobility Devices

Check all that were normally used in the past 5 days:

Check all that apply.	<input type="checkbox"/>	a. Cane/crutch
	<input type="checkbox"/>	b. Walker
	<input type="checkbox"/>	c. Wheelchair (manual or electric)
	<input type="checkbox"/>	d. Lower extremity limb prosthesis
	<input type="checkbox"/>	e. None of the above were used

G6. Bedfast

Enter <input type="text"/> Code	Has the resident been in bed or in recliner in room for more than 22 hours on at least three of the past 5 days? 0. No 1. Yes
---------------------------------------	--

Complete G7 only on Full Assessment

G7. Functional Rehabilitation Potential

Enter <input type="text"/> Code	a. Resident believes s/he is capable of increased independence in at least some ADL's. 0. No 1. Yes 9. Unable to determine
Enter <input type="text"/> Code	b. Direct care staff believe resident is capable of increased independence in at least some ADL's. 0. No 1. Yes

Section H Bladder and Bowel

H1. Urinary Appliances

Check all that applied in last 5 days:

- Check all that apply.
- a. Indwelling bladder catheter
 - b. External (condom) catheter
 - c. Ostomy (suprapubic catheter, ileostomy)
 - d. Intermittent catheterization
 - e. None of the above

H2. Urinary Toileting Program

- Enter Code
- a. **Has a trial of a toileting program (e.g. scheduled toileting, prompted voiding, or bladder training) been attempted** on admission or since urinary incontinence was noted in this facility?
- 0. **No** → Skip to H3, Urinary Continence
 - 1. **Yes** → Continue to H2b
 - 9. **Unable to determine** → Skip to H2c
- Enter Code
- b. **Response**—What was the resident's response to the trial program?
- 0. **No improvement**
 - 1. **Decreased wetness**
 - 2. **Completely dry** (continent)
 - 9. **Unable to determine**
- Enter Code
- c. **Current toileting program**—Is a toileting program (e.g. scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?
- 0. **No**
 - 1. **Yes**

H3. Urinary Continence

- Enter Code
- Urinary continence** in last 5 days. Select the one category that best describes the resident over the last 5 days:
- 0. **Always continent**
 - 1. **Occasionally incontinent** (less than 5 episodes of incontinence)
 - 2. **Frequently incontinent** (5 or more episodes of incontinence but at least one episode of continent voiding)
 - 3. **Always incontinent** (no episodes of continent voiding)
 - 9. **Not rated**, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for entire 5 days

H4. Bowel Continence

- Enter Code
- Bowel continence** in last 5 days. Select the one category that best describes the resident over the last 5 days:
- 0. **Always continent**
 - 1. **Occasionally incontinent** (one episode of bowel incontinence)
 - 2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
 - 3. **Always incontinent** (no episodes of continent bowel movements)
 - 9. **Not rated**, resident had an ostomy or did not have a bowel movement for the entire 5 days

H5. Bowel Toileting Program

- Enter Code
- Is a toileting program currently being used to manage the resident's bowel continence?**
- 0. **No**
 - 1. **Yes**

H6. Bowel Patterns

- Enter Code
- Constipation present** in the past 5 days?
- 0. **No**
 - 1. **Yes**

Section I Active Disease Diagnosis

Cancer
<input type="checkbox"/> 1. Cancer (with or without metastasis)
Heart/Circulation
<input type="checkbox"/> 2. Anemia (includes aplastic, iron deficiency pernicious, and sickle cell)
<input type="checkbox"/> 3. Atrial Fibrillation and Other Dysrhythmias (includes bradycardias, tachycardias)
<input type="checkbox"/> 4. Coronary Artery Disease (CAD) (includes angina, myocardial infarction, ASHD)
<input type="checkbox"/> 5. Deep Venous Thrombosis (DVT) / Pulmonary Embolus (PE or PTE)
<input type="checkbox"/> 6. Heart Failure (includes CHF, pulmonary edema)
<input type="checkbox"/> 7. Hypertension
<input type="checkbox"/> 8. Peripheral Vascular Disease/Peripheral Arterial Disease
Gastrointestinal
<input type="checkbox"/> 9. Cirrhosis
<input type="checkbox"/> 10. GERD/Ulcer (includes esophageal, gastric, and peptic ulcers)
<input type="checkbox"/> 11. Ulcerative Colitis/ Crohn's Disease/ Inflammatory Bowel Disease
Genitourinary
<input type="checkbox"/> 12. Benign Prostatic Hyperplasia (BPH)
<input type="checkbox"/> 13. Renal Insufficiency or Renal Failure (ESRD)
Infections
<input type="checkbox"/> 14. Human Immunodeficiency Virus (HIV) Infection (includes AIDS)
<input type="checkbox"/> 15. MRSA, VRE, Clostridium diff. Infection / Colonization
<input type="checkbox"/> 16. Pneumonia
<input type="checkbox"/> 17. Septicemia
<input type="checkbox"/> 18. Tuberculosis
<input type="checkbox"/> 19. Urinary Tract Infection (UTI)
<input type="checkbox"/> 20. Viral Hepatitis (includes Hepatitis A, B, C, D, and E)
<input type="checkbox"/> 21. Wound Infection
Metabolic
<input type="checkbox"/> 22. Diabetes Mellitus (DM) (includes diabetic retinopathy, nephropathy, and neuropathy)
<input type="checkbox"/> 23. Hyponatremia
<input type="checkbox"/> 24. Hyperkalemia
<input type="checkbox"/> 25. Hyperlipidemia (includes hypercholesterolemia)
<input type="checkbox"/> 26. Thyroid Disorder (Includes hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)

Check all that apply.

Musculoskeletal
<input type="checkbox"/> 27. Arthritis (Degenerative Joint Disease (DJD), Osteoarthritis, and Rheumatoid Arthritis (RA))
<input type="checkbox"/> 28. Osteoporosis
<input type="checkbox"/> 29. Hip Fracture (includes any hip fracture that has a relationship to current status, treatments, monitoring. Includes sub-capital fractures, fractures of the trochanter and femoral neck) (last 60 days)
<input type="checkbox"/> 30. Other Fracture
Neurological
<input type="checkbox"/> 31. Alzheimer's Disease
<input type="checkbox"/> 32. Aphasia
<input type="checkbox"/> 33. Cerebral Palsy
<input type="checkbox"/> 34. CVA/ TIA/ Stroke
<input type="checkbox"/> 35. Dementia (Non-Alzheimer's dementia, including vascular or multi-infarct dementia, mixed dementia, frontotemporal dementia (e.g., Pick's disease), and dementia related to stroke, Parkinson's, Huntington's, Pick's, or Creutzfeldt-Jakob diseases)
<input type="checkbox"/> 36. Hemiplegia/Hemiparesis/Paraplegia
<input type="checkbox"/> 37. Quadriplegia
<input type="checkbox"/> 38. Multiple Sclerosis
<input type="checkbox"/> 39. Parkinson's Disease
<input type="checkbox"/> 40. Seizure Disorder
<input type="checkbox"/> 41. Traumatic Brain Injury
Nutritional
<input type="checkbox"/> 42. Malnutrition (protein or calorie) or at risk for malnutrition
Psychiatric/Mood Disorder
<input type="checkbox"/> 42. Anxiety Disorder
<input type="checkbox"/> 43. Depression (other than Bipolar)
<input type="checkbox"/> 44. Manic Depression (Bipolar Disease)
<input type="checkbox"/> 45. Schizophrenia
Pulmonary
<input type="checkbox"/> 46. Asthma/ COPD or Chronic Lung Disease (includes chronic bronchitis and restrictive lung diseases such as asbestosis)
Vision
<input type="checkbox"/> 47. Cataracts, Glaucoma, or Macular Degeneration
Other
<input type="checkbox"/> 48. Additional Diagnoses Enter ICD-9 and diagnosis.
a. _____
b. _____
c. _____
d. _____
e. _____
f. _____
g. _____

Section J Health Conditions

J1. Pain Management (answer for all residents, regardless of current pain level)

At any time in the last 5 days, has the resident:

Enter <input type="checkbox"/> Code	a. Been on a scheduled pain medication regimen? 0. No 1. Yes
Enter <input type="checkbox"/> Code	b. Received PRN pain medications? 0. No 1. Yes
Enter <input type="checkbox"/> Code	c. Received non-medication intervention for pain? 0. No 1. Yes

J2. Should Pain Assessment Interview be Conducted?—Attempt to conduct interview with all residents

Enter <input type="checkbox"/> Code	0. No (resident is rarely/never understood) → Skip to J8, Staff Assessment for Pain 1. Yes → Continue to J3, Pain Presence
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Pain Assessment Interview

J3. Pain Presence

Enter <input type="checkbox"/> Code	Ask resident: <i>“Have you had pain or hurting at any time in the last 5 days?”</i> 0. No → Skip to J9, Shortness of Breath 1. Yes → Continue to J4, Pain Frequency 9. Unable to answer → Skip to J8, Staff Assessment for Pain
---	--

J4. Pain Frequency

Enter <input type="checkbox"/> Code	Ask resident: <i>“How much of the time have you experienced pain or hurting over the last 5 days?”</i> 1. Almost constantly 2. Frequently 3. Occasionally 4. Rarely 9. Unable to answer
---	--

J5. Pain Effect on Function

Enter <input type="checkbox"/> Code	a. Ask resident: <i>“Over the past 5 days, has pain made it hard for you to sleep at night?”</i> 0. No 1. Yes 9. Unable to answer
Enter <input type="checkbox"/> Code	b. Ask resident: <i>“Over the past 5 days, have you limited your day-to-day activities because of pain?”</i> 0. No 1. Yes 9. Unable to answer

J6. Pain Intensity

Enter Number <input type="text"/>	Ask resident: <i>“Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.”</i> (Show resident 0–10 pain scale.) Enter two-digit response. Enter 99 if unable to answer.
--------------------------------------	--



Section J Health Conditions

J7. Should the Staff Assessment for Pain be Completed?

Enter <input type="text"/> Code	<p>0. No (resident completed Pain Assessment Interview) → Skip to J9, Shortness of Breath</p> <p>1. Yes (resident was unable to complete Pain Assessment Interview) → Continue to J8, Staff Assessment for Pain</p>
---------------------------------------	---

Staff Assessment for Pain – do not conduct if Pain Assessment Interview (J2-J6) completed.

J8. Indicators of pain or possible pain in the last 5 days. Check all that apply:

Check all that apply.	<input type="checkbox"/>	a. Non-verbal sounds (crying, whining, gasping, moaning, or groaning)
	<input type="checkbox"/>	b. Vocal complaints of pain (that hurts, ouch, stop)
	<input type="checkbox"/>	c. Facial expressions (grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw)
	<input type="checkbox"/>	d. Protective body movements or postures (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
	<input type="checkbox"/>	e. None of these signs observed or documented

Other Health Conditions – Complete for all residents

J9. Shortness of Breath (dyspnea)

Select all that apply in last 5 days:

Check all that apply.	<input type="checkbox"/>	a. Shortness of breath or trouble breathing with exertion (e.g. walking, bathing, transferring)
	<input type="checkbox"/>	b. Shortness of breath or trouble breathing when sitting at rest
	<input type="checkbox"/>	c. Shortness of breath or trouble breathing when lying flat
	<input type="checkbox"/>	d. None of the above

J10. Current Tobacco Use

Enter <input type="text"/> Code	<p>Tobacco use in last 5 days.</p> <p>0. No</p> <p>1. Yes</p>
---------------------------------------	--

J11. Prognosis

Enter <input type="text"/> Code	<p>Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? (Requires physician documentation. If not documented, discuss with physician and request supporting documentation).</p> <p>0. No</p> <p>1. Yes</p>
---------------------------------------	--

J12. Problem Conditions in the last 5 days. Select all that apply:

Check all that apply.	<input type="checkbox"/>	a. Fever
	<input type="checkbox"/>	b. Vomiting
	<input type="checkbox"/>	c. None of the above

Section J Health Conditions

J13. Should the Fall History (Admission) or Fall History (Follow-up Assessment) be Completed?

Enter

 Code

What assessment type are you completing?

1. **Admission assessment** → Continue to J14, Fall History
2. **Follow-up assessment (quarterly or annual)** → Skip to J15, Any Falls Since Last Assessment

Complete J14a-d only on Admission Assessment

J14. Fall History

Enter

 Code

- a.** Did the resident fall one or more times in the **30 days** (i.e., month) before admission?
0. **No**
 1. **Yes**
 9. **Unable to determine**

Enter

 Code

- b.** Did the resident fall one or more times in the **31–180 days** (i.e., 1–6 months) before admission?
0. **No**
 1. **Yes**
 9. **Unable to determine**

Enter

 Code

- c.** Did the resident have any **fracture related to a fall in the 6 months** prior to admission?
0. **No**
 1. **Yes**
 9. **Unable to determine**

Enter

 Code

- d.** Has the resident **fallen since admission** to the nursing home?
0. **No** → Skip to Section K, Swallowing
 1. **Yes** → Skip to Section K, Swallowing

Complete J15-J16 only on Quarterly or Annual Assessment

J15. Any Falls Since Last Assessment

Enter

 Code

- Has the resident **had any falls since the last assessment**?
0. **No** → Skip to Section K, Swallowing
 1. **Yes** → Continue to J16, Number of Falls Since Last Assessment

J16. Number of Falls Since Last Assessment

Code the number of falls in each category since the last assessment.

- Coding:**
0. **None**
 1. **One**
 2. **Two or more**

↓ Enter Codes in Boxes ↓

Enter

 Code

- a. No injury**—no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall

Enter

 Code

- b. Injury (except major)**—skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain

Enter

 Code

- c. Major injury**—bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Section K Swallowing/Nutritional Status

K1. Swallowing Disorder

Signs and symptoms of possible swallowing disorder. Check all that applied in last 5 days:

Check all that apply.	<input type="checkbox"/>	a. Loss of liquids/solids from mouth when eating or drinking
	<input type="checkbox"/>	b. Holding food in mouth/cheeks or residual food in mouth after meals
	<input type="checkbox"/>	c. Coughing or choking during meals or when swallowing medications
	<input type="checkbox"/>	d. Complaints of difficulty or pain with swallowing
	<input type="checkbox"/>	e. None of the above

K2. Height and Weight

<input type="text"/> inches	a. Height (in inches). Record most recent height measure since admission. (If height includes a fraction, round up to nearest inch.)
<input type="text"/> pounds	b. Weight (in pounds). Record base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc). (If weight includes a fraction, round up to nearest pound.)

K3. Weight Loss

Enter <input type="text"/> Code	Loss of 5% or more in last 30 days (or since last assessment if sooner) or loss of 10% or more in last 180 days. 0. No or unknown 1. Yes, on physician-prescribed weight-loss regimen 2. Yes, not on physician-prescribed weight-loss regimen
---------------------------------------	---

K4. Nutritional Approaches

Check all that applied in last 5 days:

Check all that apply.	<input type="checkbox"/>	a. Parenteral/IV feeding
	<input type="checkbox"/>	b. Feeding-tube —nasogastric or abdominal (PEG)
	<input type="checkbox"/>	c. Mechanically altered diet —require change in texture of food or liquids (e.g., pureed food, thickened liquids)
	<input type="checkbox"/>	d. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)
	<input type="checkbox"/>	e. None of the above

K5. Percent Intake by Artificial Route – Complete K5 only if K4a or K4b is checked

Enter <input type="text"/> Code	a. Proportion of total calories the resident received through parenteral or tube feedings in the last 5 days. 1. 25% or less 2. 26–50% 3. 51% or more
Enter <input type="text"/> Code	b. Average fluid intake per day by IV or tube in last 5 days. 1. 500 cc/day or less 2. 501 cc/day or more

Section L Oral/Dental Status

L1. Dental

Check all that applied in last 5 days:

Check all that apply.	<input type="checkbox"/>	a. Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose)
	<input type="checkbox"/>	b. No natural teeth or tooth fragment(s) (edentulous)
	<input type="checkbox"/>	c. Abnormal mouth tissue (ulcers, masses, oral lesions, including under denture or partial if one is worn)
	<input type="checkbox"/>	d. Obvious or likely cavity or broken natural teeth
	<input type="checkbox"/>	e. Inflamed or bleeding gums or loose natural teeth
	<input type="checkbox"/>	f. Mouth or facial pain , discomfort or difficulty with chewing
	<input type="checkbox"/>	g. None of the above were present
	<input type="checkbox"/>	h. Unable to examine

Section M Skin Conditions

M1. Current Pressure Ulcer

Enter <input type="text"/> Code	<p>Did the resident have a pressure ulcer in the last 5 days?</p> <p>0. No → Skip to M10, Healed Pressure Ulcers</p> <p>1. Yes → Continue to M2, Stage 1 Ulcers</p>
---------------------------------------	--

M2. Stage 1 Ulcers

Report based on highest stage of existing ulcer(s) at its worst; do not “reverse” stage.

Enter <input type="text"/> Number	<p>Number of existing pressure ulcers at Stage 1—Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area.</p>
---	---

M3. Stage 2 Ulcers

Report based on highest stage of existing ulcer(s) at its worst; do not “reverse” stage.

Enter <input type="text"/> Number	<p>a. Number of existing pressure ulcers at Stage 2—Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. If number entered = 0 → Skip to M4, Stage 3 Ulcers.</p>
Enter <input type="text"/> Number	<p>b. Number of these Stage 2 pressure ulcers that were present on admission. Of the pressure ulcers listed in M3a, how many were first noted at Stage 2 within 48 hours of admission and not acquired in the facility?</p>
<p>Length (cm): <input type="text"/><input type="text"/>.<input type="text"/><input type="text"/></p> <p>Width (cm): <input type="text"/><input type="text"/>.<input type="text"/><input type="text"/></p>	<p>c. Current dimensions of largest Stage 2 pressure ulcer (in centimeters).</p>

M4. Stage 3 Ulcers

Report based on highest stage of existing ulcer(s) at its worst; do not “reverse” stage.

Enter <input type="text"/> Number	<p>a. Number of existing pressure ulcers at Stage 3—Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. If number entered = 0 → Skip to M5, Stage 4 Ulcers.</p>
Enter <input type="text"/> Number	<p>b. Number of these Stage 3 pressure ulcers that were present on admission. Of the pressure ulcers listed in M4a, how many were first noted at Stage 3 within 48 hours of admission and not acquired in the facility?</p>
<p>Length (cm): <input type="text"/><input type="text"/>.<input type="text"/><input type="text"/></p> <p>Width (cm): <input type="text"/><input type="text"/>.<input type="text"/><input type="text"/></p>	<p>c. Current dimensions of largest Stage 3 pressure ulcer (in centimeters).</p>

M5. Stage 4 Ulcers

Report based on highest stage of existing ulcer(s) at its worst; do not “reverse” stage.

Enter <input type="text"/> Number	<p>a. Number of existing pressure ulcers at Stage 4—Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. If number entered = 0 → Skip to M6, Unstageable Ulcers.</p>
Enter <input type="text"/> Number	<p>b. Number of these Stage 4 pressure ulcers that were present on admission. Of the pressure ulcers listed in M5a, how many were first noted at Stage 4 within 48 hours of admission and not acquired in the facility?</p>
<p>Length (cm): <input type="text"/><input type="text"/>.<input type="text"/><input type="text"/></p> <p>Width (cm): <input type="text"/><input type="text"/>.<input type="text"/><input type="text"/></p>	<p>c. Current dimensions of largest Stage 4 pressure ulcer (in centimeters).</p>

Section M Skin Conditions

M6. Unstageable Ulcers

Enter <input type="text"/> Number	a. Number of unstageable ulcers —Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed.
Enter <input type="text"/> Number	b. Number of these unstageable pressure ulcers that were present on admission. Of the pressure ulcers listed in M6a, how many were first noted as unstageable within 48 hours of admission and not acquired in the facility?

M7. Exudate Amount for Most Advanced Stage

Enter <input type="text"/> Code	Select the item that best describes the amount of exudate in the largest pressure ulcer at the most advanced stage. <ol style="list-style-type: none"> 0. None 1. Light 2. Moderate 3. Heavy 9. Not observable
---------------------------------------	---

M8. Tissue Type for Most Advanced Stage

Enter <input type="text"/> Code	Select the item that best describes the type of tissue present in the ulcer bed of the largest pressure ulcer at the most advanced stage. <ol style="list-style-type: none"> 0. Closed/resurfaced—completely covered with epithelium 1. Epithelial Tissue —new skin growing in superficial ulcer 2. Granulation Tissue —pink or red tissue with shiny, moist, granular appearance 3. Slough—yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous 4. Necrotic Tissue (Eschar) —black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin. 9. Not observable
---------------------------------------	---

M9. Worsening in Pressure Ulcer Status Since Last Assessment

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on last MDS.
 If no current pressure ulcer at a given stage, enter 0.

<input type="checkbox"/>	a. Check here if N/A (no prior MDS assessment during this stay)
Enter <input type="text"/> Number	b. Stage 2
Enter <input type="text"/> Number	c. Stage 3
Enter <input type="text"/> Number	d. Stage 4

M10. Healed Pressure Ulcers

Indicate the number of pressure ulcers that were noted on last MDS that have **completely healed**.
 If no current pressure ulcer at a given stage, enter 0.

<input type="checkbox"/>	a. Check here if N/A (no prior MDS assessment during this stay or no pressure ulcers on prior assessment)
Enter <input type="text"/> Number	b. Stage 2
Enter <input type="text"/> Number	c. Stage 3
Enter <input type="text"/> Number	d. Stage 4

Section M Skin Conditions

M11. Other Ulcers, Wounds, and Skin Problems

Check all that apply in the past 5 days:

- | | | |
|-----------------------|--------------------------|---|
| Check all that apply. | <input type="checkbox"/> | a. Venous or arterial ulcer(s) |
| | <input type="checkbox"/> | b. Diabetic foot ulcer(s) |
| | <input type="checkbox"/> | c. Other foot or lower extremity infection (cellulitis) |
| | <input type="checkbox"/> | d. Surgical wound(s) |
| | <input type="checkbox"/> | e. Open lesion(s) other than ulcers, rashes, cuts (e.g., cancer lesion) |
| | <input type="checkbox"/> | f. Burn(s) |
| | <input type="checkbox"/> | g. None of the above were present |

M12. Skin Treatments

Check all that apply in the past 5 days:

- | | | |
|-----------------------|--------------------------|--|
| Check all that apply. | <input type="checkbox"/> | a. Pressure reducing device for chair |
| | <input type="checkbox"/> | b. Pressure reducing device for bed |
| | <input type="checkbox"/> | c. Turning/repositioning program |
| | <input type="checkbox"/> | d. Nutrition or hydration intervention to manage skin problems |
| | <input type="checkbox"/> | e. Ulcer care |
| | <input type="checkbox"/> | f. Surgical wound care |
| | <input type="checkbox"/> | g. Application of dressings (with or without topical medications) other than to feet |
| | <input type="checkbox"/> | h. Applications of ointments/medications other than to feet |
| | <input type="checkbox"/> | i. Application of dressings to feet (with or without topical medications) |
| | <input type="checkbox"/> | j. None of the above were provided |

Section N Medications

N1. Injections

Days

Record the **number of days that injectable medications were received** during the last 5 days or since admission if less than 5 days.

N2. Medications Received

Check all medications the resident received at any time during the last 5 days or since admission if less than 5 days:

- | | | |
|-----------------------|--------------------------|---|
| Check all that apply. | <input type="checkbox"/> | a. Antipsychotic |
| | <input type="checkbox"/> | b. Antianxiety |
| | <input type="checkbox"/> | c. Antidepressant |
| | <input type="checkbox"/> | d. Hypnotic |
| | <input type="checkbox"/> | e. Anticoagulant (warfarin, heparin, or low-molecular weight heparin) |
| | <input type="checkbox"/> | f. None of the above were received |

Section O

Special Treatments and Procedures

O1. Special Treatments and Programs

Check treatments or programs received during the last 14 days.

Cancer Treatment		Other			
Check all that apply.	<input type="checkbox"/>	a. Chemotherapy	Check all that apply.	<input type="checkbox"/>	g. IV medications
	<input type="checkbox"/>	b. Radiation		<input type="checkbox"/>	h. Transfusions
	Respiratory Treatments			<input type="checkbox"/>	i. Dialysis
	<input type="checkbox"/>	c. Oxygen therapy		<input type="checkbox"/>	j. Hospice care
	<input type="checkbox"/>	d. Suctioning		<input type="checkbox"/>	k. Respite care
	<input type="checkbox"/>	e. Tracheostomy care		<input type="checkbox"/>	l. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)
<input type="checkbox"/>	f. Ventilator or respirator	<input type="checkbox"/>	m. None of the above treatments or programs received		

O2. Influenza Vaccine

Enter <input type="text"/> Code	<p>a. Did the resident receive the Influenza Vaccine in this facility for this year's Influenza season (October 1 through March 31)?</p> <p>0. No → Continue to O2b</p> <p>1. Yes → Skip to O3, Pneumococcal Vaccine</p> <p>9. Does not apply because assessment is between July 1 and Sept 30 → Skip to O3, Pneumococcal Vaccine</p>
Enter <input type="text"/> Code	<p>b. If Influenza Vaccine not received, state reason:</p> <p>1. Not in facility during this year's flu season</p> <p>2. Received outside of this facility</p> <p>3. Not eligible – medical contraindication</p> <p>4. Offered and declined</p> <p>5. Not offered</p> <p>6. Inability to obtain vaccine from supplier</p> <p>7. None of the above</p>

O3. Pneumococcal Vaccine

Enter <input type="text"/> Code	<p>a. Is the resident's Pneumococcal Vaccination up to date?</p> <p>0. No → Continue to O3b</p> <p>1. Yes → Skip to O4, Therapies</p>
Enter <input type="text"/> Code	<p>b. If Pneumococcal Vaccine not received, state reason:</p> <p>1. Not eligible – medical contraindication</p> <p>2. Offered and declined</p> <p>3. Not offered</p>

O4. Therapies

Record the **number of days each of the following therapies was administered** for at least 15 minutes a day in the last 7 days (column I). Enter 0 if none or less than 15 minutes daily. For Therapies a–c also record the total number of minutes (column II).

I. Days		II. Minutes			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	a. Speech-language pathology and audiology services
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	b. Occupational Therapy
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	c. Physical Therapy
<input type="text"/>	<input type="text"/>				d. Respiratory Therapy
<input type="text"/>	<input type="text"/>				e. Psychological Therapy (by any licensed mental health professional)
<input type="text"/>	<input type="text"/>				f. Recreational Therapy (includes recreational and music therapy)

Section O Special Treatments and Procedures

O5. Nursing Rehabilitation/ Restorative Care

Record the number of days each of the following rehabilitative or restorative techniques was administered (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily).

Number of Days	Technique		
<input type="text"/>	a. Range of motion (passive)		
<input type="text"/>	b. Range of motion (active)		
<input type="text"/>	c. Splint or brace assistance		
Number of Days	Training and skill practice in:	Number of Days	
<input type="text"/>	d. Bed mobility	<input type="text"/>	h. Eating or swallowing
<input type="text"/>	e. Transfer	<input type="text"/>	i. Amputation/prostheses care
<input type="text"/>	f. Walking	<input type="text"/>	j. Communication
<input type="text"/>	g. Dressing or grooming		

O6. Physician Examinations

Days Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) examine the resident?

O7. Physician Orders

Days Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?

Section P Restraints

P1. Physical Restraints - Code for last 5 days:

Physical restraints are any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body.

Coding: 0. Not used 1. Used less than daily 2. Used daily	→ Enter Codes in Boxes →	Enter Code <input type="text"/>	Used in Bed
		Enter Code <input type="text"/>	a. Bed rail (any type; e.g., full, half, one side)
		Enter Code <input type="text"/>	b. Trunk restraint
		Enter Code <input type="text"/>	c. Limb restraint
		Enter Code <input type="text"/>	d. Other
		Enter Code <input type="text"/>	Used in Chair or Out of Bed
		Enter Code <input type="text"/>	e. Trunk restraint
		Enter Code <input type="text"/>	f. Limb restraint
Enter Code <input type="text"/>	g. Chair prevents rising		
Enter Code <input type="text"/>	h. Other		

Section Q Participation in Assessment and Goal Setting

Q1. Participation in Assessment

Enter

Code

a. Resident

0. No

1. Yes

Enter

Code

b. Family or significant other

0. No

1. Yes

9. No family or significant other

Q2. Return to Community

Ask resident (or family or significant other if resident unable to respond):

Enter

Code

"Do you want to talk to someone about the possibility of returning to the community?"

0. No

1. Yes

Complete Q3 only on Admission Assessment

Q3. Resident's Overall Goals

Enter

Code

a. Select one for resident's goals established during assessment process.

1. **Post acute care**—expects to return to live in community

2. **Post acute care**—expects to have continued NH needs

3. **Respite stay**—expects to return home

4. **Other reason for admit**—expects to return to live in community

5. **Long term care** for medical, functional, and/or cognitive impairments

6. **End-of-life care** (includes palliative care and hospice)

9. **Unknown or uncertain**

Enter

Code

b. Indicate information source for this item

1. Resident

2. Family or significant other

3. Neither