MDS 3.0:
Recommended Form

Nursing Home Assessment Record — Identification Information

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

A8. Language—complete only on admission, annual, and significant change assessment (A10a = 01, 03, or 04)

Enter Code

a. 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: **b.** _____
9. **Unable to determine**

A10. Type of Assessment/Tracking

Enter Code

a. Federal OBRA Reason for Assessment/Tracking

01. **Admission assessment** (required by day 14)
02. **Quarterly review assessment**
03. **Annual assessment**
04. **Significant change in status assessment**
05. **Significant correction to prior full assessment**
06. **Significant correction to prior quarterly assessment**
99. **Not OBRA required assessment/tracking**

Enter Code

b. PPS Assessments

PPS Scheduled Assessments for a Medicare Part A Stay

1. **5-day scheduled assessment**
2. **14-day scheduled assessment**
3. **30-day scheduled assessment**
4. **60-day scheduled assessment**
5. **90-day scheduled assessment**
6. **Readmission/return assessment**

PPS Unscheduled Assessments for a Medicare Part A Stay

7. **Unscheduled assessment used for PPS** (OMRA, significant change, or significant correction assessment)
9. **Not PPS assessment**

Enter Code

c. PPS Other Medicare Required Assessment—OMRA (required when all rehabilitation therapy discontinued)

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

A11. Submission Requirement

Enter Code

a. Federal required submission

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

Enter Code

b. State required submission

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

Enter Code

c. Submission only required for other reasons (e.g. HMO, other insurance, etc.)

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

A12. Preadmission Screening and Resident Review (PASRR)—Complete only if A9a = 01, 03, or 04

Enter Code

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?

0. **No**
1. **Yes**
9. **Not a Medicaid certified unit**

A13. Medicare Stay

Enter Code

a. Is the resident currently in a Medicare-covered stay?

0. **No** ➔ Skip to A13, State Case Mix Group
1. **Yes** ➔ Continue to A12b

b. Start date of current Medicare stay

__ __ — __ __ — __ __ __ __

month day year

c. Medicare Part A HIPPS code for billing

__ __ __ __ __ __ __

(RUG-III group followed by HIPPS modifier based on type of assessment)

A14. State Case Mix Group (If required by the state)

___ ___ ___ ___ ___ ___ ___

A15. Optional Facility Items

a. Medical Record Number

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

b. Room number

___ ___ ___ ___ ___

c. Name by which resident prefers to be addressed:

_____

d. Lifetime occupation(s) – put "/" between two occupations

_____

A16. Assessment Reference Date

Observation end date

___ ___ — ___ ___ — ___ ___ ___ ___
month day year

A22. 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.

Signature	Title	Sections	Date
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			
i.			
j.			
k.			
l.			

A23. Signature of RN Assessment Coordinator Verifying Assessment Completion

a. Signature

b. Date RN Assessment Coordinator signed assessment as complete

___ ___ — ___ ___ — ___ ___ ___ ___
month day year

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 G1, Activities of Daily Living (ADL) Assistance

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) ➔ instead complete C7-C10, 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 an earlier 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

Section C Cognitive Patterns

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

Staff Assessment for Mental Status

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

C7. Short-term Memory OK

Enter Code

Seems or appears to recall after 5 minutes.

0. **Memory OK**
1. **Memory problem**

C8. Long-term Memory OK

Enter 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.

- ☐ **a. Current season**
- ☐ **b. Location of own room**
- ☐ **c. Staff names and faces**
- ☐ **d. That he or she is in a nursing home**
- ☐ **e. None of the above** were recalled

C10. Cognitive Skills for Daily Decision Making

Enter Code

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

Section C Cognitive Patterns

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.

Coding:

0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

→ **Enter Codes in Boxes** →

Enter Code	**a.**	**Inattention**—Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?
Enter 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 Code	**c.**	**Altered level of consciousness**—Did the resident have altered level of consciousness? (e.g., **vigilant**—startled easily to any sound or touch; **lethargic**—repeatedly dozed off when being asked questions, but responded to voice or touch; **stuporous**—very difficult to arouse and keep aroused for the interview; **comatose**—could not be aroused)
Enter 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 Code

Is there evidence of an acute change in mental status from the resident's baseline in last 5 days?

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

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) ➔ Instead complete (D5-D6) Staff Assessment of Mood
1. **Yes** ➔ Continue to D2, Resident Mood Interview

D2. Resident Mood Interview (PHQ-9©)

Say to resident: *"Over the last 2 weeks, have you been bothered by any of the following problems?"*	**I. Symptom Presence** If symptom is present, enter yes (1), then obtain symptom frequency in Column II.	**II. Symptom Frequency** If yes in column I, Symptom Presence, then ask the resident: *"about **how often** have you been bothered by this?"* Read and show the resident a card with the symptom frequency choices. Indicate response below.			
		1 Day "Rarely"	**2–6 Days** "Several days"	**7–11 Days** "More than half the days"	**12–14 Days** "Nearly every day"
a. ***Little interest or pleasure in doing things***	Enter Code — **0.** No **1.** Yes → **9.** No response	0	1	2	3
b. ***Feeling down, depressed, or hopeless***	Enter Code — **0.** No **1.** Yes → **9.** No response	0	1	2	3
c. ***Trouble falling or staying asleep, or sleeping too much***	Enter Code — **0.** No **1.** Yes → **9.** No response	0	1	2	3
d. ***Feeling tired or having little energy***	Enter Code — **0.** No **1.** Yes → **9.** No response	0	1	2	3
e. ***Poor appetite or overeating***	Enter 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 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 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 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*** **ii)** If "Yes", check here to indicate that responsible staff or provider has been informed: ☐	Enter Code — **0.** No **1.** Yes → **9.** No response	0	1	2	3

D3. Total Severity Score

Enter Numbers

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

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

Say to staff: *"Over the last 2 weeks, did the resident have any of the following problems or behaviors?"*	**I. Symptom Presence** If symptom is present, enter yes (1), then move to column II and select symptom frequency.		**II. Symptom Frequency** If yes in column I, Symptom Presence, select frequency.			
			1 Day "Rarely"	**2–6 Days** "Several days"	**7–11 Days** "More than half the days"	**12–14 Days** "Nearly every day"
a. ***Little interest or pleasure in doing things***	Enter Code	**0.** No **1.** Yes ⟶ **9.** No response	0	1	2	3
b. ***Feeling or appearing down, depressed, or hopeless***	Enter Code	**0.** No **1.** Yes ⟶ **9.** No response	0	1	2	3
c. ***Trouble falling or staying asleep, or sleeping too much***	Enter Code	**0.** No **1.** Yes ⟶ **9.** No response	0	1	2	3
d. ***Feeling tired or having little energy***	Enter Code	**0.** No **1.** Yes ⟶ **9.** No response	0	1	2	3
e. ***Poor appetite or overeating***	Enter 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 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 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 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.*** **ii)** If "Yes", check here to indicate that responsible staff or provider has been informed: ☐	Enter Code	**0.** No **1.** Yes ⟶ **9.** No response	0	1	2	3
j. ***Being short-tempered, easily annoyed***	Enter Code	**0.** No **1.** Yes ⟶ **9.** No response	0	1	2	3

D6. Total Severity Score

Enter Numbers

Add scores for all selected frequency 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:

- ☐ **a. Hallucinations** (perceptual experiences in the absence of real external sensory stimuli) **or illusions** (misperceptions in the presence of real external sensory stimuli)
- ☐ **b. Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
- ☐ **c. None of the above**

Behavioral Symptoms

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** →

Enter Code	
☐	**a. Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
☐	**b. Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
☐	**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 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

E4. Impact on Resident

Did any of the identified symptom(s):

Enter Code ☐

a. Put the resident at significant risk for physical illness or injury?

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

Enter Code ☐

b. Significantly interfere with the resident's care?

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

Enter 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 Code ☐

a. Put others at significant risk for physical injury?

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

Enter Code ☐

b. Significantly intrude on the privacy or activity of others?

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

Enter Code ☐

c. Significantly disrupt care or living environment?

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

Section E Behavior

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**

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**

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**
9. **N/A** because no prior MDS assessment

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 is 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) ➔ Instead complete F6, Staff Assessment of Daily and Activity Preferences
1. **Yes** ➔ Continue to F2, Interview for Daily Preferences

F2. Interview for Daily Preferences

Show resident the response options and say: "*While you are in this facility…"*

Coding:

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**

Enter Codes in Boxes ➔ ➔

Enter Code	**a.** *how important is it to you to* ***choose what clothes to wear?***
Enter Code	**b.** *how important is it to you to* ***take care of your personal belongings or things?***
Enter Code	**c.** *how important is it to you to* ***choose between a tub bath, shower, bed bath, or sponge bath?***
Enter Code	**d.** *how important is it to you to* ***have snacks available between meals?***
Enter Code	**e.** *how important is it to you to* ***choose your own bedtime?***
Enter Code	**f.** *how important is it to you to* ***have your family or a close friend involved in discussions about your care?***
Enter Code	**g.** *how important is it to you to* ***be able to use the phone in private?***
Enter Code	**h.** *how important is it to you to* ***have a place to lock your things to keep them safe****?*

F3. Interview for Activity Preferences

Show resident the response options and say: "*While you are in this facility…"*

Coding:

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**

Enter Codes in Boxes ➔ ➔

Enter Code	**a.** *how important is it to you to* ***have books, newspapers, and magazines to read?***
Enter Code	**b.** *how important is it to you to* ***listen to music you like?***
Enter Code	**c.** *how important is it to you to* ***be around animals such as pets?***
Enter Code	**d.** *how important is it to you to* ***keep up with the news?***
Enter Code	**e.** *how important is it to you to* ***do things with groups of people?***
Enter Code	**f.** *how important is it to you to* ***do your favorite activities?***
Enter Code	**g.** *how important is it to you to* ***go outside to get fresh air when the weather is good?***
Enter Code	**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 G1, Activities of Daily Living Assistance
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

F6. Staff Assessment of Daily and Activity Preferences

Do not conduct if Interview for Daily and Activity Preferences (F2 – F3) was completed

Resident Prefers:

Check all that apply.

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

Section G Functional Status

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		
☐	**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).

G2. Mobility Prior to Admission—complete only on admission assessment (A10a = 01)

Enter Code ☐

a. Did resident have a **hip fracture, hip replacement, or knee replacement** in the 30 days prior to this admission?

0. **No** ➔ Skip to G3, Balance During Transitions and Walking
1. **Yes** ➔ Continue to G2b

Check all that apply.

b. If yes, check all that apply for tasks in which the resident was independent prior to fracture/replacement.

- ☐ 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 Code ☐	**a. Moving from seated to standing position**
Enter Code ☐	**b. Walking** (with assistive device if used)
Enter Code ☐	**c. Turning around** and facing the opposite direction while walking
Enter Code ☐	**d. Moving on and off toilet**
Enter 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 Code ☐	**a. Upper extremity** (shoulder, elbow, wrist, hand)
Enter 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.

- ☐ **a. Cane/crutch**
- ☐ **b. Walker**
- ☐ **c. Wheelchair (manual or electric)**
- ☐ **d. Lower extremity limb prosthesis**
- ☐ **e. None of the above** were used

G6. Bedfast

Enter 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**

G7. Functional Rehabilitation Potential—complete only on full assessment (A10a = 01)

Enter Code ☐

a. Resident believes he or she is capable of increased independence in at least some ADL's.

0. **No**
1. **Yes**
9. **Unable to determine**

Enter 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. Appliances

Check all that applied in last 5 days:

Check all that apply.

- ☐ **a. Indwelling bladder catheter**
- ☐ **b. External (condom) catheter**
- ☐ **c. Ostomy (including suprapubic catheter, ileostomy, and colostomy)**
- ☐ **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** or trial in progress

Enter Code

c. Current toileting program or trial—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

Active Diseases in the last 30 days

Check all that apply.

Cancer

- ❑ **1. Cancer** (with or without metastasis)

Heart/Circulation

- ❑ **2. Anemia** (includes aplastic, iron deficiency pernicious, and sickle cell)
- ❑ **3. Atrial Fibrillation and Other Dysrhythmias** (includes bradycardias, tachycardias)
- ❑ **4. Coronary Artery Disease (CAD)** (includes angina, myocardial infarction, ASHD)
- ❑ **5. Deep Venous Thrombosis (DVT)/Pulmonary Embolus (PE or PTE)**
- ❑ **6. Heart Failure** (includes CHF, pulmonary edema)
- ❑ **7. Hypertension**
- ❑ **8. Peripheral Vascular Disease/Peripheral Arterial Disease**

Gastrointestinal

- ❑ **9. Cirrhosis**
- ❑ **10. GERD/Ulcer** (includes esophageal, gastric, and peptic ulcers)
- ❑ **11. Ulcerative Colitis/Crohn's Disease/ Inflammatory Bowel Disease**

Genitourinary

- ❑ **12. Benign Prostatic Hyperplasia (BPH)**
- ❑ **13. Renal Insufficiency or Renal Failure (ESRD)**

Infections

- ❑ **14. Human Immunodeficiency Virus (HIV) Infection** (includes AIDS)
- ❑ **15. MRSA, VRE, Clostridium diff. Infection/ Colonization**
- ❑ **16. Pneumonia**
- ❑ **17. Septicemia**
- ❑ **18. Tuberculosis**
- ❑ **19. Urinary Tract Infection (UTI)**
- ❑ **20. Viral Hepatitis** (includes Hepatitis A, B, C, D, and E)
- ❑ **21. Wound Infection**

Metabolic

- ❑ **22. Diabetes Mellitus (DM)** (includes diabetic retinopathy, nephropathy, and neuropathy)
- ❑ **23. Hyponatremia**
- ❑ **24. Hyperkalemia**
- ❑ **25. Hyperlipidemia** (includes hypercholesterolemia)
- ❑ **26. Thyroid Disorder** (Includes hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)

Musculoskeletal

- ❑ **27. Arthritis** (Degenerative Joint Disease (DJD), Osteoarthritis, and Rheumatoid Arthritis (RA))
- ❑ **28. Osteoporosis**
- ❑ **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)
- ❑ **30. Other Fracture**

Neurological

- ❑ **31. Alzheimer's Disease**
- ❑ **32. Aphasia**
- ❑ **33. Cerebral Palsy**
- ❑ **34. CVA/TIA/Stroke**
- ❑ **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, or Creutzfeldt-Jakob diseases)
- ❑ **36. Hemiplegia/Hemiparesis/Paraplegia**
- ❑ **37. Quadriplegia**
- ❑ **38. Multiple Sclerosis**
- ❑ **39. Parkinson's Disease**
- ❑ **40. Seizure Disorder**
- ❑ **41. Traumatic Brain Injury**

Nutritional

- ❑ **42. Malnutrition** (protein or calorie) or at risk for malnutrition

Psychiatric/Mood Disorder

- ❑ **43 Anxiety Disorder**
- ❑ **44. Depression** (other than Bipolar)
- ❑ **45. Manic Depression** (Bipolar Disease)
- ❑ **46. Schizophrenia**

Pulmonary

- ❑ **47. Asthma/COPD or Chronic Lung Disease** (includes chronic bronchitis and restrictive lung diseases such as asbestosis)

Vision

- ❑ **48. Cataracts, Glaucoma, or Macular Degeneration**

Other

- ❑ **49. Additional Diagnoses**

  Enter ICD-9 and diagnosis.

  a. _____
  b. _____
  c. _____
  d. _____
  e. _____
  f. _____

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 Code

a. Been on a scheduled pain medication regimen?

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

Enter Code

b. Received PRN pain medications?

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

Enter 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 Code

0. **No** (resident is rarely/never understood) ➔ Instead complete J8, Staff Assessment for Pain
1. **Yes** ➔ Continue to J3, Pain Presence

Pain Assessment Interview

J3. Pain Presence

Enter Code

Ask resident: "***Have you had pain or hurting at any time*** *in the last 5 days?*"

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 Code

Ask resident: "***How much of the time have you experienced pain or hurting*** *over the last 5 days?*"

1. **Almost constantly**
2. **Frequently**
3. **Occasionally**
4. **Rarely**
9. **Unable to answer**

J5. Pain Effect on Function

Enter Code

a. Ask resident: "*Over the past 5 days,* ***has pain made it hard for you to sleep at night?***"

0. **No**
1. **Yes**
9. **Unable to answer**

Enter Code

b. Ask resident: "*Over the past 5 days,* ***have you limited your day-to-day activities because of pain?***"

0. **No**
1. **Yes**
9. **Unable to answer**

Section J Health Conditions

J6. Pain Intensity—Administer **one** of the following pain intensity questions (a or b)

Enter Number

a. Numeric Rating Scale (00–10)

Ask resident: "*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.*" (Show resident 0–10 pain scale.)

Enter two-digit response. Enter 99 if unable to answer.

Enter Code

b. Verbal Descriptor Scale

Ask resident: *"Please rate the intensity of your worst pain over the last 5 days"* (Show resident verbal scale.)

1. ***Mild***
2. ***Moderate***
3. ***Severe***
4. ***Very severe, horrible***
9. **Unable to answer**

J7. Should the Staff Assessment for Pain be Completed?

Enter Code

0. **No** (resident completed Pain Assessment Interview) ➔ Skip to J9, Shortness of Breath
1. **Yes** (resident was unable to complete Pain Assessment Interview) ➔ Continue to J8, Staff Assessment for Pain

Staff Assessment for Pain

Do not conduct if Pain Assessment Interview (J2-J6) completed.

J8. Indicators of pain or possible pain.

Select all that apply in last 5 days:

Check all that apply.

- ☐ **a. Non-verbal sounds** (crying, whining, gasping, moaning, or groaning)
- ☐ **b. Vocal complaints of pain** (that hurts, ouch, stop)
- ☐ **c. Facial expressions** (grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
- ☐ **d. Protective body movements or postures** (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
- ☐ **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.

- ☐ **a. Shortness of breath or trouble breathing with exertion** (e.g. walking, bathing, transferring)
- ☐ **b. Shortness of breath or trouble breathing when sitting at rest**
- ☐ **c. Shortness of breath or trouble breathing when lying flat**
- ☐ **d. None of the above**

J10. Current Tobacco Use

Enter Code

Tobacco use in last 5 days.

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

J11. Prognosis

Enter Code

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).

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

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

Check all that apply.

- ☐ **a. Fever**
- ☐ **b. Vomiting**
- ☐ **c. None of the above**

Section J Health Conditions

J13. Should the Fall History on Admission or Fall History Since Last 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

J14. Fall History on Admission—complete only on admission assessment (A10a = 01)

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

J15. Any Falls Since Last Assessment—complete on quarterly, annual, or significant change assessments (A10a = 02, 03, or 04)

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 and Nutritional Status

K1. Swallowing Disorder

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

Check all that apply.

- ☐ **a. Loss of liquids/solids from mouth when eating or drinking**
- ☐ **b. Holding food in mouth/cheeks or residual food in mouth after meals**
- ☐ **c. Coughing or choking during meals or when swallowing medications**
- ☐ **d. Complaints of difficulty or pain with swallowing**
- ☐ **e. None of the above**

K2. Height and Weight

☐☐ inches

a. Height (in inches). Record most recent height measure since admission. (If height includes a fraction, round up to nearest inch.)

☐☐☐ pounds

b. Weight (in pounds). 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 ☐ 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.

- ☐ **a. Parenteral/IV feeding**
- ☐ **b. Feeding-tube**—nasogastric or abdominal (PEG)
- ☐ **c. Mechanically altered diet**—require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- ☐ **d. Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)
- ☐ **e. None of the above**

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

Enter ☐ 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 ☐ 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.

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

Section M Skin Conditions

M1. Current Pressure Ulcer

Enter Code

Did the resident have a pressure ulcer in the last 5 days?

0. **No** ➔ Skip to M9, Healed Pressure Ulcers
1. **Yes** ➔ Continue to M2, Stage 1 Ulcers

M2. Stage 1 Ulcers

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

Enter Number

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; in dark skin tones only, it may appear with persistent blue or purple hues.

M3. Stage 2 Ulcers

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

Enter Number	**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.**
Enter Number	**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?
Length (cm): ☐☐.☐	**c. Current length of largest Stage 2 pressure ulcer** (in centimeters).
Width (cm): ☐☐.☐	**d. Current width of largest Stage 2 pressure ulcer** (in centimeters).

M4. Stage 3 Ulcers

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

Enter Number	**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.**
Enter Number	**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?
Length (cm): ☐☐.☐	**c. Current length of largest Stage 3 pressure ulcer** (in centimeters).
Width (cm): ☐☐.☐	**d. Current width of largest Stage 3 pressure ulcer** (in centimeters).

M5. Stage 4 Ulcers

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

Enter Number	**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.**
Enter Number	**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?
Length (cm): ☐☐.☐	**c. Current length of largest Stage 4 pressure ulcer** (in centimeters).
Width (cm): ☐☐.☐	**d. Current width of largest Stage 4 pressure ulcer** (in centimeters).

Section M Skin Conditions

M6. Unstageable Ulcers

Enter 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 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. Tissue Type for Most Advanced Stage

Enter Code

Select the best description of the most severe type of tissue present in the ulcer bed of the **largest pressure ulcer at the most advanced stage**

1. **Epithelial Tissue**—new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin.
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.

M8. 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.

☐ **a. Check here if N/A** (no prior MDS assessment during this stay)

Enter Number

b. Stage 2

Enter Number

c. Stage 3

Enter Number

d. Stage 4

M9. Healed Pressure Ulcers — Complete on all residents

Indicate the number of pressure ulcers that were noted on last MDS that have completely closed (resurfaced with epithelium).
If no healed PU at a given stage since last assessment, enter 0.

☐ **a. Check here if N/A** (no prior MDS assessment during this stay **or** no pressure ulcers on prior assessment)

Enter Number

b. Stage 2

Enter Number

c. Stage 3

Enter Number

d. Stage 4

Section M Skin Conditions

M10. Other Ulcers, Wounds, and Skin Problems

Check all that apply in the past 5 days:

Check all that apply.

- ☐ **a. Venous or arterial ulcer(s)**
- ☐ **b. Diabetic foot ulcer(s)**
- ☐ **c. Other foot or lower extremity infection** (cellulitis)
- ☐ **d. Surgical wound(s)**
- ☐ **e. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
- ☐ **f. Burn(s)**
- ☐ **g. None of the above** were present

M11. Skin and Ulcer Treatments

Check all that apply in the past 5 days:

Check all that apply.

- ☐ **a. Pressure reducing device for chair**
- ☐ **b. Pressure reducing device for bed**
- ☐ **c. Turning/repositioning program**
- ☐ **d. Nutrition or hydration intervention** to manage skin problems
- ☐ **e. Ulcer care**
- ☐ **f. Surgical wound care**
- ☐ **g. Application of dressings** (with or without topical medications) other than to feet
- ☐ **h. Applications of ointments/medications** other than to feet
- ☐ **i. Application of dressings to feet** (with or without topical medications)
- ☐ **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.

- ☐ **a. Antipsychotic**
- ☐ **b. Antianxiety**
- ☐ **c. Antidepressant**
- ☐ **d. Hypnotic**
- ☐ **e. Anticoagulant** (warfarin, heparin, or low-molecular weight heparin)
- ☐ **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.

Check all that apply.

	Cancer Treatment
☐	**a. Chemotherapy**
☐	**b. Radiation**
	Respiratory Treatments
☐	**c. Oxygen therapy**
☐	**d. Suctioning**
☐	**e. Tracheostomy care**
☐	**f. Ventilator or respirator**

Check all that apply.

	Other
☐	**g. IV medications**
☐	**h. Transfusions**
☐	**i. Dialysis**
☐	**j. Hospice care**
☐	**k. Respite care**
☐	**l. Isolation or quarantine** for active infectious disease does not include standard body/fluid precautions)
☐	**m. None of the above** treatments or programs received

O2. Influenza Vaccine

Enter Code

a. Did the **resident receive the Influenza Vaccine <u>in this facility</u>** for this year's Influenza season (October 1 through March 31)?

0. **No** ➔ Continue to O2b
1. **Yes** ➔ Skip to O3, Pneumococcal Vaccine
9. **Does not apply because assessment is between July 1 and Sept 30** ➔ Skip to O3, Pneumococcal Vaccine

Enter Code

b. If Influenza Vaccine not received, state reason:

1. **Not in facility** during this year's flu season
2. **Received outside of this facility**
3. **Not eligible**—medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Vaccine on order but not yet received in the facility**
7. **None of the above**

O3. Pneumococcal Vaccine

Enter Code

a. Is the resident's **Pneumococcal Vaccination up to date?**

0. **No** ➔ Continue to O3b
1. **Yes** ➔ Skip to O4, Therapies

Enter Code

b. If Pneumococcal Vaccine not received, state reason:

1. **Not eligible**—medical contraindication
2. **Offered and declined**
3. **Not offered**

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	
☐	☐☐☐	**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)
☐		**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	Number of Days	
☐	**a. Range of motion (passive)**		
☐	**b. Range of motion (active)**		
☐	**c. Splint or brace assistance**		
Number of Days	**Training and skill practice in:**	**Number of Days**	
☐	**d. Bed mobility**	☐	**h. Eating or swallowing**
☐	**e. Transfer**	☐	**i. Amputation/prostheses care**
☐	**f. Walking**	☐	**j. Communication**
☐	**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	
	Used in Bed
☐	**a. Bed rail** (any type; e.g., full, half, one side)
☐	**b. Trunk restraint**
☐	**c. Limb restraint**
☐	**d. Other**
	Used in Chair or Out of Bed
☐	**e. Trunk restraint**
☐	**f. Limb restraint**
☐	**g. Chair prevents rising**
☐	**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): *"Do you want to talk to someone about the possibility of returning to the community?"*

Enter Code

0. **No**
1. **Yes**
9. **Resident unable to respond and family or significant other not available**

Q3. Resident's Overall Goals—complete only on admission assessment (A10a = 01)

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**

Section T Therapy Supplement for PPS

T1. Ordered Therapies

Enter Code

a. Has physician ordered any of the following therapies to begin in first 14 days of stay: physical therapy, occupational therapy, or speech pathology service?
0. **No**
1. **Yes**

Enter Number

b. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered

Enter Number

c. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered