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OPTOMETRIC CARE OF

NURSING HOME RESIDENTS

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OPTOMETRIC CARE OF NURSING HOME RESIDENTS

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FOREWORD

The "old-elderly" - those ages 85 and older - are the fastest growing segment of the population, increasing by 43 percent by the year 2010. The "old-elderly" are at the greatest risk of being in need of health care, social services, and caregiving by friends and family. They are also most likely to suffer from one or more of the major causes of visual impairment - cataracts, age-related macular degeneration, glaucoma, and diabetic retinopathy. While many persons in this group are in relatively good health, the solution for many "well-but-frail" elderly is to enter a nursing home. The demand for nursing home beds is expected to rise by 50 percent over the next 20 years.

Among nursing home residents, recent research indicates that approximately 3 percent have no vision and 25-48 percent are severely visually impaired.[1] The primary care optometrist has an increasingly important role in helping elderly individuals maintain independent life styles, thereby reducing their need for earlier institutionalization. The optometrist also has a professional responsibility to help enhance the quality of life for those who are institutionalized.

This Manual is designed to provide helpful information in regard to the evaluation of visual function and ocular health among individuals residing in nursing homes or other types of assisted living facilities. The goal of the Manual is to provide knowledge and understanding of the diagnostic and management elements needed for comprehensive evaluation and care of this growing and significantly neglected segment of the patient population. This Manual includes discussions of administrative and professional staffing, the role and clinical responsibilities of the optometric consultant, instrument and equipment needs, and nursing home records and forms, including coding and billing for services. Implicit

in this Manual is the patient care responsibilities for diagnosis and management of nursing home residents by the primary care optometrist. Indeed, geriatric optometry as represented in the care of the persons within nursing facilities provides the fullest realization of primary care services.

Alfred A. Rosenbloom, O.D., M.A.

I. DEMOGRAPHICS OF VISION CARE IN NURSING HOMES

Visual impairment represents one of the most common disabilities among nursing home residents.[2] It is also one of the most unrecognized disabilities by nursing home staffs.[2] One study found that visual impairment is 13-15 times more common among the nursing home population than among an age-matched ambulatory population.[1] Multiple studies have shown that few residents receive vision care after admission to a nursing home. Although some variability is seen from study to study, it can be estimated that 80 percent or more of all nursing home residents receive no vision care at any point after admission.[2] Vision and eye care currently are not mandated services within long term care facilities. Vision care is required to be provided by the nursing home at the request of the resident or family or if indicated by a change in status particularly in the presence of cognitive impairment. The current system of identifying residents in need of vision care services is inadequate.

Prevalence rates for virtually all eye diseases increase with age. Advanced age is a strong risk factor for nursing home placement, but the degree of eye disease among the nursing home population is far in excess of what would be predicted simply based upon age.[1] Virtually all nursing home residents will have at least one ocular pathology, and almost half will have two or more ocular pathological conditions. The most commonly identified ocular problem within the nursing home population is cataract. The prevalence rate of cataract varies considerably from study to study in this population with ranges from 35 percent to over 80 percent.[3] Age-related macular degeneration and glaucoma are also more common and found in excess of that in the ambulatory population.

Visual status is important in the overall function of residents. It has been demonstrated that performance of activities of daily living is highly correlated with vision level (i.e., vision better than 20/70) in the nursing home population.[2-4] Residents with low vision have been shown to have greater difficulty in transfer ability, washing the upper and lower body, and dressing than comparable residents without visual impairment. Newly visually impaired persons are known to undergo personality changes, which may

manifest as disengagement from activities, low self-esteem, depression, and high anxiety levels. In the presence of what is assumed to be adequate visual acuity, the nursing home staff may surmise that personality changes due to visual impairment are the result of mental status deterioration. In turn, the visually impaired resident may become increasingly dependent on staff for activities that can possibly be performed with the assistance of appropriate visual appliances or training. Dependence resulting from severe impairment of vision may contribute significantly to the cost of long term care.[5] Since it has been estimated that teaching a resident visual impairment adaptive skills for self feeding may reduce the annual institutionalized cost by more than $2,000,[5] alternative interventions may not only increase independence for the individual but also may reduce the financial burden on society.

II. OVERVIEW OF NURSING HOME FACILITIES

A. TYPES OF FACILITIES

There are three basic types of long term care facilities which exist in the United States: Skilled Nursing Facilities (SNF), Intermediate Care Facilities (ICF), and Adult Congregate Living Facilities (ACLF). These facilities are categorized based on the type and intensity of care they provide. References to "nursing homes" are almost always describing Skilled Nursing and Intermediate Care Facilities. Within this Manual, Long Term Care Facilities (LTCF) will refer to all three types of facilities.

1. **Skilled Nursing Facilities** - provide rehabilitative and restorative services under the direct supervision of an attending physician or medical director. Residents are typically admitted for additional recovery after a hospitalization for conditions such as hip fracture, fall, or stroke. The length of stay of this type of resident is expected to be relatively short. Residents in this type of facility are assumed to require 24-hour supervision, with the emphasis being on restorative and rehabilitative care provided by speech, occupational, or physical therapists.

2. **Intermediate Care Facilities** - provide a level of care somewhere in between that of the SNF and ACLF. The basic services generally consist of help with activities of daily living (e.g., toileting, feeding, grooming, etc.) and medication management. The distinction between skilled and intermediate care can be blurred. Skilled nursing and intermediate care typically coexist within the same nursing home, with certain numbers of beds allocated to each. It is not uncommon for a person to be admitted as a skilled nursing resident and then be shifted to intermediate care. Intermediate care residents are characterized by the deteriorating Alzheimer's patient who may remain a nursing facility resident for many years.

3. **Adult Congregate Living Facilities** - also known as Residential Care Facilities - provide limited services to their residents which may include dietary, housekeeping, social and recreational support, and limited medical monitoring (such as blood pressure checks). Residents of these facilities are typically high functioning seniors who have sought out the social and recreational interactions of group living. While nursing staff may be available at these facilities, the services they provide are limited. They may provide services such as arrangement of transportation and scheduling of medical visits.

Both SNFs and ICFs are subject to federal regulation under the Medicare Requirements for Long Term Care Facilities, Code of Federal Regulations Title 42, Chapter IV, Part 483. These regulations provide guidelines for operating standards for nursing homes which seek reimbursement through Medicare and Medicaid. The number of beds allocated for SNFs and ICFs is limited and regulated in each state. In some states this may be by certificate of need committees in the same way that hospital beds are regulated or by other regulatory mechanisms.

B. STATISTICS

As of 1995, there were approximately 16,000 nursing homes in the United States.[6] The majority of these nursing homes are small (under 100 beds) and are run as-for-profit institutions. There are between 1.5 and 2 million nursing home beds available in the United States. This is almost double the number of acute care hospital beds. The occupancy rate for nursing home beds is high, typically above 85 percent.[6] As the population in the United States ages, tremendous growth will be seen in the nursing home population. The number of nursing home beds is expected to more than double to greater than 5 million over the next 30 years.[6]

At any given point in time 5 percent of the population over the age of 65 resides in a nursing home. The nursing home population is, however, not static. Discharges to home and the acute care hospital, as well as

death, cause a continuous flux in the population. Due to this high turnover rate, the lifetime risk of nursing home placement is underestimated. Some studies have shown that the lifetime risk of a nursing home admission may be as high as 50 percent for those over the age of 65.[7] A number of risk factors for nursing home placement have been identified including: advanced age, dementia, cerebrovascular accident, urinary incontinence, falls and fall risk, and lack of social support.[8]

Nursing home residents can roughly be divided into two groups based on length of stay: those that reside longer than 6 months and those who stay less than 6 months.[8] The median length of time spent in nursing homes in the United States is approximately 6 months; however, about 21 percent stay more than 5 years.[5-8] Individuals who stay in the nursing home for relatively short lengths of time include those who are admitted with terminal disease and those who need rehabilitation or subacute (skilled nursing) care. Residents who stay more than 6 months can be broadly classified into three groups: those who are primarily cognitively impaired; those who are primarily physically impaired; and those who have both significant cognitive and physical impairment.

Nursing home care is paid for largely through two federal entitlement programs, Medicare and Medicaid. Medicare covers payments to nursing homes for the first 100 days of care after a hospital admission. After the first 100 days, the resident is then required to pay for services out-of-pocket. This period is referred to as the "spend down time." During this time, the life time savings of the resident is spent to pay for nursing home care. After a period of time, the resident's resources are exhausted, rendering him/her indigent and eligible for Medicaid. In terms of absolute dollars, the vast majority of nursing home care is paid for through the Medicaid program. Long term care, in fact, accounts for the largest percentage of Medicaid expenditures. Optometric services within nursing homes are covered under Medicare and Medicaid programs as they are for in-office services (See XIII. Coding and Billing).

C. ADMINISTRATIVE STAFFING

Federal regulations require that all nursing facilities seeking Medicare or Medicaid reimbursement have a governing body and employ certain defined personnel.[9] The governing body or those empowered to act as the governing body are legally responsible for setting and enacting the policies and procedures of the facility. These same regulations require facilities to employ an administrator, designated nursing staff, social services personnel, dietary staff, an activities director, medical director and staff, pharmacist, dentist, rehabilitation personnel, and housekeeping/maintenance personnel. The roles of key staff as described by federal regulations are outlined below. State and local agencies may place more stringent requirements on facilities. Some latitude is also granted to small and rural facilities in terms of staffing requirements in recognition of the difficulty in recruiting licensed personnel.

1. Nursing Home Administrator. The nursing home administrator is appointed by the governing body. Federal regulations require that a nursing home be supervised by an administrator licensed by the state. The administrator is charged with management of the facility. He/she is expected to administer the facility in a manner that allows each resident to maximize physical, mental and psychosocial well-being.

2. Director of Admissions. There is no separate federal designation for the position of director of admissions. This position frequently exists in nursing facilities to coordinate the large numbers of admissions, discharges, and beds being held for persons in the hospital. The director of nursing, a social worker, an assistant administrator, or other personnel associated with the nursing home may fill this position.

3. Director of Social Services. Each facility is required to provide medically-related social services to attain or maintain the highest practical physical, mental, and psychological well-being of the resident. Facilities with more than 120 beds are required to employ a full-time social worker. The broad mandate of the social worker may include activities such as coordinating eye care, maintaining contact with the

resident's family, coordinating health and medical decisions between staff and residents, and assisting the resident in obtaining legal or other services.

4. **Director of Nursing**. Each facility must have a registered nurse that serves as the director of nursing. The director of nursing acts largely in a supervisory capacity to ensure that the goals for each resident assessment and care plan are met. The director of nursing may serve as a charge nurse only in small facilities. Unlicensed nursing assistants provide much of the direct care to residents. Federal guidelines describe the type of care that may be provided and educational requirements for these positions.

5. **Director of Activities**. Each facility must employ a qualified professional to serve as director of the activities program. This may be a therapeutic recreation specialist, or, in some circumstances, an occupational therapist or occupational therapy assistant. The role of the activities director is to provide activities for the residents that help them achieve their highest possible level of function. These are based on the individual resident's preference and might include music, reading, and social gatherings.

6. **Medical Director**. Each facility must appoint a physician to serve as medical director. The medical director provides, directs, and coordinates medical care in the facility. Duties of the medical director include development of written rules and regulations and delineation of the responsibilities of attending physicians. Coordination of medical care includes liaison with attending physicians to ensure that physicians' orders are written promptly upon admission of a resident, that periodic evaluations of the adequacy and appropriateness of health professional and supportive staff and services are conducted, and that the medical needs of the residents are met.

D. PROFESSIONAL STAFFING

The federal requirements for Long Term Care Facilities also describe the types and roles of various health care professionals, who must be available to provide services to the residents. Brief descriptions of these professionals and the services they provide, as set forth in the federal regulations, are described below.

1. **Attending Physicians**. Each resident is under the supervision of a physician (M.D. or D.O.), selected by the resident or resident's guardian. That physician evaluates and monitors the resident's immediate and long-term needs and prescribes measures necessary for the health, safety, and welfare of the resident. The number of physicians at any facility may vary from one to many. Residents may be admitted and discharged only upon the direct order of a physician. A physician is required to evaluate the resident every 30 days for the first 90 days after admission and once every 60 days thereafter. When absent, an attending physician is required to make arrangements for the medical care of his/her residents. At the time of each visit, the physician reviews the resident's medications and other orders, reviews the plan of care required, and writes, dates, and signs a note on the resident's progress.

2. **Dental Consultant**. Facilities are required to provide routine and emergency dental care for their residents. Each nursing facility must retain a consultant dentist to meet this requirement. The frequency of required routine dental care is specified by state regulations.

Each nursing facility makes arrangements for dental care for residents who do not have a private dentist, including arrangements for transportation to and from the dentist's office. It also arranges for emergency dental care when a resident's attending dentist is unavailable.

3. **Pharmacy Consultant**. Each facility is required to retain the services of a consultant pharmacist. The pharmacist’s role is to establish record keeping and oversight monitoring for all medications and biologicals maintained and administered within the facility.

4. **Rehabilitation Consultants**. Each nursing facility either arranges or provides for specialized rehabilitative services as needed by the resident to improve and maintain functional abilities as outlined in the resident's care plan. Specialized services may include, but are not limited to, physical therapy, speech language therapy, occupational therapy, and mental health rehabilitation services.

5. **Other Consultants**. The services of a variety of other consultants may be needed within the nursing home such as optometry, podiatry, psychiatry, psychology, and physiatry (i.e., physical medicine). Optometry or other vision care services are not currently mandated for nursing home residents. Nursing homes are required to assist the resident in obtaining an examination if the resident or his or her family makes a request or if a visit is deemed medically necessary. (See IV. Access to Residents)

III. APPOINTMENTS TO NURSING HOME PROFESSIONAL STAFFS

A. OBTAINING AN APPOINTMENT

As with other areas of practice, determining the need for optometric services within local nursing homes is a logical starting point. Lists of nursing homes may be obtained from the state regulatory agency, the state nursing home association, the local area agency on aging, and the local hospitals. More recently, multidisciplinary groups, which supply doctors and other staff to nursing homes, have been formed. These groups typically consist of optometrists, podiatrists, physicians, and physical and occupational therapists among others. Determining if such groups are operating in the local area is also an avenue that can be explored.

Sending a letter to local nursing home administrators introducing yourself, your background, and letting them know of your interest in the area of vision care within long term care facilities is an appropriate starting point. The nursing home administrator is the chief administrative official within the nursing home and will ultimately make the decision as to whether optometric services will be provided in-house. In some rare cases a board of directors may need to approve appointments to nursing home staffs, similar to the system for hospital appointments. Credentialing may be required by some nursing homes as well.

Most nursing homes are delighted to have optometrists interested in providing care within the facility; however, if no contact is received from the nursing home, a follow-up phone call to arrange a face-to-face meeting should be the next step. At this meeting, services to be provided and general contractual arrangements can be discussed. Points of discussion should include who will be the administrative contact person(s) within the nursing home, how scheduling will be accomplished, what space is available for examinations, legal responsibilities of the provider (See IV. C. Governmental Regulations), and ophthalmic policy. The types of contractual arrangements can vary widely, from loosely patterned to more formal agreements requiring the services of an attorney. Once an agreement to proceed is reached, a

second meeting should be arranged to meet with other staff within the facility (e.g., the Medical Director, Director of Nursing, and Director of Social Services). Once the nursing home vision program is started, it is wise to periodically review the agreement with the nursing home and to meet with these key staff to discuss problems.

B. BENEFITS OF OBTAINING HOSPITAL PRIVILEGES

The advent of managed care has brought increases in the number of health care systems providing a continuum of services. In these systems, a single entity may be involved in ambulatory care, inpatient hospital services, home care, and long-term nursing care. In many instances, these systems revolve around the hospital as a focal point. Optometrists who are not members of the hospital staff may find it difficult to obtain privileges to see nursing home residents. Conversely, seeking privileges to see nursing home residents may be a valuable entree into the hospital and ambulatory care network.

Due to the unstable health status of many nursing home residents, hospital admissions with discharge back to the nursing home are not uncommon. These frequent admissions and discharges can make continuing care difficult. The optometrist should be alert to the fact that each new admission to the nursing home may result in a new chart being started. It is possible that during the course of multiple admissions and discharges that ophthalmic medications may be left off of physicians' orders. Obtaining privileges that allow optometrists to evaluate nursing home residents while in the hospital can alleviate this problem. **[A more complete reference and additional information can be found in the American Optometric Association's Optometric Hospital Privileges Manual (See Suggested Readings)].**

IV. ACCESS TO RESIDENTS

A. MEDICARE REQUIREMENTS AND ACCREDITATION FOR LONG TERM CARE FACILITIES

Nursing facilities are regulated by the federal government through rules and operating standards established by the Health Care Financing Administration (HCFA). In response to reports of widespread neglect and abuse in nursing homes, the Congress, in 1987, enacted legislation to reform nursing home regulations and require nursing homes participating in the Medicare and Medicaid programs to comply with certain requirements. This legislation, included in the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987), also known as the Nursing Home Reform Act, specifies that a nursing home "must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care..."[10]

These rules and operating standards were established to protect the rights of the residents living in nursing facilities and to guarantee the availability of a minimum level of services to meet their health and psychosocial needs. Nursing facilities must comply with the requirements of the federal government in order to be certified and to receive payment under the Medicare and Medicaid entitlement programs.

A standard survey of nursing facilities, performed on a yearly basis, assures the public that the Life Safety Code Requirements and Resident Care Requirements are being met. The survey is a resident-centered, outcome-oriented inspection and assesses the following areas:

- The facility's compliance with residents' rights
- The accuracy of the residents' comprehensive assessments and the adequacy of care plans based on these assessments

- The quality of services furnished as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutritional services, activities and social participation, sanitation, infection control, and the physical environment.

The Resident Care Requirements for Long Term Care Facilities experienced major revisions in 1989, 1991, and 1994.

In addition to federal laws regulating the quality of care in nursing homes, most states have enacted laws prescribing licensure requirements for nursing facilities in their state. In many states, the state licensing body acts as the federal government's agent in determining whether a facility has met the federal (and state) requirements for Medicare/Medicaid certification. For Medicare/Medicaid purposes, the state laws must be at least as stringent as the federal laws. Some states have adopted laws that are stricter than the federal laws. As an example, California nursing home care and services are regulated under Title 22 of the California Code of Regulations.

At this time, nursing facilities are not specifically mandated to provide routine or emergency vision and eye health services to their residents. Since vision and eye health care is not a required service in nursing facilities, the addition of an eye care program helps to improve the quality of care provided to the residents, and, as an added benefit, may positively impact the outcome of the nursing facility's annual survey. Nursing facilities are required to assist residents in obtaining eye care if they or their family makes a request for such services or in the case that services are triggered through the Minimum Data Set (MDS)/Resident Assessment Protocol (RAP) system. (See IV. B. Resident Assessment, Care Plan, and the Minimum Data Set) (See Appendix)

B. RESIDENT ASSESSMENT, CARE PLAN, AND THE MINIMUM DATA SET

During the 1980's as the population of citizens residing in nursing facilities increased so did concerns over the quality of care being delivered. The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) mandated a national assessment system for evaluating all residents in nursing facilities in the United States. Each resident admitted to a facility is required to be evaluated using a Resident Assessment Inventory (RAI). The MDS and RAP and triggers are required by federal law to be components of the RAI. States may add other assessment tools or more in-depth data to be collected. Federal statutes also require facilities to screen for mental illness and mental retardation as a part of the initial evaluation at the time of admission. The Preadmission Screening and Routine Review (PASARR) of mental illness along with the MDS and RAP compose a common RAI battery.

When mandating use of the RAI for nursing facilities, legislators recognized the need for uniformity among the data to be collected so that care practices could be monitored. The MDS was developed to meet this requirement.[11] (See Appendix) The MDS, now in its second revision, is a multidimensional tool that evaluates a wide range of areas including medical, cognitive, and social-behavioral status. The MDS was designed to give structure and uniformity to the evaluation of long term care residents and has been used as the national assessment model since 1991.

The purpose of the MDS is two-fold: (1) it is a gross assessment of functional status and, more importantly, (2) it serves as the basis by which specific intervention protocols are triggered. It is in relation to the second objective that the MDS can be thought of as a functional assessment tool being used as an indicator of clinical status, rather than the more typical situation where clinical status is used as a proxy of functional status. It includes a section on Vision Patterns that evaluates three areas the designers of the MDS have termed: Vision, Visual Limitations/Difficulties, and Visual Appliances. (See Section D of the MDS in the Appendix)

The Vision subsection categorizes visual acuity (VA) into one of four levels based on reading criteria. Descriptors directly from the MDS are as follows:

- Grade 0-adequate, sees fine detail and reads newspaper size print
- Grade 1-impaired, sees newspaper headlines but not regular print in newspapers
- Grade 2-highly impaired, limited vision, not able to see newspaper headlines but appears to follow objects
- Grade 3-severely impaired, no vision or appears to see only lights, shapes, or colors.

Visual Limitation and Difficulties are divided into three categories:

a) Side vision impaired, bumps into objects or has difficulty seeing objects to the side

b) Flashes and/or floaters present or halos around lights

c) None of the above.

Visual Appliances subsection evaluates whether prosthetic devices such as spectacles, contact lenses, or low vision devices are present. The subsection is assessed as: (1) yes or (2) no. As an example, the MDS assessment of someone with adequate visual acuity, no visual field deficit, and wearing glasses would be 0/c/1. That is, "O" indicates adequate visual acuity; "c" indicates no visual limitations and difficulties; and "1" indicates that a prosthetic device is present.

The MDS assessment is required to be completed within 14 days of admission to the facility. It is typically generated through nursing home staff meetings and preadmission sessions with family and staff. Social workers, nursing staff, the activity director, and dietary staff usually attend these meetings. The MDS is intended to be a measure of the resident's status during the past 7 days. The actual plan of care for the resident is developed as a result of the MDS assessment and must be completed within 7 days after the MDS assessment. Understanding the roles of the MDS, RAP, and care plan is crucial in understanding

how care is delivered to a nursing home resident. All care to a particular resident is directed to addressing deficiencies or problems detected within the MDS and RAP system. Changes or deficiencies in the MDS trigger specific interventions that are to be addressed through the care plan. Timetables are laid out for addressing problems noted. The RAP (See Appendix) details specific courses of action for each assessed problem indicated by the MDS. The RAP serves as a crucial bridge between the problems and needs identified by the MDS and the actual plans for care that are developed. In the case of vision, one RAP intervention is a call for professional evaluation by an optometrist or ophthalmologist. Vision care services are not currently mandated in long term care facilities. Unless a deficiency is documented on the MDS or triggered through RAP, residents are not required to receive any vision care services. This makes the MDS assessment of visual status **crucial** in initiating vision care. The MDS is updated yearly, with significant changes in status, or with discharge and readmission. Optometrists can be immensely helpful to nursing facility staff and residents by reviewing and addressing shortcomings in MDS evaluation and care plans for vision. (See Appendix)

C. GOVERNMENTAL REGULATIONS AND REIMBURSEMENT

Access may be the most challenging and important component of providing care to nursing facility residents. Failure to follow regulations can result in fines, penalties, and possible sanctions against those participating in government programs. It is the provider's responsibility to research and understand Medicare/Medical Assistance (Medicaid) policies and to be certain that the optometrist and optometrist's employees are following them. Described below are general concepts regarding government compliance issues. Each state and carrier may have specific rules and regulations unique to that area. Optometrists should research and read all provider manuals and contact their local state association and Medicare/Medical Assistance carriers for specific local policies.

Several different individuals or processes may identify a resident’s need for optometric services. These include requests from the director of nursing or social services, the attending physician, the resident or

family themselves, through the MDS assessment process, through a pharmacy request for consultation, or as a referral from a visual screening. While identifying the need for optometric services and obtaining authorization to examine the resident is the first step, following the correct protocols for reimbursement is equally important. Recent interpretations of federal statutes by regional Medicare carriers have made it incumbent upon optometrists to understand the role of the attending physician in approving eye care services. As outlined below the attending physician clearly plays a key role in assuring that optometric services are indicated and therefore covered by third party payors. Interpretation of these guidelines may also cover the ability to access residents even when third party payors are not involved. Individual Medicare carriers are responsible for applying these guidelines to providers in their area. The importance of knowing local third party payor regulations for access to residents and requirements for reimbursement cannot be over emphasized. Many residents have Medicare coverage and, just as in the office, Medicare requires a symptom or complaint for the visit to be covered. Refractions and screenings are noncovered services under the Medicare program.

Each state may have different rules and benefits that cover Medicaid recipients. Some states allow "routine" examinations and eyeglasses, while other states may have less generous benefits. Recipients that are covered by ERISA plans or indemnity plans will have quite different coverages. Health maintenance organizations (HMOs) may have even more specific guidelines and include restrictions such as using a gatekeeper. The provider must be familiar with all plans for which services are provided and be certain to remain in compliance with all of their rules and regulations.

Medicare, a federal program that is administered by state or regional carriers, will be the primary insurance for most nursing facility residents. Although federal statute governs the Medicare program, each carrier may administer the program in slightly different ways. An example of this is a requirement by some carriers that mandates that the resident's primary care physician must first evaluate the resident and issue a written order for a specific optometric service prior to an optometrist being able to see the resident and seek

reimbursement for those services. The following are examples of reimbursement mechanisms or policies which carriers may apply.

- The carrier will not provide reimbursement for a service or procedure unless:

    1. The resident's attending physician or nurse practitioner evaluates the resident and authorizes the order for the service or procedure.

    2. The resident's attending physician or nurse practitioner evaluates the resident and authorizes the referral to another practitioner.

    3. A named physician, whose attendance is requested only by the resident or the resident's interested family member or legal guardian, evaluates the resident and authorizes the order for the services or procedure. The attending physician must be notified of any change in the resident’s physical, mental or psychosocial status, or of the need to alter the resident's treatment significantly.

- Standing or "prn" orders DO NOT establish medical necessity.

- Documentation of the attending physician's order for the clinical problem requiring consultation in the nursing home record, as well as accurate optometric record documentation, is critical in complying with these policies.[12]

V. THE TRADITIONAL ROLE OF THE ATTENDING PHYSICIAN

A. COORDINATOR OF RESIDENT'S HEALTH CARE

Health care delivered to a nursing facility resident is under the direction of the attending physician. Medicare Part B guidelines state that a facility must ensure that the medical care of each resident is supervised by a physician and that physician's visits must take into account the resident's total program of care, including medications and treatments.[10] The primary physician retains the overall responsibility for the coordination and direction of the resident's care. In order for an optometrist who provides services to a resident to obtain Medicare or Medicaid reimbursement for those services, the resident's physician must first have a written order for those services. The attending physician not only performs periodic examinations and assessments of the resident but also coordinates the entire care of the individual. If physical therapy, blood tests, or an eye examination is needed, the attending physician must authorize the service through the issuing of a physician order.

B. PROVIDER OF EYE HEALTH CARE

There may be some overlapping of eye care services between the primary care physician and the optometrist in the nursing facility, just as there is in clinical practice. For example, if a resident presents with conjunctivitis and the primary care physician is comfortable in managing it, an order for optometric services may not be written. If, however, the physician is not available to diagnose the condition, or wishes to have an optometrist examine and treat the resident, it is the physician who has the ultimate authority to write the order for optometric services to be performed. Even though the optometrist may have treated the resident previously, the optometrist has no authority to examine the resident and obtain reimbursement unless a specific order has been written by the attending physician. Close communication between the nursing facility staff, nurses, attending physicians, and optometrist is essential for this system to work effectively and in the resident's best interest.

VI. THE ROLE OF THE OPTOMETRIST

A. OPTOMETRIC CONSULTANT TO THE NURSING HOME FACILITY

The role played as an optometric consultant in a nursing facility can be as creative and unique as one desires. In the role of consultant, the optometrist may be asked to assist the nursing home in developing policies or to provide suggestions on ways to improve the function of residents other than providing examinations. Optometrists certainly provide eye care services to the residents, but many other areas of optometric expertise may be needed. Who better to consult regarding floor coverings or wall color selection to enhance visual discrimination and reduce glare effects than the optometrist. Can falls be reduced, resident mobility be improved, and reading enhanced with a change in the facility lighting? How much lighting is optimal for residents and staff? A discussion of computer workstation design may be helpful. Are there large print materials including talking books and magnification devices available for the residents' use? The facility may need an eye safety workplace evaluation and a safety vision program started. How about organizing a health fair for the staff, residents, and families? Many facilities have newsletters that go to not only the residents but their families as well. Timely articles about eye care issues would be most welcomed by the newsletter editor.

As a consultant, the optometrist may be asked to present lectures or inservice training sessions to staff or to residents and their families. Topics of interest might include the aging eye, low vision care, diabetic retinopathy, macular degeneration, cataracts, and glaucoma. Nursing staff members may benefit from a presentation on dry eye, how to instill eye drops, how to correctly administer hot packs or lid scrubs, or how to recognize common subjective symptoms of common eye problems or eye emergencies. Advice may be requested to design the best way to administer the eye portion of the MDS and assess the accuracy of the assessment. What other factors should the nursing staff consider in making appropriate referrals for optometric care? Residents with diabetes should have annual dilated exams. Residents with glaucoma

need follow-up and medications reviewed periodically. Residents on long-term steroids need examinations to detect glaucoma and cataracts.

B. PROVIDER OF EYE HEALTH AND VISION CARE SERVICES

Optometric provision of eye care services is certainly an important facet of the optometric consultant's role. Studies suggest that nearly 80 percent of nursing home residents never receive eye care once they enter a nursing home.[3] If optometric services are available within the facility, this number can be dramatically reduced. Although it takes time and effort to transport optometric equipment to the facility, the benefits are tremendous to both the resident and optometrist. Comprehensive examinations or problem-oriented visits can be performed with modern portable equipment. (See X. Instruments and Equipment.) Eyeglasses can be provided when appropriate; however, most optometrists find optical services and dispensing to be a small portion of a nursing home practice. Utilization of optometric assistants is critical to efficiency in delivering care to nursing facility residents. From assisting in the examination to frame selection and dispensing services, optometric assistants play a very valuable role.

VII. THE OPTOMETRIC CONSULTANT'S CLINICAL RESPONSIBILITIES

A. ASSESSMENT OF NEW ADMISSIONS

Newly admitted residents to a nursing facility need to be identified as to their needs for eye care services and whom they want to perform those services. The nursing facility may require the optometrist's assistance in defining the process the facility will use first to identify when a resident needs an optometric examination, and then how he/she will receive it. Some nursing facilities may utilize a form asking the resident or his or her family to either select the in-house consultant as their eye doctor or to specifically name someone else. The form may also identify when the resident last had an examination, if one is needed immediately, or at what later point in time one may be needed.

As discussed in Section VII, federal law requires that each new resident have a resident comprehensive assessment completed upon admission. The MDS section regarding visual problems will help identify who has reduced visual acuity or peripheral vision problems. A recent study, however, found that only 34 percent of these MDS evaluations actually were valid when compared to the results of an examination.[13] The MDS does not trigger an optometric referral for other important criteria such as glaucoma follow-up, diabetes, high-risk medicines (e.g., corticosteroids), or previously diagnosed ocular diseases such as macular degeneration or cataract or the presence of an intraocular lens implant. The consultant needs to make the nursing facility staff aware of the limitations in the MDS and also assist them in properly administering the visual section of the MDS.

B. REASSESSMENT OF ESTABLISHED RESIDENTS

Once a system has been established to identify a new resident's need for optometric care, one must develop a system to assure appropriate follow-up care. The optometrist needs to assist the nursing facility in addressing the mechanisms to identify residents in need of follow-up. Will the optometrist provide the

recall of residents or is it the responsibility of the facility? Perhaps a system that provides checks and balances itself is desirable. The optometrist may want to indicate in the resident's progress notes when he or she should be examined again. Be certain as to which nursing facility staff person is responsible for tracking this information and scheduling the next appointment. It may be advantageous to track the resident through an optometric recall system, keeping in mind that all visits are ordered by the attending physician and re-evaluation of residents is solely at the discretion of the attending physician.

The optometric consultant will want to make emergency care personally available or through another source. Be certain that this has been discussed with the facility and that a plan has been established. Also, discuss with the appropriate nursing personnel what constitutes an eye emergency and what requires prompt but not immediate care. The optometrist should be available 24 hours a day.

C. MANAGEMENT OF EYE HEALTH AND VISION CONDITIONS

Management of eye health and vision conditions is an integral part of consultation responsibilities. Seventy-two to eighty-four percent of nursing facility residents have been found to have cataracts, 25-37 percent have macular degeneration, and 6-15 percent have glaucoma.[1,14] The prevalence of dry eye, conjunctivitis, and blepharitis is quite high as well. A nursing home practice may grow into quite a challenging and satisfying primary care practice because of the prevalence of eye disease in this unique population.

Refractive error, of course, is extremely common in nursing home residents. In the over 50 age group, nearly all residents will be presbyopic. Myopia, hyperopia, and astigmatism are quite common in all age groups. Proper correction can improve the visual acuities significantly. Studies have found that 20-40 percent of residents showed marked improvement in visual acuities after a complete eye examination.[1,15] The optometric consultant is responsible for providing refractive and dispensing services or for arranging

for them. The simple service of routine adjustment of eyeglasses is welcomed by both the staff and the residents. It is important to have this service available.

D. COMANAGEMENT OF SURGICAL EYE CARE

Primary eye care services include the provision of postoperative care to residents. Nursing home residents will require these important services just as clinic-based patients do. With proper portable equipment these important services can be provided to residents without transporting them to the optometrist's office or the office of the surgeon. Postoperative care of residents after cataract extraction requires objective assessment of the cornea, anterior chamber, conjunctiva, the implant, the vitreous, retina, and intraocular pressure. This along with a detailed case history, visual acuity measurement, and review of medicines constitutes a postoperative visit. These services are convenient and cost effective if they can be provided within the facility. The postoperative course of YAG capsulotomies, laser photocoagulation, and glaucoma surgeries, among others, can be followed as well.

E. SUPERVISION OF OPTICAL SERVICES

The vast majority of nursing home residents will not have had a vision examination for a number of years. Studies have estimated that visual impairment can be significantly reduced by the provision of appropriate optical devices.[1,15-16] Eyeglasses represent the majority of optical prescribing needs within the nursing home. The majority of nursing home residents will be dually covered under both Medicare and Medicaid. Many state Medicaid programs have provisions for eyeglasses. Therefore, it is important to understand the provisions for eyeglasses under the individual state Medicaid program. If the resident is not covered under the Medicaid program for eyeglasses, the family or guardian should be informed regarding the resident's need for eyeglasses. It is often helpful if the family or guardian is approached through a familiar nursing home contact such as the social worker. The social worker is often more familiar with the level of family support for the resident than any other individual and can be an invaluable contact in working with the

family. Once spectacles are prescribed, making sure that the spectacles stay with and are used by the resident is a challenge. Lost glasses are an extremely common nursing home problem. All spectacles provided to nursing home residents should be etched or labeled in some way for identification.

Contact lenses within the nursing facility present a unique challenge. Aphakia or penetrating keratoplasty probably represent the most common conditions requiring contact lenses. The cognitive ability of the resident and his or her manual dexterity to handle and care for the lenses are key factors. If the resident is unable to care for lenses, nursing staff will need to be trained for the task. It is helpful if a contact lens-wearing staff member can be identified.

Visual impairment is extremely common in the nursing home population and many nursing home residents may benefit from low vision devices and/or environmental modifications. Again, the cognitive and physical abilities of the nursing home resident to use low vision devices need to be evaluated.

It is important early on in the negotiations to assist the nursing facility in setting an ophthalmic materials policy. Points to be considered include: what is the emergency and urgency policy; what to do in case of lost or broken spectacles and frame repairs; and the expected length of time for ordering and delivering materials. Setting these policies early can avoid the frustration of receiving an emergency call only to find out that a screw is missing from a frame. It is extremely helpful to train one of the contact persons in the nursing home to make simple repairs on spectacles.

VIII. THE OPTOMETRIC CONSULTANT'S RESPONSIBILITIES IN THE RESTORATIVE CARE PROGRAM

A. OPTOMETRY AND THE REHABILITATION TEAM

One of the important but frequently overlooked aspects of nursing home care is rehabilitation. Patients are frequently admitted to nursing homes for rehabilitation after acute care hospitalizations. These rehabilitation stays can be related to conditions such as injurious falls resulting in hip fractures and cerebrovascular accidents. Rehabilitation may involve many disciplines including occupational, physical, and speech therapists. The optometrist, as the vision consultant for the rehabilitation team, may be called upon to evaluate and make recommendations for vision rehabilitation, document the cause and nature of the vision loss, certify residents as legally blind, make recommendations for visual impairment precautions, provide recommendations to reduce falls, and conduct vision rehabilitation for residents with impairments due to stroke. The optometrist should coordinate treatment recommendations with the resident's physician and therapists. Good communication with the rehabilitation team is imperative for quality patient care.

B. ESTABLISHING A LOW VISION REHABILITATION PROGRAM

Low vision care is an essential component of a comprehensive rehabilitation program. A functional, problem-specific approach is recommended. As with most aspects of nursing home care, the level of cognitive ability of each individual is frequently the limiting factor in the type and complexity of low vision care. A suggested list of low vision devices is found in the Instruments and Equipment section of this Manual. (See pages 22-24.)

IX. ETHICAL ISSUES IN NURSING HOME CARE

As with any aspect of professional care, the optometrist who provides services within nursing homes is expected to display the highest degree of professional conduct and regard for the overall welfare of his or her patients. Nursing home care can present a number of ethical issues in the evaluation of residents, provision of spectacles, and decisions not to treat or provide interventions. The optometrist is expected to evaluate nursing home residents only as requested by attending physicians, to follow all rules of examination and documentation set by governmental and third party agencies, and to bill charges only as appropriate.

Given the level of under utilization of eye care in nursing homes, it might be expected that provision of spectacles would constitute a large portion of nursing home practice. Decisions to prescribe spectacles or to recommend cataract surgery should be tempered by ethical decision making in regard to how beneficial the intervention is likely to be. Residents who are terminally ill or in a persistent vegetative state also represent a unique challenge. The optometrist should assist residents and their families in carefully weighing the benefits and burdens of intervening or not intervening for these individuals. Decisions regarding highly debilitated residents in nursing homes are frequently not clear cut. Seeking input from other professionals within the nursing home, family members, and the resident himself or through the resident's advanced directives can make the process easier. Residents have the legal right and should participate in treatment decisions to the extent that they are able. Foremost in the evaluation of each individual should be the question, **"Am I improving this resident's quality of life?"**

X. INSTRUMENTS AND EQUIPMENT

A. BASIC INSTRUMENTS AND EQUIPMENT FOR NURSING HOME PRACTICE

The key issue in determining the type of equipment needed for a nursing home examination is whether an examining room will be set up in the facility or not. This will depend upon a variety of factors including the size of the facility, frequency of optometry visits, available space, and the type of residents to be seen. Many nursing home patients will be seen in wheelchairs, geri-chairs, or in their own beds, making the setting up of a lane impractical. More often than not the optometrist will be called on to do evaluations in space allocated for another purpose. Spaces may include areas such as dining halls, recreation rooms, offices, beauty parlors, and dental examination areas. Under such circumstances, flexibility is the key. This usually means bringing portable equipment from the optometrist's office to the nursing home. The equipment needed is essentially the same as required for providing hospital or other out-of-office services. A variety of hand-held equipment is now available including lensometers, tonometers, slit lamps, autorefractors, and binocular indirect ophthalmoscopes. A list of possible equipment needed for nursing home service is found below. It is best to remember the golden rule of out-of-office care: "if you think you might need it, bring it with you."

Suggested Equipment for Out-of-Office Examinations:

Distance visual acuity charts (including low vision charts)

Near visual acuity charts

Standard hand-held equipment (occluder paddle, fixation targets, penlights, etc.)

Retinoscope

Retinoscopy lens rack

Refracting instrumentation (trial frame and lenses, Halberg clips, Jackson cross cylinder, Perlstein flip cylinder, etc.)

Direct ophthalmoscope

Binocular indirect ophthalmoscope

Condensing lenses

Hand-held slit lamp

Hand-held tonometer

Hand-held lensometer

Pharmaceutical agents

Small surgical kit (cilia forceps, lid speculum, etc.)

Frames for selection and dispensing/adjusting/repair equipment

Black out drapes, extension cords, outlet adapters

B. OTHER INSTRUMENTS AND EQUIPMENT

Amsler grid

Color vision test

Hand-held autorefractor

Hand-held keratometer

Hand-held fundus camera

Foreign body removal kit

Interferometer

Exophthalmometer

Suggested Low Vision Equipment*

NOTE: This would be a starting list of recommended devices. Depending on the setting, you might need a more extensive inventory, or a much less extensive inventory. The goal is to have an adequate assortment of the various categories of devices, without being "overloaded."

Trial lens and frame set (the most important piece of testing equipment)

Prism readers

Binocular microscopes: +12, +16, +20, 6X (+24), 8X (+32), 10X (+40)

Hand-held magnifiers (illuminated or non-illuminated)

+5

+7

+8 large lens

+8 small lens

+12 large lens

+12 small lens

+16

+20

+24

+32

+40

Stand magnifiers

Plano-convex ("dome") magnifier

Non-illuminated: 3X, 4X, 8X, 10X

Illuminated: 3X, 4X, 5X, 6X, 10X

Illuminated handles: regular bulb, halogen bulb

Telescopes

2.5X clip-on

2.5X head-mounted

4X hand-held

4X head-mounted

Fitover sunfilters

Medium gray

Dark gray

Medium amber

Yellow

Floor lamp - incandescent - gooseneck style

Lap desk

Non-optical devices (e.g., typoscopes, talking watch, signature guide, felt tip pen, bold lined paper)

*** This list was produced by Roy Cole, O.D., Paul Freeman, O.D., and Jay Cohen, O.D.**

XI. THE NURSING HOME RESIDENT EVALUATION

The approach to a nursing home resident evaluation must be one of flexibility. The examination of the nursing home resident who is primarily physically disabled may be no different than the examination of any other older adult. The evaluation of the cognitively impaired resident requires much the same approach as the evaluation of the very young pediatric patient (i.e., getting the most important information in the least time possible). Cognitively impaired residents will have good and bad days. If the exam is on a bad day, pressing the issue and agitating both the optometrist and the resident are counterproductive. Reschedule, and, if necessary, request that the resident be sedated prior to the visit.

Goals to consider should be:

1. Update the nursing home staff on the functional status of the resident, keeping in mind that statements such as "compound myopic astigmatism" is going to mean little to the staff. Chart notes that will be meaningful to the staff such as "will benefit from spectacles, needs to wear full time."

2. Review the resident's MDS to make sure the visual status is accurate and, if not, suggest modifications. Review the care plan for vision and suggest modifications based on examination findings.

3. Identify if vision can be improved with optical devices and, equally important, if optical devices are justified given the resident's cognitive status. (See IX. Ethical Issues in Nursing Home Care)

4. Treat active eye disease as far as is feasible on site and within the scope of optometric licensure.

5. Identify and ameliorate ocular inflammation and pain.

The following is a suggested examination protocol:

- History, predominantly from medical chart including all pertinent medical history categories (subjective history of present illness should be taken within the resident's capacity to respond)
- Visual acuity
- Cover test, pupils, extraocular motility (if possible), near point of convergence
- Anterior segment assessment
- Intraocular pressures
- Pupillary dilation
- Dry or wet retinoscopy
- Refraction
- Visual field assessment
- Posterior segment assessment
- Charting

XII. NURSING HOME RECORDS AND FORMS

A. NURSING HOME RECORDS

Records of nursing home residents are typically maintained in top or side bound plastic-ring file folders. They will be found at nursing stations throughout the facility. The resident's name, room number, and ID are usually found on the end section of the folder. The top cover of the folder will list any alerts associated with the resident. These alerts might include: name alert (two persons on the same ward with same/similar names); specific drug allergy alert; infectious disease alert (TB, Hepatitis A, HIV positive); or infection control precautions (methacillin resistant staph aureus).

The nursing home record is divided into numerous sections. All appropriate sections should be reviewed prior to the evaluation of the resident so that the current status may be determined. The record typically will include the following sections:

1. **Demographic Data**. This section includes typical identifying information in addition to insurance information.

2. **Admitting History**. This section will include the initial physical evaluation (why the resident was admitted), and his or her previous medical history. It will often contain information on hospitalizations prior to admission, particularly if the nursing home and hospital are in an affiliated network.

3. **Advanced Directives**. This section will include information on issues such as code status (full code vs. no code), designated types of care procedures to be done (e.g., no artificial ventilation, no heroic measures, no elective surgery). It is important to be aware of the code status in the unlikely event of a cardiac arrest during the course of an optometric examination.

4. **Care Plan/MDS/RAP**. Contains the MDS document(s) and any care plan generated by the MDS/RAP process. This is a critical part of the chart to review.

5. **Physician Orders**. This section is essentially the prescription pad within the record. Medications being ordered, requests for laboratory and other tests, dietary, and other action items (e.g., needs dilated eye exam) will be charted in this section. Medications administered to the resident will be listed in this section and may be different from those in the admitting history. Physicians' orders are frequently preprinted with updates handwritten. Physicians' orders are typically reviewed every 1-3 months to assure that medications to be taken on a limited time basis are not administered inappropriately.

6. **Physician's Progress Notes**. This section contains the attending physician's examination notes for the resident. Many facilities may request the optometrist's charting be done in this section of the chart.

7. **Nursing Notes**. This section contains the nurses' charting of their interactions with the resident. It will often include information on when new complaints were first noticed by nursing staff (e.g., resident has red eye, complains of blurred vision).

8. **Laboratory**. This section will contain reports generated by laboratory testing.

9. **Social Service**. This section contains the social worker's evaluations of the resident's interactions with staff, other residents, and family members.

10. **Consultations**. This section will contain notes from examinations done by nonstaff physicians. Specialty evaluations done in physicians' offices (e.g., optometry and ophthalmology) will often appear in this section.

Charting procedures can vary somewhat from nursing home to nursing home. It may be helpful to discuss charting issues with the medical records department shortly after getting approval to see nursing home residents. In most cases, the optometrist will chart within the progress notes or consultation section.

B. FORMS

Nursing homes may have specific preprinted consultation forms that are to be filled out and placed within the consultation section of the record. In other cases, a physician's progress note page of the record can be used. Notes from the examination or procedure performed must be kept in the resident's record. A copy of the examination form should be retained for files in the optometrist's office. Many facilities have two-sheet, auto-carbon consult forms which can alleviate the need for making photocopy duplicates.

An examination finding, request for action (e.g., resident needs a laboratory test), or a procedure performed that needs immediate attention should follow nursing facility procedure for identifying records requiring urgent action. One common way this is done is by folding the examination form so that a portion sticks out of the medical record. The charge nurse, unit secretary, or medical records personnel can give specific procedures used within the facility.

If medications are to be ordered, the optometrist should chart this in the physician's orders section. Again, this should be charted so that it is brought to the nurse's and attending physician's attention.

XIII. CODING AND BILLING

Reimbursement for optometric care begins with proper coding of procedures and services and proper coding of the diagnosis. The basis for service coding is the Physicians' Current Procedural Terminology (CPT) of the American Medical Association. The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is the basis of diagnosis coding. Individuals should familiarize themselves with these publications in their entirety before beginning to use them. The explanations that follow are intended to explain specific nursing facility coding issues. Please refer to copies of CPT and ICD-9-CM manuals for a complete explanation of these coding systems. [*12]

A. EVALUATION AND MANAGEMENT (E/M) SERVICES

Subsequent Nursing Facility Care Evaluation and Management (E/M) Service codes may be used for services rendered by optometrists in a nursing facility setting. These codes provide a classification system based on the key components of history, examination, and medical decision making. Additionally, counseling, coordination of care, and the nature of the presenting problem are contributory factors in selecting the appropriate E/M level of care. The final component, time, is considered as the key component only when counseling and/or coordination of care involves more than 50 percent of the optometrist/resident encounter. Nursing Facility E/M codes are classified in three levels of care, with the appropriate classification dependent on very specific criteria involving history, examination, and medical decision making. The record must document these components to justify the code selection.

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* Coding is constantly changing and is subject to local variations and modifications. Please refer to specific carrier policies and current year coding manuals for specifics to your practice. Proper record keeping procedures must be followed to document utilization of selected codes.

Proper identification of place of service, dates of service, and referring physician UPIN numbers must accompany the claim for proper reimbursement.

Comprehensive Nursing Facility Assessments E/M codes may not be used by optometrists. These codes are reserved for the admitting physician. Office or Other Outpatient Service E/M codes are not to be used if services are performed in the nursing facility itself.

E/M codes for nursing facility practice include nursing facility inpatient services and consultations (Table 1).[17]

Table 1
EVALUATION AND MANAGEMENT SERVICE CODES

Category of Service	CPT Code
Nursing Facility Services	
Subsequent Nursing Facility Care, New or Established Patient	99311-99313
Consultations	
Initial Inpatient Consultations	99251-99255
Follow-up Inpatient Consultations	99261-99263
Confirmatory Consultations	99271-99275

Consultations are services provided by an optometrist whose opinion or advice regarding a specific problem is requested by a physician or appropriate source. The request must be documented in the resident's medical record. The consultant's opinion and any services ordered or performed must also be documented in the medical record and communicated to the requesting physician. When billing

consultation codes, you must have documentation in the resident's record that all qualifying criteria have been met.

Five levels of care are recognized in the initial inpatient consultations subcategory and three levels of care are recognized in the follow-up inpatient consultations subcategory. Consultation codes are subject to intense scrutiny by local Medicare claims processing companies. Optometrists should take special care to assure that all necessary documentation for the use of consultation codes is being met. It is advisable to seek explicit clarification of when these codes are appropriate from your carrier.

Confirmatory consultations are used to report services provided to residents when the consulting optometrist is aware of the confirmatory nature of the opinion sought (e.g., a second opinion confirming a cataract). Confirmatory consultations may be provided in any setting including the nursing facility. Five levels of care are recognized in this subcategory.

B. OPHTHALMOLOGICAL SERVICES

General Ophthalmological Services codes are also appropriate codes for reporting services provided in long term care facilities. Place of service, of course, must be identified. Special Ophthalmological Services codes (e.g., refraction, gonioscopy, visual fields, serial tonometry services/procedures) may be used, subject to the rules associated with CPT and, for Medicare, the correct Coding Initiative. Ophthalmoscopy, other specialized services, contact lens and spectacle services, and appropriate surgical codes may also be used (Table 2).[12] A complete listing of these services may be found in the CPT manual and in Codes for Optometry (published by the American Optometric Association) which includes the CPT minibook containing codes for ophthalmology.

Table 2

OPHTHALMOLOGICAL SERVICES

Service	**CPT Code**
General Ophthalmological Services	
Intermediate, new patient	92002
Intermediate, established patient	92012
Comprehensive, new patient	92004
Comprehensive, established patient	92014
Special Ophthalmological Services	92015-92140
Ophthalmoscopy	92225-92260
Other Specialized Services	92265-92287
Contact Lens Services	92310-92326
Ocular Prosthetics	92330-92335
Spectacle Services	92340-92371
Supply of Materials	92390-92396
Unlisted Ophthalmological Service or Procedure	92499

The appropriate fee is determined by each individual optometrist. Actual reimbursement, of course, is determined by each individual third party payor. This may vary from payor to payor and from region to region. Relative value units (RVUs) are specific to services. Table 3 contains RVUs for some commonly performed nursing facility services.[12,17] The RVU can be multiplied by a specific dollar amount (i.e., conversion factor) to set an appropriate fee level or to determine a reimbursement amount.

Table 3

RELATIVE VALUE UNITS FOR NURSING FACILITY SERVICES
(* EXAMPLE)

CPT E/M Codes	**RVUs**
Subsequent Nursing Facility Care	
99311	0.97
99312	1.44
99313	1.92
Initial Inpatient Consultation	
99251	1.41
99252	2.17
99253	2.87
Follow-up Inpatient Consultations	
99261	0.78
99262	1.35
99263	1.98
Confirmatory Consultation	
99271	1.10
99272	1.64
99273	2.32
Intermediate Ophthalmology	
92002	1.39
92012	1.13
Comprehensive Ophthalmology	
92004	2.26
92014	1.66
Extended Ophthalmoscopy	
92225	0.85
Foreign Body Removal Corneal, with slit lamp	
65222	1.53

* **Relative value units, representing the amount of work, overhead expenses, and malpractice costs, vary from locale to locale and change yearly. Please refer to your area's physician's fee schedule for detailed information.**[17]

XIV. SUMMARY

The aging of the population in the United States is resulting in an explosion of growth in the nursing home population. This growth will continue well into the next millennium. The visual and eye health care needs of the nursing home population represent a tremendous challenge. Unfortunately, too few residents ever receive the eye care they need. Nursing home care can be very satisfying for the practitioner and provide improved quality of life for a group of persons in need of optometry's unique services. While the delivery of care outside the office has become easier with an array of portable equipment now available, the administrative aspects of services within long term care facilities have grown increasingly complex. This Manual is intended to serve only as an overview of nursing home care. Rules and regulations concerning provision of services in long term care facilities are constantly changing. Optometrists are strongly encouraged to seek out local regulations concerning provisions of services in these facilities. State optometric association committees on nursing home care and third party payors can be extremely helpful.

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XVII. APPENDIX

Appendix A: General Public Fact Sheet Optometry and Nursing Homes
Appendix B: Fact Sheet for Nursing Home Administrators
Appendix C: Minimum Data Set (MDS)
Appendix D: Resident Assessment Protocols for Vision (RAP)
Appendix E: Examples of Care Plans Involving Vision

XVII. APPENDIX

APPENDIX A

FACTS ABOUT OPTOMETRIC NURSING HOME CARE

Doctors of Optometry (optometrist, optometric physician, O.D.) are educated and trained in regionally and nationally accredited schools and colleges and are licensed by state boards to provide vision and eye health care.

Doctors of Optometry examine, diagnose, treat and manage disorders of the visual system, the eye, and associated structures as well as diagnose related systemic conditions. They provide services to residents of nursing facilities to improve their quality of eye and vision care, to increase their quality of life, and to assist them in attaining, maintaining, and enhancing their functional capacity.

Eye disease and vision disorders increase with age. One-fourth to one-half of nursing home residents has vision impairment. Primary causes of vision loss include cataracts, age-related macular degeneration, glaucoma, and diabetic retinopathy.

Doctors of Optometry provide treatment for residents with glaucoma, cataract, diabetic complications, stroke sequella, and other conditions that may affect the eye and vision system. They also co-manage resident care with attending physicians and other specialists.

Doctors of Optometry provide vision services to residents with healthy eyes as well as to residents who have eye disease that result in low vision.

Doctors of Optometry are vital members of the rehabilitation team. When vision conditions are properly diagnosed and managed, the resident's rehabilitation program will be more effective.

Nursing facilities are regulated by the federal government and must comply with Medicare Requirements for Long Term Care Facilities. Under these regulations, the facilities must provide the necessary care for residents to maintain their highest practical level of function and independence.

Nursing facilities are required to assist residents in obtaining eye care as needed. Doctors of Optometry provide the expertise to assist nursing homes in maintaining compliance with these regulations.

Nursing facilities must meet and comply with both federal and state regulations to receive payment from both Medicare and Medicaid.

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APPENDIX B

FACTS ABOUT OPTOMETRIC NURSING FACILITY CARE FOR NURSING HOME ADMINISTRATORS

Doctors of Optometry (optometrist, optometric physician, O.D.) are educated and trained in regionally and nationally accredited schools and colleges and are licensed by state boards to provide vision and eye health care.

Doctors of Optometry examine, diagnose, treat and manage disorders of the visual system, the eye, and associated structures as well as diagnose related systemic conditions. They provide services to residents of nursing facilities to improve their quality of eye and vision care, to increase their quality of life, and to assist them in attaining, maintaining, and enhancing their functional capacity.

Eye disease and vision disorders increase with age. One-fourth to one-half of nursing home residents has vision impairment. Primary causes of vision loss include cataracts, age-related macular degeneration, glaucoma, and diabetic retinopathy.

Doctors of Optometry provide treatment for residents with glaucoma, cataract, diabetic complications, stroke sequella, and other conditions that may affect the eye and vision system. They also co-manage resident care with attending physicians and other specialists.

Doctors of Optometry can assist health care planning teams in determining the visual needs and abilities of residents. When vision conditions are properly diagnosed and managed, the resident's rehabilitation program may be more effective. Impaired vision has been shown to be associated with decreased transfer ability, decreased self care, and falls.

Doctors of Optometry provide vision services to residents with healthy eyes as well as to residents who have eye disease that result in low vision. Services may include provision of spectacles, medication management, specialized optical devices, and training for visual impairment.

Optometric care can be delivered within the facility through a large array of portable and hand-held equipment removing the burden of transportation of the resident to a doctor's office. The use of portable equipment allows flexibility in space requirements within the facility.

Doctors of Optometry are independent health care providers whose services are covered under Medicare Part B, Medicaid, and many other forms of insurance. Optometric services are not bundled with payments to the nursing facility.

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APPENDIX C: MINIMUM DATA SET (MDS)

Numeric Identifier_____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ④	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
2.	GENDER ④	1. Male 2. Female
3.	BIRTHDATE ④	Month — Day — Year
4.	RACE/ ④ ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY ④ AND MEDICARE NUMBERS ④ [C in 1st box if non med. no.]	**a.** Social Security Number **b.** Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ④	**a.** State No. **b.** Federal No.
7.	MEDICAID NO. *["+" if pending, "N" if not a Medicaid recipient]* ④	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] **a.** Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* **b.** ***Codes for assessments required for Medicare PPS or the State*** *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

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

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

GENERAL INSTRUCTIONS

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

④ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter **a.** = When letter in box, check if condition applies

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1. DATE OF ENTRY

Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date

Month — Day — Year

2. ADMITTED FROM (AT ENTRY)

1. Private home/apt. with no home health services
2. Private home/apt. with home health services
3. Board and care/assisted living/group home
4. Nursing home
5. Acute care hospital
6. Psychiatric hospital, MR/DD facility
7. Rehabilitation hospital
8. Other

3. LIVED ALONE (PRIOR TO ENTRY)

0. No
1. Yes
2. In other facility

4. ZIP CODE OF PRIOR PRIMARY RESIDENCE

5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY

(***Check all settings*** *resident* ***lived in*** *during 5 years prior to date of entry given in item AB1 above)*

- Prior stay at this nursing home — a.
- Stay in other nursing home — b.
- Other residential facility—board and care home, assisted living, group home — c.
- MH/psychiatric setting — d.
- MR/DD setting — e.
- *NONE OF ABOVE* — f.

6. LIFETIME OCCUPATION(S) [Put "/" between two occupations]

7. EDUCATION (*Highest Level Completed*)

1. No schooling
2. 8th grade/less
3. 9-11 grades
4. High school
5. Technical or trade school
6. Some college
7. Bachelor's degree
8. Graduate degree

8. LANGUAGE

(*Code for correct response*)

a. Primary Language

0. English 1. Spanish 2. French 3. Other

b. If other, specify

9. MENTAL HEALTH HISTORY

Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem?

0. No 1. Yes

10. CONDITIONS RELATED TO MR/DD STATUS

(***Check all conditions*** *that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely*)

- Not applicable—no MR/DD (Skip to AB11) — a.
- MR/DD with organic condition
  - Down's syndrome — b.
  - Autism — c.
  - Epilepsy — d.
  - Other organic condition related to MR/DD — e.
- MR/DD with no organic condition — f.

11. DATE BACKGROUND INFORMATION COMPLETED

Month — Day — Year

SECTION AC. CUSTOMARY ROUTINE

1. CUSTOMARY ROUTINE (*In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home*)

(***Check all that apply.*** *If all information UNKNOWN, check last box only.*)

CYCLE OF DAILY EVENTS

- Stays up late at night (e.g., after 9 pm) — a.
- Naps regularly during day (at least 1 hour) — b.
- Goes out 1+ days a week — c.
- Stays busy with hobbies, reading, or fixed daily routine — d.
- Spends most of time alone or watching TV — e.
- Moves independently indoors (with appliances, if used) — f.
- Use of tobacco products at least daily — g.
- *NONE OF ABOVE* — h.

EATING PATTERNS

- Distinct food preferences — i.
- Eats between meals all or most days — j.
- Use of alcoholic beverage(s) at least weekly — k.
- *NONE OF ABOVE* — l.

ADL PATTERNS

- In bedclothes much of day — m.
- Wakens to toilet all or most nights — n.
- Has irregular bowel movement pattern — o.
- Showers for bathing — p.
- Bathing in PM — q.
- *NONE OF ABOVE* — r.

INVOLVEMENT PATTERNS

- Daily contact with relatives/close friends — s.
- Usually attends church, temple, synagogue (etc.) — t.
- Finds strength in faith — u.
- Daily animal companion/presence — v.
- Involved in group activities — w.
- *NONE OF ABOVE* — x.

UNKNOWN—Resident/family unable to provide information — y.

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:

a. Signature of RN Assessment Coordinator — Date

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

	Signature and Title	Sections	Date
b.			
c.			
d.			
e.			
f.			
g.			

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

Resident _____ Numeric Identifier _____

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

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

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME

a. (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)

2. ROOM NUMBER

3. ASSESSMENT REFERENCE DATE

a. *Last day of MDS observation period*

Month — Day — Year

b. Original (0) or corrected copy of form (enter number of correction)

4a. DATE OF REENTRY

Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)

Month — Day — Year

5. MARITAL STATUS

1. Never married
2. Married
3. Widowed
4. Separated
5. Divorced

6. MEDICAL RECORD NO.

7. CURRENT PAYMENT SOURCES FOR N.H. STAY

(*Billing Office to indicate;* ***check all that apply in last 30 days***)

Medicaid per diem	a.	VA per diem	f.
Medicare per diem	b.	Self or family pays for full per diem	g.
Medicare ancillary part A	c.	Medicaid resident liability or Medicare co-payment	h.
Medicare ancillary part B	d.	Private insurance per diem (including co-payment)	i.
CHAMPUS per diem	e.	Other per diem	j.

8. REASONS FOR ASSESSMENT

[Note—If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed]

a. Primary reason for assessment

1. Admission assessment (required by day 14)
2. Annual assessment
3. Significant change in status assessment
4. Significant correction of prior full assessment
5. Quarterly review assessment
6. Discharged—return not anticipated
7. Discharged—return anticipated
8. Discharged prior to completing initial assessment
9. Reentry
10. Significant correction of prior quarterly assessment
0. *NONE OF ABOVE*

b. ***Codes for assessments required for Medicare PPS or the State***

1. *Medicare 5 day assessment*
2. *Medicare 30 day assessment*
3. *Medicare 60 day assessment*
4. *Medicare 90 day assessment*
5. *Medicare readmission/return assessment*
6. *Other state required assessment*
7. *Medicare 14 day assessment*
8. *Other Medicare required assessment*

9. RESPONSIBILITY/ LEGAL GUARDIAN

(***Check all that apply***)

Legal guardian	a.	Durable power attorney/financial	d.
Other legal oversight	b.	Family member responsible	e.
Durable power of attorney/health care	c.	Patient responsible for self	f.
		NONE OF ABOVE	g.

10. ADVANCED DIRECTIVES

(*For those items with supporting* ***documentation*** *in the medical record,* ***check all that apply***)

Living will	a.	Feeding restrictions	f.
Do not resuscitate	b.	Medication restrictions	g.
Do not hospitalize	c.	Other treatment restrictions	h.
Organ donation	d.		
Autopsy request	e.	*NONE OF ABOVE*	i.

SECTION B. COGNITIVE PATTERNS

1. COMATOSE

(*Persistent vegetative state/no discernible consciousness*)
0. No 1. Yes (**If yes, skip to Section G**)

2. MEMORY

(*Recall of what was learned or known*)

a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 1. Memory problem

b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 1. Memory problem

3. MEMORY/ RECALL ABILITY

(***Check all*** *that resident was* ***normally able to recall during last 7 days***)

Current season	a.	That he/she is in a nursing home	d.
Location of own room	b.		
Staff names/faces	c.	*NONE OF ABOVE* are recalled	e.

4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING

(*Made decisions regarding tasks of daily life*)

0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS

(*Code for behavior in the* ***last 7 days.)*** ***[Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time]***.

0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)

b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)

d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)

e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)

f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

6. CHANGE IN COGNITIVE STATUS

Resident's cognitive status, skills, or abilities have changed as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING

(*With hearing appliance, if used*)

0. *HEARS ADEQUATELY*—normal talk, TV, phone
1. *MINIMAL DIFFICULTY* when not in quiet setting
2. *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly
3. *HIGHLY IMPAIRED*/absence of useful hearing

2. COMMUNICATION DEVICES/ TECHNIQUES

(***Check all that apply*** *during last 7 days*)

Hearing aid, present and used	a.
Hearing aid, present and not used regularly	b.
Other receptive comm. techniques used (e.g., lip reading)	c.
NONE OF ABOVE	d.

3. MODES OF EXPRESSION

(***Check all used*** *by resident to make needs known*)

Speech	a.	Signs/gestures/sounds	d.
Writing messages to express or clarify needs	b.	Communication board	e.
		Other	f.
American sign language or Braille	c.	*NONE OF ABOVE*	g.

4. MAKING SELF UNDERSTOOD

(*Expressing information content—however able*)

0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

5. SPEECH CLARITY

(*Code for speech in the* ***last 7 days***)

0. *CLEAR SPEECH*—distinct, intelligible words
1. *UNCLEAR SPEECH*—slurred, mumbled words
2. *NO SPEECH*—absence of spoken words

6. ABILITY TO UNDERSTAND OTHERS

(*Understanding verbal information content—however able*)

0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

7. CHANGE IN COMMUNICATION/ HEARING

Resident's ability to express, understand, or hear information has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

Resident _____ Numeric Identifier _____

SECTION D. VISION PATTERNS

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

SECTION E. MOOD AND BEHAVIOR PATTERNS

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

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

SECTION F. PSYCHOSOCIAL WELL-BEING

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

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE—(***Code*** *for resident's* ***PERFORMANCE OVER ALL SHIFTS during last 7 days****—Not including setup*)

0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
—Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(***Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless*** *of resident's self-performance classification*)

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

Resident _____ Numeric Identifier _____

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

SECTION H. CONTINENCE IN LAST 14 DAYS

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

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

SECTION I. DISEASE DIAGNOSES

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

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

SECTION J. HEALTH CONDITIONS

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

Resident _____ Numeric Identifier _____

2.	**PAIN SYMPTOMS**	(*Code the **highest level of pain** present in the **last 7 days***)	
		a. FREQUENCY with which resident complains or shows evidence of pain 0. No pain (***skip to J4***) 1. Pain less than daily 2. Pain daily	**b. INTENSITY** of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating
3.	**PAIN SITE**	(*If pain present, **check all sites** that apply in **last 7 days***)	
		Back pain **a.** Bone pain **b.** Chest pain while doing usual activities **c.** Headache **d.** Hip pain **e.**	Incisional pain **f.** Joint pain (other than hip) **g.** Soft tissue pain (e.g., lesion, muscle) **h.** Stomach pain **i.** Other **j.**
4.	**ACCIDENTS**	(***Check all that apply***)	
		Fell in **past 30 days** **a.** Fell in **past 31-180 days** **b.**	Hip fracture in **last 180 days** **c.** Other fracture in **last 180 days** **d.** *NONE OF ABOVE* **e.**
5.	**STABILITY OF CONDITIONS**	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating) **a.** Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem **b.** End-stage disease, 6 or fewer months to live **c.** *NONE OF ABOVE* **d.**	

SECTION K. ORAL/NUTRITIONAL STATUS

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

SECTION L. ORAL/DENTAL STATUS

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

SECTION M. SKIN CONDITION

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

SECTION N. ACTIVITY PURSUIT PATTERNS

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

Resident _____ Numeric Identifier _____

5. PREFERS CHANGE IN DAILY ROUTINE

Code for resident preferences in daily routines
0. No change 1. Slight change 2. Major change

a. Type of activities in which resident is currently involved
b. Extent of resident involvement in activities

SECTION O. MEDICATIONS

1. NUMBER OF MEDICATIONS (***Record the number of different*** *medications used in the* ***last 7 days****; enter "0" if none used*)

2. NEW MEDICATIONS (*Resident currently receiving medications that were initiated during the* ***last 90 days***)
0. No 1. Yes

3. INJECTIONS (***Record the number of DAYS*** *injections of any type received during the* ***last 7 days****; enter "0" if none used*)

4. DAYS RECEIVED THE FOLLOWING MEDICATION (***Record the number of DAYS*** *during* ***last 7 days****; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*)

a. Antipsychotic
b. Antianxiety
c. Antidepressant
d. Hypnotic
e. Diuretic

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

a. SPECIAL CARE—***Check*** *treatments or programs received during the* ***last 14 days***

TREATMENTS
Chemotherapy — a.
Dialysis — b.
IV medication — c.
Intake/output — d.
Monitoring acute medical condition — e.
Ostomy care — f.
Oxygen therapy — g.
Radiation — h.
Suctioning — i.
Tracheostomy care — j.
Transfusions — k.
Ventilator or respirator — l.

PROGRAMS
Alcohol/drug treatment program — m.
Alzheimer's/dementia special care unit — n.
Hospice care — o.
Pediatric unit — p.
Respite care — q.
Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) — r.
NONE OF ABOVE — s.

b. THERAPIES - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the* ***last 7 calendar days*** *(Enter 0 if none or less than 15 min. daily)*
[Note—count only post admission therapies]

	DAYS (A)	MIN (B)
(A) = # of days administered for **15 minutes or more**		
(B) = total # of minutes provided in **last 7 days**		
a. Speech - language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		

2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS (**Check all interventions or strategies used in last 7 days**—no matter where received)

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

3. NURSING REHABILITATION/ RESTORATIVE CARE *Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was* ***provided to the resident for more than or equal to 15 minutes per day in the last 7 days*** *(Enter 0 if none or less than 15 min. daily.)*

a. Range of motion (passive)
b. Range of motion (active)
c. Splint or brace assistance
TRAINING AND SKILL PRACTICE IN:
d. Bed mobility
e. Transfer
f. Walking
g. Dressing or grooming
h. Eating or swallowing
i. Amputation/prosthesis care
j. Communication
k. Other

4. DEVICES AND RESTRAINTS (*Use the following codes for* ***last 7 days***:)
0. Not used
1. Used less than daily
2. Used daily

Bed rails
a. — Full bed rails on all open sides of bed
b. — Other types of side rails used (e.g., half rail, one side)
c. Trunk restraint
d. Limb restraint
e. Chair prevents rising

5. HOSPITAL STAY(S) Record number of times resident was admitted to hospital with an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no hospital admissions*)

6. EMERGENCY ROOM (ER) VISIT(S) Record number of times resident visited ER without an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no ER visits*)

7. PHYSICIAN VISITS In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (*Enter 0 if none*)

8. PHYSICIAN ORDERS In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change.* (*Enter 0 if none*)

9. ABNORMAL LAB VALUES Has the resident had any abnormal lab values during the **last 90 days** (or since admission)?
0. No 1. Yes

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1. DISCHARGE POTENTIAL

a. Resident expresses/indicates preference to return to the community
0. No 1. Yes

b. Resident has a support person who is positive towards discharge
0. No 1. Yes

c. Stay projected to be of a short duration— discharge projected **within 90 days** (do not include expected discharge due to death)
0. No 2. Within 31-90 days
1. Within 30 days 3. Discharge status uncertain

2. OVERALL CHANGE IN CARE NEEDS Resident's overall self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support

SECTION R. ASSESSMENT INFORMATION

1. PARTICIPATION IN ASSESSMENT

a. Resident: 0. No 1. Yes
b. Family: 0. No 1. Yes 2. No family
c. Significant other: 0. No 1. Yes 2. None

2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete — Month — Day — Year

Resident _____ Numeric Identifier _____

SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1. SPECIAL TREATMENTS AND PROCEDURES

a. RECREATION THERAPY—*Enter number of days and total minutes of recreation therapy administered* (***for at least 15 minutes a day***) *in the* ***last 7 days*** (*Enter 0 if none*)

(A) = # of days administered for 15 minutes or more
(B) = total # of minutes provided in last 7 days

DAYS	MIN
(A)	(B)

Skip unless this is a Medicare 5 day or Medicare readmission/return assessment.

b. ORDERED THERAPIES—*Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service*?
0. No 1. Yes

If not ordered, skip to item 2

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

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

2. WALKING WHEN MOST SELF SUFFICIENT

Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0,1,2, or 3 AND at least one of the following are present:

- Resident received physical therapy involving gait training (P.1.b.c)
- Physical therapy was ordered for the resident involving gait training (T.1.b)
- Resident received nursing rehabilitation for walking (P.3.f)
- Physical therapy involving walking has been discontinued within the past 180 days

Skip to item 3 if resident did not walk in last 7 days

(***FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.***)

a. Furthest distance walked without sitting down during this episode.

0. 150+ feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. Time walked without sitting down during this episode.

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31+ minutes

c. Self-Performance in walking during this episode.

0. *INDEPENDENT*—No help or oversight
1. *SUPERVISION*—Oversight, encouragement or cueing provided
2. *LIMITED ASSISTANCE*—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance
3. *EXTENSIVE ASSISTANCE*—Resident received weight bearing assistance while walking

d. Walking support provided associated with this episode (code regardless of resident's self-performance classification).

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist

e. Parallel bars used by resident in association with this episode.

0. No 1. Yes

3. CASE MIX GROUP

Medicare _____ **State** _____

Resident _____ Numeric Identifier_____

MINIMUM DATA SET (MDS) - *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

SECTION W. SUPPLEMENTAL MDS ITEMS

1.	**National Provider ID**	Enter for all assessments and tracking forms, if available. ☐☐☐☐☐☐☐☐☐☐	
		If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.	
2.	**Influenza Vaccine**	a . Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3) 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 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine	
3.	**Pneumo-coccal Vaccine**	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

Numeric Identifier_____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ④	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
2.	GENDER ④	1. Male 2. Female
3.	BIRTHDATE ④	Month — Day — Year
4.	RACE/ ④ ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY ④ AND MEDICARE NUMBERS ④ [C in 1st box if non med. no.]	**a.** Social Security Number **b.** Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ④	**a.** State No. **b.** Federal No.
7.	MEDICAID NO. *["+" if pending, "N" if not a Medicaid recipient]* ④	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] **a.** Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* **b.** ***Codes for assessments required for Medicare PPS or the State*** *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

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

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

GENERAL INSTRUCTIONS

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

④ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter **a.** = When letter in box, check if condition applies

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1. DATE OF ENTRY

Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date

Month — Day — Year

2. ADMITTED FROM (AT ENTRY)

1. Private home/apt. with no home health services
2. Private home/apt. with home health services
3. Board and care/assisted living/group home
4. Nursing home
5. Acute care hospital
6. Psychiatric hospital, MR/DD facility
7. Rehabilitation hospital
8. Other

3. LIVED ALONE (PRIOR TO ENTRY)

0. No
1. Yes
2. In other facility

4. ZIP CODE OF PRIOR PRIMARY RESIDENCE

5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY

(***Check all settings*** *resident* ***lived in*** *during 5 years prior to date of entry given in item AB1 above)*

- Prior stay at this nursing home — a.
- Stay in other nursing home — b.
- Other residential facility—board and care home, assisted living, group home — c.
- MH/psychiatric setting — d.
- MR/DD setting — e.
- *NONE OF ABOVE* — f.

6. LIFETIME OCCUPATION(S) [Put "/" between two occupations]

7. EDUCATION (*Highest Level Completed*)

1. No schooling
2. 8th grade/less
3. 9-11 grades
4. High school
5. Technical or trade school
6. Some college
7. Bachelor's degree
8. Graduate degree

8. LANGUAGE

(*Code for correct response*)

a. Primary Language

0. English 1. Spanish 2. French 3. Other

b. If other, specify

9. MENTAL HEALTH HISTORY

Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem?

0. No 1. Yes

10. CONDITIONS RELATED TO MR/DD STATUS

(***Check all conditions*** *that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely*)

- Not applicable—no MR/DD (Skip to AB11) — a.
- MR/DD with organic condition
  - Down's syndrome — b.
  - Autism — c.
  - Epilepsy — d.
  - Other organic condition related to MR/DD — e.
- MR/DD with no organic condition — f.

11. DATE BACKGROUND INFORMATION COMPLETED

Month — Day — Year

SECTION AC. CUSTOMARY ROUTINE

1. CUSTOMARY ROUTINE (*In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home*)

(***Check all that apply.*** *If all information UNKNOWN, check last box only.*)

CYCLE OF DAILY EVENTS

- Stays up late at night (e.g., after 9 pm) — a.
- Naps regularly during day (at least 1 hour) — b.
- Goes out 1+ days a week — c.
- Stays busy with hobbies, reading, or fixed daily routine — d.
- Spends most of time alone or watching TV — e.
- Moves independently indoors (with appliances, if used) — f.
- Use of tobacco products at least daily — g.
- *NONE OF ABOVE* — h.

EATING PATTERNS

- Distinct food preferences — i.
- Eats between meals all or most days — j.
- Use of alcoholic beverage(s) at least weekly — k.
- *NONE OF ABOVE* — l.

ADL PATTERNS

- In bedclothes much of day — m.
- Wakens to toilet all or most nights — n.
- Has irregular bowel movement pattern — o.
- Showers for bathing — p.
- Bathing in PM — q.
- *NONE OF ABOVE* — r.

INVOLVEMENT PATTERNS

- Daily contact with relatives/close friends — s.
- Usually attends church, temple, synagogue (etc.) — t.
- Finds strength in faith — u.
- Daily animal companion/presence — v.
- Involved in group activities — w.
- *NONE OF ABOVE* — x.

UNKNOWN—Resident/family unable to provide information — y.

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:

a. Signature of RN Assessment Coordinator — Date

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

	Signature and Title	Sections	Date
b.			
c.			
d.			
e.			
f.			
g.			

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

Resident _____ Numeric Identifier _____

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

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

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME

a. (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)

2. ROOM NUMBER

3. ASSESSMENT REFERENCE DATE

a. *Last day of MDS observation period*

Month — Day — Year

b. Original (0) or corrected copy of form (enter number of correction)

4a. DATE OF REENTRY

Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)

Month — Day — Year

5. MARITAL STATUS

1. Never married
2. Married
3. Widowed
4. Separated
5. Divorced

6. MEDICAL RECORD NO.

7. CURRENT PAYMENT SOURCES FOR N.H. STAY

(*Billing Office to indicate;* ***check all that apply in last 30 days***)

Medicaid per diem	a.	VA per diem	f.
Medicare per diem	b.	Self or family pays for full per diem	g.
Medicare ancillary part A	c.	Medicaid resident liability or Medicare co-payment	h.
Medicare ancillary part B	d.	Private insurance per diem (including co-payment)	i.
CHAMPUS per diem	e.	Other per diem	j.

8. REASONS FOR ASSESSMENT

[Note—If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed]

a. Primary reason for assessment

1. Admission assessment (required by day 14)
2. Annual assessment
3. Significant change in status assessment
4. Significant correction of prior full assessment
5. Quarterly review assessment
6. Discharged—return not anticipated
7. Discharged—return anticipated
8. Discharged prior to completing initial assessment
9. Reentry
10. Significant correction of prior quarterly assessment
0. *NONE OF ABOVE*

b. ***Codes for assessments required for Medicare PPS or the State***

1. *Medicare 5 day assessment*
2. *Medicare 30 day assessment*
3. *Medicare 60 day assessment*
4. *Medicare 90 day assessment*
5. *Medicare readmission/return assessment*
6. *Other state required assessment*
7. *Medicare 14 day assessment*
8. *Other Medicare required assessment*

9. RESPONSIBILITY/ LEGAL GUARDIAN

(***Check all that apply***)

Legal guardian	a.	Durable power attorney/financial	d.
Other legal oversight	b.	Family member responsible	e.
Durable power of attorney/health care	c.	Patient responsible for self	f.
		NONE OF ABOVE	g.

10. ADVANCED DIRECTIVES

(*For those items with supporting* ***documentation*** *in the medical record,* ***check all that apply***)

Living will	a.	Feeding restrictions	f.
Do not resuscitate	b.	Medication restrictions	g.
Do not hospitalize	c.	Other treatment restrictions	h.
Organ donation	d.		
Autopsy request	e.	*NONE OF ABOVE*	i.

SECTION B. COGNITIVE PATTERNS

1. COMATOSE

(*Persistent vegetative state/no discernible consciousness*)
0. No 1. Yes (**If yes, skip to Section G**)

2. MEMORY

(*Recall of what was learned or known*)

a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 1. Memory problem

b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 1. Memory problem

3. MEMORY/ RECALL ABILITY

(***Check all*** *that resident was* ***normally able to recall during last 7 days***)

Current season	a.	That he/she is in a nursing home	d.
Location of own room	b.		
Staff names/faces	c.	*NONE OF ABOVE* are recalled	e.

4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING

(*Made decisions regarding tasks of daily life*)

0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS

(*Code for behavior in the* ***last 7 days.)*** ***[Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time]***.

0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)

b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)

d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)

e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)

f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

6. CHANGE IN COGNITIVE STATUS

Resident's cognitive status, skills, or abilities have changed as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING

(*With hearing appliance, if used*)

0. *HEARS ADEQUATELY*—normal talk, TV, phone
1. *MINIMAL DIFFICULTY* when not in quiet setting
2. *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly
3. *HIGHLY IMPAIRED*/absence of useful hearing

2. COMMUNICATION DEVICES/ TECHNIQUES

(***Check all that apply*** *during last 7 days*)

Hearing aid, present and used	a.
Hearing aid, present and not used regularly	b.
Other receptive comm. techniques used (e.g., lip reading)	c.
NONE OF ABOVE	d.

3. MODES OF EXPRESSION

(***Check all used*** *by resident to make needs known*)

Speech	a.	Signs/gestures/sounds	d.
Writing messages to express or clarify needs	b.	Communication board	e.
		Other	f.
American sign language or Braille	c.	*NONE OF ABOVE*	g.

4. MAKING SELF UNDERSTOOD

(*Expressing information content—however able*)

0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

5. SPEECH CLARITY

(*Code for speech in the* ***last 7 days***)

0. *CLEAR SPEECH*—distinct, intelligible words
1. *UNCLEAR SPEECH*—slurred, mumbled words
2. *NO SPEECH*—absence of spoken words

6. ABILITY TO UNDERSTAND OTHERS

(*Understanding verbal information content—however able*)

0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

7. CHANGE IN COMMUNICATION/ HEARING

Resident's ability to express, understand, or hear information has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

Resident _____ Numeric Identifier _____

SECTION D. VISION PATTERNS

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

SECTION E. MOOD AND BEHAVIOR PATTERNS

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

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

SECTION F. PSYCHOSOCIAL WELL-BEING

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

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE—(***Code*** *for resident's* ***PERFORMANCE OVER ALL SHIFTS during last 7 days****—Not including setup*)

0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
—Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(***Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless*** *of resident's self-performance classification*)

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

Resident _____ Numeric Identifier _____

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

SECTION H. CONTINENCE IN LAST 14 DAYS

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

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

SECTION I. DISEASE DIAGNOSES

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

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

SECTION J. HEALTH CONDITIONS

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

Resident _____ Numeric Identifier _____

2.	**PAIN SYMPTOMS**	(*Code the **highest level of pain** present in the **last 7 days***)	
		a. FREQUENCY with which resident complains or shows evidence of pain 0. No pain (***skip to J4***) 1. Pain less than daily 2. Pain daily	**b. INTENSITY** of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating
3.	**PAIN SITE**	(*If pain present, **check all sites** that apply in **last 7 days***)	
		Back pain **a.** Bone pain **b.** Chest pain while doing usual activities **c.** Headache **d.** Hip pain **e.**	Incisional pain **f.** Joint pain (other than hip) **g.** Soft tissue pain (e.g., lesion, muscle) **h.** Stomach pain **i.** Other **j.**
4.	**ACCIDENTS**	(***Check all that apply***)	
		Fell in **past 30 days** **a.** Fell in **past 31-180 days** **b.**	Hip fracture in **last 180 days** **c.** Other fracture in **last 180 days** **d.** *NONE OF ABOVE* **e.**
5.	**STABILITY OF CONDITIONS**	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating) **a.** Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem **b.** End-stage disease, 6 or fewer months to live **c.** *NONE OF ABOVE* **d.**	

SECTION K. ORAL/NUTRITIONAL STATUS

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

SECTION L. ORAL/DENTAL STATUS

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

SECTION M. SKIN CONDITION

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

SECTION N. ACTIVITY PURSUIT PATTERNS

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

Resident _____ Numeric Identifier _____

5. PREFERS CHANGE IN DAILY ROUTINE

Code for resident preferences in daily routines
0. No change 1. Slight change 2. Major change

a. Type of activities in which resident is currently involved
b. Extent of resident involvement in activities

SECTION O. MEDICATIONS

1. NUMBER OF MEDICATIONS (***Record the number of different*** *medications used in the* ***last 7 days****; enter "0" if none used*)

2. NEW MEDICATIONS (*Resident currently receiving medications that were initiated during the* ***last 90 days***)
0. No 1. Yes

3. INJECTIONS (***Record the number of DAYS*** *injections of any type received during the* ***last 7 days****; enter "0" if none used*)

4. DAYS RECEIVED THE FOLLOWING MEDICATION (***Record the number of DAYS*** *during* ***last 7 days****; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*)

a. Antipsychotic
b. Antianxiety
c. Antidepressant
d. Hypnotic
e. Diuretic

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

a. SPECIAL CARE—***Check*** *treatments or programs received during the* ***last 14 days***

TREATMENTS
Chemotherapy — a.
Dialysis — b.
IV medication — c.
Intake/output — d.
Monitoring acute medical condition — e.
Ostomy care — f.
Oxygen therapy — g.
Radiation — h.
Suctioning — i.
Tracheostomy care — j.
Transfusions — k.
Ventilator or respirator — l.

PROGRAMS
Alcohol/drug treatment program — m.
Alzheimer's/dementia special care unit — n.
Hospice care — o.
Pediatric unit — p.
Respite care — q.
Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) — r.
NONE OF ABOVE — s.

b. THERAPIES - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the* ***last 7 calendar days*** *(Enter 0 if none or less than 15 min. daily)*
[Note—count only post admission therapies]

	DAYS (A)	MIN (B)
(A) = # of days administered for **15 minutes or more**		
(B) = total # of minutes provided in **last 7 days**		
a. Speech - language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		

2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS (**Check all interventions or strategies used in last 7 days**—no matter where received)

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

3. NURSING REHABILITATION/ RESTORATIVE CARE *Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was* ***provided to the resident for more than or equal to 15 minutes per day in the last 7 days*** *(Enter 0 if none or less than 15 min. daily.)*

a. Range of motion (passive)
b. Range of motion (active)
c. Splint or brace assistance
TRAINING AND SKILL PRACTICE IN:
d. Bed mobility
e. Transfer
f. Walking
g. Dressing or grooming
h. Eating or swallowing
i. Amputation/prosthesis care
j. Communication
k. Other

4. DEVICES AND RESTRAINTS (*Use the following codes for* ***last 7 days***:)
0. Not used
1. Used less than daily
2. Used daily

Bed rails
a. — Full bed rails on all open sides of bed
b. — Other types of side rails used (e.g., half rail, one side)
c. Trunk restraint
d. Limb restraint
e. Chair prevents rising

5. HOSPITAL STAY(S) Record number of times resident was admitted to hospital with an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no hospital admissions*)

6. EMERGENCY ROOM (ER) VISIT(S) Record number of times resident visited ER without an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no ER visits*)

7. PHYSICIAN VISITS In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (*Enter 0 if none*)

8. PHYSICIAN ORDERS In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change.* (*Enter 0 if none*)

9. ABNORMAL LAB VALUES Has the resident had any abnormal lab values during the **last 90 days** (or since admission)?
0. No 1. Yes

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1. DISCHARGE POTENTIAL

a. Resident expresses/indicates preference to return to the community
0. No 1. Yes

b. Resident has a support person who is positive towards discharge
0. No 1. Yes

c. Stay projected to be of a short duration— discharge projected **within 90 days** (do not include expected discharge due to death)
0. No 2. Within 31-90 days
1. Within 30 days 3. Discharge status uncertain

2. OVERALL CHANGE IN CARE NEEDS Resident's overall self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support

SECTION R. ASSESSMENT INFORMATION

1. PARTICIPATION IN ASSESSMENT

a. Resident: 0. No 1. Yes
b. Family: 0. No 1. Yes 2. No family
c. Significant other: 0. No 1. Yes 2. None

2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete — Month — Day — Year

Resident _____ Numeric Identifier _____

SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1. SPECIAL TREATMENTS AND PROCEDURES

a. RECREATION THERAPY—*Enter number of days and total minutes of recreation therapy administered* (***for at least 15 minutes a day***) *in the* ***last 7 days*** (*Enter 0 if none*)

(A) = # of days administered for 15 minutes or more
(B) = total # of minutes provided in last 7 days

DAYS	MIN
(A)	(B)

Skip unless this is a Medicare 5 day or Medicare readmission/return assessment.

b. ORDERED THERAPIES—*Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service*?
0. No 1. Yes

If not ordered, skip to item 2

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

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

2. WALKING WHEN MOST SELF SUFFICIENT

Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0,1,2, or 3 AND at least one of the following are present:

- Resident received physical therapy involving gait training (P.1.b.c)
- Physical therapy was ordered for the resident involving gait training (T.1.b)
- Resident received nursing rehabilitation for walking (P.3.f)
- Physical therapy involving walking has been discontinued within the past 180 days

Skip to item 3 if resident did not walk in last 7 days

(***FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.***)

a. Furthest distance walked without sitting down during this episode.

0. 150+ feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. Time walked without sitting down during this episode.

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31+ minutes

c. Self-Performance in walking during this episode.

0. *INDEPENDENT*—No help or oversight
1. *SUPERVISION*—Oversight, encouragement or cueing provided
2. *LIMITED ASSISTANCE*—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance
3. *EXTENSIVE ASSISTANCE*—Resident received weight bearing assistance while walking

d. Walking support provided associated with this episode (code regardless of resident's self-performance classification).

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist

e. Parallel bars used by resident in association with this episode.

0. No 1. Yes

3. CASE MIX GROUP

Medicare _____ **State** _____

Resident _____ Numeric Identifier_____

MINIMUM DATA SET (MDS) - *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

SECTION W. SUPPLEMENTAL MDS ITEMS

1.	**National Provider ID**	Enter for all assessments and tracking forms, if available. ☐☐☐☐☐☐☐☐☐☐	
		If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.	
2.	**Influenza Vaccine**	a . Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3) 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 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine	
3.	**Pneumo-coccal Vaccine**	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

MDS QUARTERLY ASSESSMENT FORM

Numeric Identifier _____

A1. RESIDENT NAME

a. (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)

A2. ROOM NUMBER

A3. ASSESSMENT REFERENCE DATE

a. Last day of MDS observation period

Month — Day — Year

b. Original (0) or corrected copy of form (enter number of correction)

A4a. DATE OF REENTRY

Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)

Month — Day — Year

A6. MEDICAL RECORD NO.

B1. COMATOSE

(*Persistent vegetative state/no discernible consciousness*)
0. No 1. Yes (***Skip to Section G***)

B2. MEMORY

(*Recall of what was learned or known*)

a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 1. Memory problem

b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 1. Memory problem

B4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING

(*Made decisions regarding tasks of daily life*)

0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

B5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS

(*Code for behavior in the* ***last 7 days.)*** **[*Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time*].**

0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)

b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)

d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)

e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)

f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

C4. MAKING SELF UNDERSTOOD

(*Expressing information content—however able*)

0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

C6. ABILITY TO UNDERSTAND OTHERS

(*Understanding verbal information content—however able*)

0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. S*OMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

(***Code for indicators observed in last 30 days, irrespective of the assumed cause***)

0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

VERBAL EXPRESSIONS OF DISTRESS

a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"

b. Repetitive questions—e.g., "*Where do I go; What do I do?*"

c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")

d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received

e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (cont.)

VERBAL EXPRESSIONS OF DISTRESS

f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others

g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack

h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions

i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues

SLEEP-CYCLE ISSUES

j. Unpleasant mood in morning

k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE

l. Sad, pained, worried facial expressions—e.g., furrowed brows

m. Crying, tearfulness

n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST

o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends

p. Reduced social interaction

E2. MOOD PERSISTENCE

One or more indicators of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days**

0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered

E4. BEHAVIORAL SYMPTOMS

(A) *Behavioral* *symptom* *frequency in last 7 days*

0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) *Behavioral* *symptom* *alterability in last 7 days*

0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)		
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)		
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)		

G1. (A) ADL SELF-PERFORMANCE—(***Code*** *for resident's* ***PERFORMANCE OVER ALL SHIFTS during last 7 days****—Not including setup*)

0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
— Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

		(A)
a.	**BED MOBILITY** How resident moves to and from lying position, turns side to side, and positions body while in bed	
b.	**TRANSFER** How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	
c.	**WALK IN ROOM** How resident walks between locations in his/her room.	
d.	**WALK IN CORRIDOR** How resident walks in corridor on unit.	
e.	**LOCOMOTION ON UNIT** How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	
f.	**LOCOMOTION OFF UNIT** How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	
g.	**DRESSING** How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis	
h.	**EATING** How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).	

Resident_____ Numeric Identifier _____

i. TOILET USE — How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes

j. PERSONAL HYGIENE — How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)

G2. BATHING — How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.)
Code for most dependent *in self-performance.*
(A) BATHING SELF PERFORMANCE codes appear below

(A)

0. Independent—No help provided
1. Supervision—Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence
8. Activity itself did not occur during entire 7 days

G4. FUNCTIONAL LIMITATION IN RANGE OF MOTION — (*Code for limitations during* ***last 7 days*** *that interfered with daily functions or placed residents at risk of injury*)

(A) *RANGE OF MOTION*: 0. No limitation; 1. Limitation on one side; 2. Limitation on both sides

(B) *VOLUNTARY MOVEMENT*: 0. No loss; 1. Partial loss; 2. Full loss

	(A)	(B)
a. Neck		
b. Arm—Including shoulder or elbow		
c. Hand—Including wrist or fingers		
d. Leg—Including hip or knee		
e. Foot—Including ankle or toes		
f. Other limitation or loss		

G6. MODES OF TRANSFER — (***Check all that apply*** *during* ***last 7 days***)

Bedfast all or most of time **a.** | Bed rails used for bed mobility or transfer **b.** | *NONE OF ABOVE* **f.**

H1. CONTINENCE SELF-CONTROL CATEGORIES
(***Code for resident's PERFORMANCE OVER ALL SHIFTS***)

0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]*
1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a. BOWEL CONTINENCE — Control of bowel movement, with appliance or bowel continence programs, if employed

b. BLADDER CONTINENCE — Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed

H2. BOWEL ELIMINATION PATTERN — Fecal impaction **d.** | *NONE OF ABOVE* **e.**

H3. APPLIANCES AND PROGRAMS

Any scheduled toileting plan	**a.**	Indwelling catheter	**d.**
Bladder retraining program	**b.**	Ostomy present	**i.**
External (condom) catheter	**c.**	*NONE OF ABOVE*	**j.**

I2. INFECTIONS — Urinary tract infection **in last 30 days** **j.** | *NONE OF ABOVE* **m.**

I3. OTHER CURRENT DIAGNOSES AND ICD-9 CODES — (*Include* ***only those diseases diagnosed in the last 90 days that have a relationship*** *to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death*)

a. _____ | | | | • | |

b. _____ | | | | • | |

J1. PROBLEM CONDITIONS — (***Check all problems present*** *in* ***last 7 days***)

Dehydrated; output exceeds input **c.** | Hallucinations **i.** | *NONE OF ABOVE* **p.**

J2. PAIN SYMPTOMS — (*Code the* ***highest level of pain*** *present in the* ***last 7 days***)

a. FREQUENCY with which resident complains or shows evidence of pain
0. No pain (***skip to J4***)
1. Pain less than daily
2. Pain daily

b. INTENSITY of pain
1. Mild pain
2. Moderate pain
3. Times when pain is horrible or excrutiating

J4. ACCIDENTS — (***Check all that apply***)

Fell in **past 30 days** **a.** | Fell in **past 31-180 days** **b.** | Hip fracture in **last 180 days** **c.** | Other fracture in **last 180 days** **d.** | *NONE OF ABOVE* **e.**

J5. STABILITY OF CONDITIONS — Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating) **a.**
Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem **b.**
End-stage disease, 6 or fewer months to live **c.**
NONE OF ABOVE **d.**

K3. WEIGHT CHANGE

a. Weight loss—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**
0. No 1. Yes

b. Weight gain—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**
0. No 1. Yes

K5. NUTRITIONAL APPROACHES

Feeding tube **b.**
On a planned weight change program **h.**
NONE OF ABOVE **i.**

M1. ULCERS (Due to any cause) — *(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during* ***last 7 days****. Code 9 = 9 or more.)* ***[Requires full body exam.]***

	Number at Stage
a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	

M2. TYPE OF ULCER — (*For each type of ulcer,* ***code for the highest stage in the last 7 days*** *using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4*)

a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue

b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities

N1. TIME AWAKE — (***Check appropriate time periods over last 7 days***)
Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:
Morning **a.** | Evening **c.** | Afternoon **b.** | *NONE OF ABOVE* **d.**

(If resident is comatose, skip to Section O)

N2. AVERAGE TIME INVOLVED IN ACTIVITIES — (**When awake and not receiving treatments or ADL care**)
0. Most—more than 2/3 of time
1. Some—from 1/3 to 2/3 of time
2. Little—less than 1/3 of time
3. None

O1. NUMBER OF MEDICATIONS — (***Record the number of different*** *medications used in the* ***last 7 days****; enter "0" if none used*)

O4. DAYS RECEIVED THE FOLLOWING MEDICATION — (***Record the number of DAYS*** *during* ***last 7 days****; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*)

a. Antipsychotic | **b.** Antianxiety | **c.** Antidepressant | **d.** Hypnotic | **e.** Diuretic

P4. DEVICES AND RESTRAINTS — *Use the following codes for* ***last 7 days***:
0. Not used
1. Used less than daily
2. Used daily

Bed rails
a. — Full bed rails on all open sides of bed
b. — Other types of side rails used (e.g., half rail, one side)
c. Trunk restraint
d. Limb restraint
e. Chair prevents rising

Q2. OVERALL CHANGE IN CARE NEEDS — Resident's overall level of self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change
1. Improved—receives fewer supports, needs less restrictive level of care
2. Deteriorated—receives more support

R2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete — Month ___ Day ___ Year ____

Resident _____ Numeric Identifier_____

MINIMUM DATA SET (MDS) - *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

SECTION W. SUPPLEMENTAL MDS ITEMS

1.	**National Provider ID**	Enter for all assessments and tracking forms, if available. ☐☐☐☐☐☐☐☐☐☐	
		If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.	
2.	**Influenza Vaccine**	a . Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3) 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 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine	
3.	**Pneumo-coccal Vaccine**	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

Numeric Identifier _____

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

A1. RESIDENT NAME

a. (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)

A2. ROOM NUMBER

A3. ASSESSMENT REFERENCE DATE

a. Last day of MDS observation period

Month — Day — Year

b. Original (0) or corrected copy of form (enter number of correction)

A4. DATE OF REENTRY

Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)

Month — Day — Year

A6. MEDICAL RECORD NO.

B1. COMATOSE (*Persistent vegetative state/no discernible consciousness*)
0. No 1. Yes (***Skip to Section G***)

B2. MEMORY (*Recall of what was learned or known*)

a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 1. Memory problem

b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 1. Memory problem

B3. MEMORY/ RECALL ABILITY (***Check all*** *that resident was* ***normally able to recall during last 7 days***)

Current season **a.**
Location of own room **b.**
Staff names/faces **c.**
That he/she is in a nursing home **d.**
NONE OF ABOVE are recalled **e.**

B4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING (*Made decisions regarding tasks of daily life*)

0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

B5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS (*Code for behavior in the* ***last 7 days.)*** ***[Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time*****].**

0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)

b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)

d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)

e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)

f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

C4. MAKING SELF UNDERSTOOD (*Expressing information content—however able*)

0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

C6. ABILITY TO UNDERSTAND OTHERS (*Understanding verbal information content—however able*)

0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (***Code for indicators observed in last 30 days, irrespective of the assumed cause***)

0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

VERBAL EXPRESSIONS OF DISTRESS

a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"

b. Repetitive questions—e.g., "*Where do I go; What do I do?*"

c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")

d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received

e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"

f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others

g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack

h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions

i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues

SLEEP-CYCLE ISSUES

j. Unpleasant mood in morning

k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE

l. Sad, pained, worried facial expressions—e.g., furrowed brows

m. Crying, tearfulness

n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST

o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends

p. Reduced social interaction

E2. MOOD PERSISTENCE

One or more indicators of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days**

0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered

E4. BEHAVIORAL SYMPTOMS

(A) ***Behavioral*** *symptom* ***frequency in last 7 days***
0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) ***Behavioral*** *symptom* ***alterability in last 7 days***
0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)		
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)		
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)		

G1. **(A)** ADL SELF-PERFORMANCE—(***Code*** *for resident's* ***PERFORMANCE OVER ALL SHIFTS during last 7 days****—Not including setup*)

0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
— Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(***Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless*** *of resident's self-performance classification*)

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

		(A) SELF-PERF	(B) SUPPORT
a.	**BED MOBILITY** How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	**TRANSFER** How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		

Resident_____ Numeric Identifier _____

G1. (A) (B)

c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

G2. BATHING — How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) ***Code for most dependent*** *in self-performance.*

(A) BATHING SELF PERFORMANCE codes appear below — (A)

0. Independent—No help provided
1. Supervision—Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence
8. Activity itself did not occur during entire 7 days

G3. TEST FOR BALANCE (see training manual) — (*Code for ability during test in the* ***last 7 days***)

0. Maintained position as required in test
1. Unsteady, but able to rebalance self without physical support
2. Partial physical support during test; or stands (sits) but does not follow directions for test
3. Not able to attempt test without physical help

a. Balance while standing
b. Balance while sitting—position, trunk control

G4. FUNCTIONAL LIMITATION IN RANGE OF MOTION (*Code for limitations during* ***last 7 days*** *that interfered with daily functions or placed residents at risk of injury*)

(A) *RANGE OF MOTION*: 0. No limitation; 1. Limitation on one side; 2. Limitation on both sides

(B) *VOLUNTARY MOVEMENT*: 0. No loss; 1. Partial loss; 2. Full loss

	(A)	(B)
a. Neck		
b. Arm—Including shoulder or elbow		
c. Hand—Including wrist or fingers		
d. Leg—Including hip or knee		
e. Foot—Including ankle or toes		
f. Other limitation or loss		

G6. MODES OF TRANSFER — (***Check all that apply*** *during* ***last 7 days***)

Bedfast all or most of time **a.** — *NONE OF ABOVE* **f.**
Bed rails used for bed mobility or transfer **b.**

G7. TASK SEGMENTATION — Some or all of ADL activities were broken into subtasks during **last 7 days** so that resident could perform them. 0. No 1. Yes

H1. CONTINENCE SELF-CONTROL CATEGORIES (***Code for resident's PERFORMANCE OVER ALL SHIFTS***)

0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]*
1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed

H2. BOWEL ELIMINATION PATTERN — Diarrhea **c.** — *NONE OF ABOVE* **e.**; Fecal impaction **d.**

H3. APPLIANCES AND PROGRAMS

Any scheduled toileting plan **a.**
Bladder retraining program **b.**
External (condom) catheter **c.**
Indwelling catheter **d.**
Ostomy present **i.**
NONE OF ABOVE **j.**

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

I1. DISEASES (***If none apply, CHECK the NONE OF ABOVE box***)

MUSCULOSKELETAL
Hip fracture **m.**
NEUROLOGICAL
Aphasia **r.**
Cerebral palsy **s.**
Cerebrovascular accident (stroke) **t.**
Hemiplegia/Hemiparesis **v.**
Multiple sclerosis **w.**
Quadriplegia **z.**
PSYCHIATRIC/MOOD
Depression **ee.**
Manic depressive (bipolar disease) **ff.**
OTHER
NONE OF ABOVE **rr.**

I2. INFECTIONS (***If none apply, CHECK the NONE OF ABOVE box***)

Antibiotic resistant infection (e.g., Methicillin resistant staph) **a.**
Clostridium difficile (c. diff.) **b.**
Conjunctivitis **c.**
HIV infection **d.**
Pneumonia **e.**
Respiratory infection **f.**
Septicemia **g.**
Sexually transmitted diseases **h.**
Tuberculosis **i.**
Urinary tract infection **in last 30 days** **j.**
Viral hepatitis **k.**
Wound infection **l.**
NONE OF ABOVE **m.**

I3. OTHER CURRENT DIAGNOSES AND ICD-9 CODES (*Include* ***only those diseases diagnosed in the last 90 days that have a relationship*** *to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death*)

a. _____ | | | | • | |
b. | | | | • | |

J1. PROBLEM CONDITIONS (***Check all problems present*** *in* ***last 7 days*** *unless other time frame is indicated*)

INDICATORS OF FLUID STATUS
Weight gain or loss of 3 or more pounds within a 7 day period **a.**
Inability to lie flat due to shortness of breath **b.**
Dehydrated; output exceeds input **c.**
Insufficient fluid; did **NOT** consume all/almost all liquids provided during **last 3 days** **d.**

OTHER
Delusions **e.**
Edema **g.**
Fever **h.**
Hallucinations **i.**
Internal bleeding **j.**
Recurrent lung aspirations in **last 90 days** **k.**
Shortness of breath **l.**
Unsteady gait **n.**
Vomiting **o.**
NONE OF ABOVE **p.**

J2. PAIN SYMPTOMS (*Code the* ***highest level of pain*** *present in the* ***last 7 days***)

a. FREQUENCY with which resident complains or shows evidence of pain
0. No pain (***skip to J4***)
1. Pain less than daily
2. Pain daily

b. INTENSITY of pain
1. Mild pain
2. Moderate pain
3. Times when pain is horrible or excrutiating

J4. ACCIDENTS (***Check all that apply***)

Fell in **past 30 days** **a.**
Fell in **past 31-180 days** **b.**
Hip fracture in **last 180 days** **c.**
Other fracture in **last 180 days** **d.**
NONE OF ABOVE **e.**

J5. STABILITY OF CONDITIONS

Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating) **a.**
Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem **b.**
End-stage disease, 6 or fewer months to live **c.**
NONE OF ABOVE **d.**

K1. ORAL PROBLEMS

Chewing problem **a.**
Swallowing problem **b.**
NONE OF ABOVE **d.**

K2. HEIGHT AND WEIGHT — *Record* ***(a.) height in inches*** *and* ***(b.) weight in pounds****. Base weight on most recent measure in* ***last 30 days****; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes*

a. HT (in.) | | **b.** WT (lb.) | | |

K3. WEIGHT CHANGE

a. Weight loss—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**. 0. No 1. Yes

b. Weight gain—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**. 0. No 1. Yes

Resident_____ Numeric Identifier _____

K5. NUTRITIONAL APPROACHES — (***Check all that apply in last 7 days***)

- Parenteral/IV — a.
- Feeding tube — b.
- On a planned weight change program — h.
- *NONE OF ABOVE* — i.

M1. ULCERS (Due to any cause) — *(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during **last 7 days**. Code 9 = 9 or more.)* ***[Requires full body exam.]***

		Number at Stage
a.	Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
b.	Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
c.	Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
d.	Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	

M2. TYPE OF ULCER — (*For each type of ulcer, **code for the highest stage in the last 7 days** using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4*)

- a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue
- b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities

M4. OTHER SKIN PROBLEMS OR LESIONS PRESENT — (***Check all that apply** during **last 7 days***)

- Abrasions, bruises — a.
- Burns (second or third degree) — b.
- Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) — c.
- Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster — d.
- Skin desensitized to pain or pressure — e.
- Skin tears or cuts (other than surgery) — f.
- Surgical wounds — g.
- *NONE OF ABOVE* — h.

M5. SKIN TREATMENTS — (***Check all that apply** during **last 7 days**)*

- Pressure relieving device(s) for chair — a.
- Pressure relieving device(s) for bed — b.
- Turning/repositioning program — c.
- Nutrition or hydration intervention to manage skin problems — d.
- Ulcer care — e.
- Surgical wound care — f.
- Application of dressings (with or without topical medications) other than to feet — g.
- Application of ointments/medications (other than to feet) — h.
- Other preventative or protective skin care (other than to feet) — i.
- *NONE OF ABOVE* — j.

M6. FOOT PROBLEMS AND CARE — (***Check all that apply** during **last 7 days**)*

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

N1. TIME AWAKE — (***Check appropriate time periods over last 7 days***)

Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:

- Morning — a.
- Afternoon — b.
- Evening — c.
- *NONE OF ABOVE* — d.

(If resident is comatose, skip to Section O)

N2. AVERAGE TIME INVOLVED IN ACTIVITIES — (**When awake and not receiving treatments or ADL care**)

0. Most—more than 2/3 of time
1. Some—from 1/3 to 2/3 of time
2. Little—less than 1/3 of time
3. None

O1. NUMBER OF MEDICATIONS — (***Record the number of different** medications used in the **last 7 days**; enter "0" if none used*)

O3. INJECTIONS — (***Record the number of DAYS** injections of any type received during the **last 7 days**; enter "0" if none used*)

O4. DAYS RECEIVED THE FOLLOWING MEDICATION — (***Record the number of DAYS** during **last 7 days**; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*)

- a. Antipsychotic — d. Hypnotic
- b. Antianxiety — e. Diuretic
- c. Antidepressant

P1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS — a. **SPECIAL CARE**—***Check** treatments or programs received during the **last 14 days***

TREATMENTS

- Chemotherapy — a.
- Dialysis — b.
- IV medication — c.
- Intake/output — d.
- Monitoring acute medical condition — e.
- Ostomy care — f.
- Oxygen therapy — g.
- Radiation — h.
- Suctioning — i.
- Tracheostomy care — j.
- Transfusions — k.
- Ventilator or respirator — l.

PROGRAMS

- Alcohol/drug treatment program — m.
- Alzheimer's/dementia special care unit — n.
- Hospice care — o.
- Pediatric unit — p.
- Respite care — q.
- Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) — r.
- *NONE OF ABOVE* — s.

b. **THERAPIES** - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the **last 7 calendar days** (Enter 0 if none or less than 15 min. daily)* **[Note—count only post admission therapies]**

(A) = # of days administered for **15 minutes or more**
(B) = total # of minutes provided in **last 7 days**

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

P3. NURSING REHABILITATION/ RESTORATIVE CARE — *Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was **provided to the resident for more than or equal to 15 minutes per day in the last 7 days** (Enter 0 if none or less than 15 min. daily.)*

- a. Range of motion (passive)
- b. Range of motion (active)
- c. Splint or brace assistance

TRAINING AND SKILL PRACTICE IN:

- d. Bed mobility
- e. Transfer
- f. Walking
- g. Dressing or grooming
- h. Eating or swallowing
- i. Amputation/prosthesis care
- j. Communication
- k. Other

P4. DEVICES AND RESTRAINTS — *Use the following codes for **last 7 days**:*
0. Not used
1. Used less than daily
2. Used daily

Bed rails

- a. — Full bed rails on all open sides of bed
- b. — Other types of side rails used (e.g., half rail, one side)
- c. Trunk restraint
- d. Limb restraint
- e. Chair prevents rising

P7. PHYSICIAN VISITS — In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (*Enter 0 if none*)

P8. PHYSICIAN ORDERS — In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change.* (*Enter 0 if none*)

Q2. OVERALL CHANGE IN CARE NEEDS — Resident's overall level of self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days)

0. No change
1. Improved—receives fewer supports, needs less restrictive level of care
2. Deteriorated—receives more support

R2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete — Month ___ Day ___ Year ____

Resident _____ Numeric Identifier_____

MINIMUM DATA SET (MDS) - *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

SECTION W. SUPPLEMENTAL MDS ITEMS

1.	**National Provider ID**	Enter for all assessments and tracking forms, if available. ☐☐☐☐☐☐☐☐☐☐	
		If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.	
2.	**Influenza Vaccine**	a . Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3) 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 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine	
3.	**Pneumo-coccal Vaccine**	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

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

Numeric Identifier _____

A1. RESIDENT NAME
a. (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)

A2. ROOM NUMBER

A3. ASSESSMENT REFERENCE DATE
a. Last day of MDS observation period
Month — Day — Year
b. Original (0) or corrected copy of form (enter number of correction)

A4a. DATE OF REENTRY
Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)
Month — Day — Year

A6. MEDICAL RECORD NO.

B1. COMATOSE
(*Persistent vegetative state/no discernible consciousness*)
0. No 1. Yes (***Skip to Section G***)

B2. MEMORY
(*Recall of what was learned or known*)
a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 1. Memory problem
b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 1. Memory problem

B3. MEMORY/ RECALL ABILITY
(***Check all*** *that resident was* ***normally able to recall during last 7 days***)
Current season **a.**
Location of own room **b.**
Staff names/faces **c.**
That he/she is in a nursing home **d.**
NONE OF ABOVE are recalled **e.**

B4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING
(*Made decisions regarding tasks of daily life*)
0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

B5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS
(*Code for behavior in the* ***last 7 days.)*** **[*Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time*].**
0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)
b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)
e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)
f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

C4. MAKING SELF UNDERSTOOD
(*Expressing information content—however able*)
0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

C6. ABILITY TO UNDERSTAND OTHERS
(*Understanding verbal information content—however able*)
0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD
(***Code for indicators observed in last 30 days, irrespective of the assumed cause***)
0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

VERBAL EXPRESSIONS OF DISTRESS
a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"
b. Repetitive questions—e.g., "*Where do I go; What do I do?*"
c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")
d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received
e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"
f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others
g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack
h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions
i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues

SLEEP-CYCLE ISSUES
j. Unpleasant mood in morning
k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE
l. Sad, pained, worried facial expressions—e.g., furrowed brows
m. Crying, tearfulness
n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST
o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends
p. Reduced social interaction

E2. MOOD PERSISTENCE
One or more indicators of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days**
0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered

E4. BEHAVIORAL SYMPTOMS
(A) ***Behavioral*** *symptom* ***frequency in last 7 days***
0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) ***Behavioral*** *symptom* ***alterability in last 7 days***
0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)		
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)		
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)		

G1. **(A)** ADL SELF-PERFORMANCE—(***Code*** *for resident's* ***PERFORMANCE OVER ALL SHIFTS during last 7 days***—*Not including setup*)
0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
— Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(***Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless*** *of resident's self-performance classification*)
0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	**BED MOBILITY**	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	**TRANSFER**	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		

Resident_____ Numeric Identifier _____

G1.			(A)	(B)
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

G2. BATHING

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) ***Code for most dependent*** *in self-performance.*

(A) BATHING SELF PERFORMANCE codes appear below

	(A)
0. Independent—No help provided	
1. Supervision—Oversight help only	
2. Physical help limited to transfer only	
3. Physical help in part of bathing activity	
4. Total dependence	
8. Activity itself did not occur during entire 7 days	

G3. TEST FOR BALANCE (see training manual)

(*Code for ability during test in the* ***last 7 days***)

0. Maintained position as required in test
1. Unsteady, but able to rebalance self without physical support
2. Partial physical support during test; or stands (sits) but does not follow directions for test
3. Not able to attempt test without physical help

a. Balance while standing	
b. Balance while sitting—position, trunk control	

G4. FUNCTIONAL LIMITATION IN RANGE OF MOTION

(*Code for limitations during* ***last 7 days*** *that interfered with daily functions or placed residents at risk of injury*)

(A) *RANGE OF MOTION*
0. No limitation
1. Limitation on one side
2. Limitation on both sides

(B) *VOLUNTARY MOVEMENT*
0. No loss
1. Partial loss
2. Full loss

	(A)	(B)
a. Neck		
b. Arm—Including shoulder or elbow		
c. Hand—Including wrist or fingers		
d. Leg—Including hip or knee		
e. Foot—Including ankle or toes		
f. Other limitation or loss		

G6. MODES OF TRANSFER

(***Check all that apply*** *during* ***last 7 days***)

Bedfast all or most of time	a.	*NONE OF ABOVE*	f.
Bed rails used for bed mobility or transfer	b.		

G7. TASK SEGMENTATION

Some or all of ADL activities were broken into subtasks during **last 7 days** so that resident could perform them
0. No 1. Yes

H1. CONTINENCE SELF-CONTROL CATEGORIES
(***Code for resident's PERFORMANCE OVER ALL SHIFTS***)

0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]*
1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	

H2. BOWEL ELIMINATION PATTERN

Diarrhea	c.	*NONE OF ABOVE*	e.
Fecal impaction	d.		

H3. APPLIANCES AND PROGRAMS

Any scheduled toileting plan	a.	Indwelling catheter	d.
Bladder retraining program	b.	Ostomy present	i.
External (condom) catheter	c.	*NONE OF ABOVE*	j.

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

I1. DISEASES (***If none apply, CHECK the NONE OF ABOVE box***)

ENDOCRINE/METABOLIC/ NUTRITIONAL		Hemiplegia/Hemiparesis	v.
Diabetes mellitus	a.	Multiple sclerosis	w.
MUSCULOSKELETAL		Quadriplegia	z.
Hip fracture	m.	**PSYCHIATRIC/MOOD**	
NEUROLOGICAL		Depression	ee.
Aphasia	r.	Manic depressive (bipolar disease)	ff.
Cerebral palsy	s.	**OTHER**	
Cerebrovascular accident (stroke)	t.	*NONE OF ABOVE*	rr.

I2. INFECTIONS (***If none apply, CHECK the NONE OF ABOVE box***)

Antibiotic resistant infection (e.g., Methicillin resistant staph)	a.	Septicemia	g.
		Sexually transmitted diseases	h.
Clostridium difficile (c. diff.)	b.	Tuberculosis	i.
Conjunctivitis	c.	Urinary tract infection **in last 30 days**	j.
HIV infection	d.	Viral hepatitis	k.
Pneumonia	e.	Wound infection	l.
Respiratory infection	f.	NONE OF ABOVE	m.

I3. OTHER CURRENT DIAGNOSES AND ICD-9 CODES

(*Include* ***only those diseases diagnosed in the last 90 days that have a relationship*** *to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death*)

a. _____ | | | | • | |

b. | | | | • | |

J1. PROBLEM CONDITIONS

(***Check all problems present*** *in* ***last 7 days*** *unless other time frame is indicated*)

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

J2. PAIN SYMPTOMS

(*Code the* ***highest level of pain*** *present in the* ***last 7 days***)

a. FREQUENCY with which resident complains or shows evidence of pain
0. No pain (***skip to J4***)
1. Pain less than daily
2. Pain daily

b. INTENSITY of pain
1. Mild pain
2. Moderate pain
3. Times when pain is horrible or excrutiating

J4. ACCIDENTS

(***Check all that apply***)

Fell in **past 30 days**	a.	Hip fracture in **last 180 days**	c.
		Other fracture in **last 180 days**	d.
Fell in **past 31-180 days**	b.	*NONE OF ABOVE*	e.

J5. STABILITY OF CONDITIONS

Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating)	a.
Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem	b.
End-stage disease, 6 or fewer months to live	c.
NONE OF ABOVE	d.

K1. ORAL PROBLEMS

Chewing problem	a.
Swallowing problem	b.
NONE OF ABOVE	d.

K2. HEIGHT AND WEIGHT

Record ***(a.) height in inches*** *and* ***(b.) weight in pounds****. Base weight on most recent measure in* ***last 30 days****; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes*

a. HT (in.) | | **b.** WT (lb.) | | |

K3. WEIGHT CHANGE

a. Weight loss—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**
0. No 1. Yes

b. Weight gain—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**
0. No 1. Yes

Resident_____ Numeric Identifier _____

K5. NUTRITIONAL APPROACHES (***Check all that apply in last 7 days***)

- a. Parenteral/IV
- b. Feeding tube
- On a planned weight change program → h.
- *NONE OF ABOVE* → i.

K6. PARENTERAL OR ENTERAL INTAKE (***Skip to Section M if neither 5a nor 5b is checked***)

a. Code the proportion of **total calories** the resident received through parenteral or tube feedings in the **last 7 days**
0. None; 1. 1% to 25%; 2. 26% to 50%; 3. 51% to 75%; 4. 76% to 100%

b. Code the average **fluid intake** per day by IV or tube in **last 7 days**
0. None; 1. 1 to 500 cc/day; 2. 501 to 1000 cc/day; 3. 1001 to 1500 cc/day; 4. 1501 to 2000 cc/day; 5. 2001 or more cc/day

M1. ULCERS (Due to any cause) — *(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during **last 7 days**. Code 9 = 9 or more.)* ***[Requires full body exam.]***

		Number at Stage
a. Stage 1.	A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
b. Stage 2.	A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
c. Stage 3.	A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
d. Stage 4.	A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	

M2. TYPE OF ULCER (*For each type of ulcer, **code for the highest stage in the last 7 days** using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4*)

- **a.** Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue
- **b.** Stasis ulcer—open lesion caused by poor circulation in the lower extremities

M4. OTHER SKIN PROBLEMS OR LESIONS PRESENT (***Check all that apply** during **last 7 days***)

- Abrasions, bruises → a.
- Burns (second or third degree) → b.
- Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) → c.
- Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster → d.
- Skin desensitized to pain or pressure → e.
- Skin tears or cuts (other than surgery) → f.
- Surgical wounds → g.
- *NONE OF ABOVE* → h.

M5. SKIN TREATMENTS (***Check all that apply** during **last 7 days)***

- Pressure relieving device(s) for chair → a.
- Pressure relieving device(s) for bed → b.
- Turning/repositioning program → c.
- Nutrition or hydration intervention to manage skin problems → d.
- Ulcer care → e.
- Surgical wound care → f.
- Application of dressings (with or without topical medications) other than to feet → g.
- Application of ointments/medications (other than to feet) → h.
- Other preventative or protective skin care (other than to feet) → i.
- *NONE OF ABOVE* → j.

M6. FOOT PROBLEMS AND CARE (***Check all that apply** during **last 7 days)***

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

N1. TIME AWAKE (***Check appropriate time periods over last 7 days***)
Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:

- a. Morning
- b. Afternoon
- Evening → c.
- *NONE OF ABOVE* → d.

(If resident is comatose, skip to Section O)

N2. AVERAGE TIME INVOLVED IN ACTIVITIES (**When awake and not receiving treatments or ADL care**)
0. Most—more than 2/3 of time; 1. Some—from 1/3 to 2/3 of time; 2. Little—less than 1/3 of time; 3. None

O1. NUMBER OF MEDICATIONS (***Record the number of different** medications used in the **last 7 days**; enter "0" if none used*)

O3. INJECTIONS (***Record the number of DAYS** injections of any type received during the **last 7 days**; enter "0" if none used*)

O4. DAYS RECEIVED THE FOLLOWING MEDICATION (***Record the number of DAYS** during **last 7 days**; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*)

- **a.** Antipsychotic
- **b.** Antianxiety
- **c.** Antidepressant
- **d.** Hypnotic
- **e.** Diuretic

P1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

a. SPECIAL CARE—***Check** treatments or programs received during the **last 14 days***

TREATMENTS
- Chemotherapy → a.
- Dialysis → b.
- IV medication → c.
- Intake/output → d.
- Monitoring acute medical condition → e.
- Ostomy care → f.
- Oxygen therapy → g.
- Radiation → h.
- Suctioning → i.
- Tracheostomy care → j.
- Transfusions → k.
- Ventilator or respirator → l.

PROGRAMS
- Alcohol/drug treatment program → m.
- Alzheimer's/dementia special care unit → n.
- Hospice care → o.
- Pediatric unit → p.
- Respite care → q.
- Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) → r.
- *NONE OF ABOVE* → s.

b. THERAPIES - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the **last 7 calendar days** (Enter 0 if none or less than 15 min. daily)*
[Note—count only post admission therapies]

(A) = # of days administered for **15 minutes or more** **(B) = total # of minutes** provided in **last 7 days**	DAYS (A)	MIN (B)
a. Speech - language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		

P3. NURSING REHABILITATION/ RESTORATIVE CARE — *Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was **provided to the resident for more than or equal to 15 minutes per day in the last 7 days** (Enter 0 if none or less than 15 min. daily.)*

- **a.** Range of motion (passive)
- **b.** Range of motion (active)
- **c.** Splint or brace assistance

TRAINING AND SKILL PRACTICE IN:
- **d.** Bed mobility
- **e.** Transfer
- **f.** Walking
- **g.** Dressing or grooming
- **h.** Eating or swallowing
- **i.** Amputation/prosthesis care
- **j.** Communication
- **k.** Other

P4. DEVICES AND RESTRAINTS — *Use the following codes for **last 7 days**:*
0. Not used; 1. Used less than daily; 2. Used daily

Bed rails
- **a.** — Full bed rails on all open sides of bed
- **b.** — Other types of side rails used (e.g., half rail, one side)
- **c.** Trunk restraint
- **d.** Limb restraint
- **e.** Chair prevents rising

P7. PHYSICIAN VISITS — In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (*Enter 0 if none*)

P8. PHYSICIAN ORDERS — In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change.* (*Enter 0 if none*)

Q2. OVERALL CHANGE IN CARE NEEDS — Resident's overall level of self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change; 1. Improved—receives fewer supports, needs less restrictive level of care; 2. Deteriorated—receives more support

R2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete — Month / Day / Year

Resident _____ Numeric Identifier_____

MINIMUM DATA SET (MDS) - *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

SECTION W. SUPPLEMENTAL MDS ITEMS

1.	**National Provider ID**	Enter for all assessments and tracking forms, if available. ☐☐☐☐☐☐☐☐☐☐	
		If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.	
2.	**Influenza Vaccine**	a . Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3) 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 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine	
3.	**Pneumo-coccal Vaccine**	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

Numeric Identifier_____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

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

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ⊛	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
2.	GENDER ⊛	1. Male 2. Female
3.	BIRTHDATE ⊛	Month — Day — Year
4.	RACE/ ETHNICITY ⊛	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY AND MEDICARE NUMBERS ⊛ [C in 1st box if non med. no.]	**a.** Social Security Number — — **b.** Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ⊛	**a.** State No. **b.** Federal No.
7.	MEDICAID NO. [*"+" if pending, "N" if not a Medicaid recipient*] ⊛	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] **a.** Primary reason for assessment 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

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

Signature and Title	Sections	Date
a.		
b.		
c.		

SECTION AB. DEMOGRAPHIC INFORMATION

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

1.	DATE OF ENTRY	*Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date* Month — Day — Year
2.	ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

6.	MEDICAL RECORD NO.	

SECTION R. ASSESSMENT/DISCHARGE INFORMATION

3.	DISCHARGE STATUS	**a.** *Code for resident disposition upon discharge* 1. Private home/apartment with no home health services 2. Private home/apartment with home health services 3. Board and care/assisted living 4. Another nursing facility 5. Acute care hospital 6. Psychiatric hopital, MR/DD facility 7. Rehabilitation hospital 8. Deceased 9. Other **b.** *Optional State Code*
4.	DISCHARGE DATE	*Date of death or discharge* Month — Day — Year

⊛ = Key items for computerized resident tracking

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

Resident _____ Numeric Identifier_____

MINIMUM DATA SET (MDS) - *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

SECTION W. SUPPLEMENTAL MDS ITEMS

1.	**National Provider ID**	Enter for all assessments and tracking forms, if available. ☐☐☐☐☐☐☐☐☐☐	
		If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.	
2.	**Influenza Vaccine**	a . Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3) 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 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine	
3.	**Pneumo-coccal Vaccine**	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

Numeric Identifier_____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

REENTRY TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ④	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
2.	GENDER ④	1. Male 2. Female
3.	BIRTHDATE ④	Month — Day — Year
4.	RACE/ ETHNICITY ④	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY ④ AND MEDICARE NUMBERS ④ [C in 1st box if non med. no.]	**a.** Social Security Number — — **b.** Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ④	**a.** State No. **b.** Federal No.
7.	MEDICAID NO. [*"+" if pending, "N" if not a Medicaid recipient*] ④	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] **a.** Primary reason for assessment 9. Reentry

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

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

Signature and Title	Sections	Date
a.		
b.		
c.		

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

4a.	DATE OF REENTRY	**Date of reentry** Month — Day — Year
4b.	ADMITTED FROM (AT REENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other
6.	MEDICAL RECORD NO.	

④ = Key items for computerized resident tracking

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

Resident _____ Numeric Identifier_____

MINIMUM DATA SET (MDS) - *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

SECTION W. SUPPLEMENTAL MDS ITEMS

1.	**National Provider ID**	Enter for all assessments and tracking forms, if available. ☐☐☐☐☐☐☐☐☐☐	
If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.			
2.	**Influenza Vaccine**	a. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3) 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 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine	
3.	**Pneumo-coccal Vaccine**	a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered	

W2 inactive on reentry

W3 inactive on reentry

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

Correction Request Form

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

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

TO INACTIVATE A RECORD IN THE STATE DATABASE:
1. Complete this correction request form;
2. Create an electronic record of the Correction Request Form; and
3. Electronically submit this Correction Request record to the MDS database at the State.

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

Prior AA1.	RESIDENT NAME	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
Prior AA2.	GENDER	1. Male 2. Female
Prior AA3.	BIRTHDATE	Month — Day — Year
Prior AA5.	SOCIAL SECURITY	**a.** Social Security Number
Prior AA8.	REASONS FOR ASSESSMENT	**a.** Primary reason for assessment ASSESSMENT (Complete Prior Date item Prior A3a *ONLY*) 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* DISCHARGE TRACKING (Complete Prior Date item Prior R4 *ONLY*) 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. DIscharged prior ro completing initial assessment REENTRY TRACKING (Complete Prior Date item Prior A4a *ONLY*) 9. Rentry **b. *Codes for assessments required for Medicare PPS or the State*** *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*
	PRIOR DATE	(***Complete one only***) Complete Prior A3a if Primary Reason (Prior AA8a) equals 1, 2, 3, 4, 5, 10, or 0. Complete Prior R4 if Primary Reason (Prior AA8a) equals 6, 7, or 8. Complete Prior A4a if Primary Reason (Prior AA8a) equals 9.
Prior A3.	ASSESSMENT REFERENCE DATE	**a.** *Last day of MDS observation period* Month — Day — Year
Prior R4.	DISCHARGE DATE	*Date of discharge* Month — Day — Year
Prior A4a.	DATE OF REENTRY	*Date of reentry* Month — Day — Year

CORRECTION ATTESTATION SECTION.
COMPLETE THIS SECTION TO EXPLAIN AND ATTEST TO THE CORRECT REQUEST

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

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

RN COORDINATOR ATTESTATION OF COMPLETION

AT5.	ATTESTING INDIVIDUAL NAME	**a.** (First) **b.** (Last) **c.** (Title)
	SIGNATURE	
AT6.	ATTESTATION DATE	Month — Day — Year

AT7. ATTESTATION OF ACCURACY AND SIGNATURES OF PERSONS WHO CORRECT A PORTION OF ASSESSMENT OR TRACKING INFORMATION

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

Signature and Title	Attestation Date
a.	
b.	
c.	
d.	
e.	
f.	

3. RESIDENT ASSESSMENT PROTOCOL: VISUAL FUNCTION

I. PROBLEM

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

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

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

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

II. TRIGGERS

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

- Side Vision Problem *(Reverse*)
  [D2a = checked]
- Cataracts (*Reverse*)
  [I1jj = checked]

- Glaucoma (*Reverse*)
  [I1ll = checked]
- Vision Impaired (*Improve*)
  [D1 = 1, 2, 3]

III. GUIDELINES

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

Eye Medications

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

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

Diabetes, Cataracts, Glaucoma, or Macular Degeneration

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

Exam by Ophthalmologist or Optometrist Since Problem Noted

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

If Neurological Diagnosis or Dementia Exam by Physician Since Problem Noted

Check the medical record to see if a physician has examined the resident for visual/perceptual difficulties. Some residents with diseases such as myasthenia gravis, stroke, and dementia will have such difficulties associated with central nervous system in the absence of diseases of the eye.

Sad or Anxious Mood

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

Appropriate Use of Visual Appliances

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

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

Functional Need for Eye Exam/New Glasses

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

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

Environmental Modifications

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

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

Acute Problems that May Have Been Missed: Eye Pain, Blurry Vision, Double Vision, or Sudden Loss of Vision

These symptoms are usually associated with acute eye problems.

- Has resident been evaluated by a physician or ophthalmologist?

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

3. VISUAL FUNCTION RAP KEY

(For MDS Version 2.0)

TRIGGER – REVISION

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

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

GUIDELINES

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

- Eye Medications **[from record]**.
- Diabetes **[I1a]**, Cataracts **[I1jj]**, Glaucoma **[I1ll]**, Macular Degeneration **[I1mm]**.
- Exam by Ophthalmologist Since Problem Noted **[from record]**.
- Neurological Diagnosis or Dementia **[I1q to I1cc]**.
- Indicators of Depression, Anxiety, Sad Mood **[E1]**.
- Appropriate Use of Visual Appliances **[D3; from record observation]**.
- Functional Need for Eye Exam/New Glasses **[from observation]**.
- Environmental Modifications **[from record, observation]**.
- Other Acute Problems: Eye Pain, Blurry Vision, Double Vision, Sudden Loss of Vision **[from record, observation]**.

Appendix D: Resident Assessment Protocols for Vision (RAP)

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

Numeric Identifier _____

Resident's Name:	Medical Record No.:

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

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

B. _____

1. Signature of RN Coordinator for RAP Assessment Process

2. ☐☐ — ☐☐ — ☐☐☐☐ (Month — Day — Year)

_____

3. Signature of Person Completing Care Planning Decision

4. ☐☐ — ☐☐ — ☐☐☐☐ (Month — Day — Year)

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

Key:

- ● = One item required to trigger
- ❷ = Two items required to trigger
- ✱ = One of these three items, plus at least one other item required to trigger
- ⓐ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

MDS ITEM		CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A @	ADL-Maintenance Trigger B @	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	
B2a	Short term memory	1		●																			B2a
B2b	Long term memory	1		●																			B2b
B4	Decision making	1,2,3		●																			B4
B4	Decision making	3					●																B4
B5a to B5f	Indicators of delirium	2	●																	●			B5a to B5f
B6	Change in cognitive status	2	●																	●			B6
C1	Hearing	1,2,3				●																	C1
C4	Understood by others	1,2,3				●																	C4
C6	Understand others	1,2,3		●		●																	C6
C7	Change in communication	2																		●			C7
D1	Vision	1,2,3			●																		D1
D2a	Side vision problem	✓			●																		D2a
E1a to E1p	Indicators of depression, anxiety, sad mood	1,2									●												E1a to E1p
E1n	Repetitive movement	1,2																		●			E1n
E1o	Withdrawal from activities	1,2							●														E1o
E2	Mood persistence	1,2									●												E2
E3	Change in Mood	2	●																	●			E3
E4aA	Wandering	1,2,3													●								E4aA
E4aA- E4eA	Behavioral symptoms	1,2,3									●												E4aA - E4eA
E5	Change in behavioral symptoms	1									●												E5
E5	Change in behavioral symptoms	2	●																	●			E5
F1d	Establishes own goals	✓							●														F1d
F2a to F2d	Unsettled relationships	✓							●														F2a to F2d
F3a	Strong id. past roles	✓							●														F3a
F3b	Lost roles	✓							●														F3b
F3c	Daily routine different	✓							●														F3c
G1aA - G1jA	ADL self-performance	1,2,3,4					●																G1aA - G1jA
G1aA	Bed mobility	2,3,4,8																	●				G1aA
G2A	Bathing	1,2,3,4					●																G2A
G3b	Balance while sitting	1,2,3																		●			G3b
G6a	Bedfast	✓																	●				G6a
G8a,b	Resident, staff believe capable	✓					●																G8a,b
H1a	Bowel incontinence	1,2,3,4																	●				H1a
H1b	Bladder incontinence	2,3,4						●															H1b
H2b	Constipation	✓																		●			H2b
H2d	Fecal impaction	✓																		●			H2d
H3c,d,e	Catheter use	✓						●															H3c,d,e
H3g	Use of pads/briefs	✓						●															H3g
I1i	Hypotension	✓																		●			I1i
I1j	Peripheral vascular disease	✓																	●				I1j
I1ee	Depression	✓																		●			I1ee
I1ii	Cataracts	✓			●																		I1ii
I1ll	Glaucoma	✓			●																		I1ll
I2j	UTI	✓															●						I2j
I3	Dehydration diagnosis	276.5															●						I3
J1a	Weight fluctuation	✓															●						J1a
J1c	Dehydrated	✓															●						J1c
J1d	Insufficient fluid	✓															●						J1d
J1f	Dizziness	✓													●					●			J1f
J1h	Fever	✓															●						J1h
J1i	Hallucinations	✓																		●			J1i
J1j	Internal bleeding	✓															●						J1j
J1k	Lung aspirations	✓																		●			J1k
J1m	Syncope	✓																		●			J1m

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

Key:

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Proceed to RAP Review once triggered

MDS ITEM		CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A ⓐ	ADL-Maintenance Trigger B ⓐ	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	
J1n	Unsteady gait	✓																		●			J1n
J4a,b	Fell	✓													●					●			J4a,b
J4c	Hip fracture	✓																		●			J4c
K1b	Swallowing problem	✓																		●			K1b
K1c	Mouth pain	✓																●					K1c
K3a	Weight loss	1														●							K3a
K4a	Taste alteration	✓														●							K4a
K4c	Leave 25% food	✓														●							K4c
K5a	Parenteral/IV feeding	✓														●		●					K5a
K5b	Feeding tube	✓															●	●					K5b
K5c	Mechanically altered	✓														●							K5c
K5d	Syringe feeding	✓														●							K5d
K5e	Therapeutic diet	✓														●							K5e
L1a,c,d,e	Dental	✓																	●				L1a,c,d,e
L1f	Daily cleaning teeth	Not ✓																	●				L1f
M2a	Pressure ulcer	2,3,4														●							M2a
M2a	Pressure ulcer	1,2,3,4																	●				M2a
M3	Previous pressure ulcer	1																	●				M3
M4e	Impaired tactile sense	✓																	●				M4e
N1a	Awake morning	✓											❷										N1a
N2	Involved in activities	0											❷										N2
N2	Involved in activities	2,3										●											N2
N5a,b	Prefers change in daily routine	1,2										●											N5a,b
O4a	Antipsychotics	1-7																		✱			O4a
O4b	Antianxiety	1-7													●					✱			O4b
O4c	Antidepressants	1-7													●					✱			O4c
O4e	Diuretic	1-7																●					O4e
P4c	Trunk restraint	1,2													●						●		P4c
P4c	Trunk restraint	2																	●				P4c
P4d	Limb restraint	1,2																			●		P4d
P4e	Chair prevents rising	1,2																			●		P4e

Appendix E: Examples of Care Plans Involving Vision

Care Plan

Name:	Res.#:	Bed:
Physician:	Current Adm Date:	DOB:

Careplan Date: 07/23/97
FP RESIDENT :
DIET : Low Calorie May substitute Sustacel for meal prn
ALLERGIES :

CODE STATUS : FULL CODE

Signatures

Reviewed, _____
Edited and _____
Approved _____

PROBLEM / STRENGTH	GOAL	DISC / APPROACH	REVIEW
VISUAL FUNCTION: Sees only light or shades of light and shapes, bright colors due to diabetic retinopathy. Color recognition has worsened, but is stable for now. Problem Dt: 07/23/97	Will adapt to visual impairment and will not be injured due to poor vision. Target Date: 10/15/98	Nsg/SS/Act/Diet: Explain all procedures to prior to happening. Nsg/SS/Act/Diet: Keep passages & personal areas free of obstacles. Nursing: Keep call light & personal articles within reach. Activities Nursing Social Service: Encourage participation in facility activities.	

Name:	Res.#:	Bed:	
Physician:	Current Adm Date:	DOB:	
PROBLEM/STRENGTH	GOAL	DISC/APPROACH	REVIEW
VISUAL FUNCTION: Sees large print only due to cataracts; son wishes to explore cataract surgery. Associated RAPs: Visual, Problem Dt: 09/02/98	Will receive eye exam and family will be informated/included in decisions regarding further treatment. Target Date: 12/01/98	Nsg/SS/Act/Diet: Identify yourself when approaching the patient and explain all procedures. Activities Nursing Social Service: Provide large text print. Nursing Social Service: Provide…and facilitate optometry consult. Nursing: Keep call light & personal articles within reach.	