Resident

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2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) *Code for most dependent in self-performance and support.* (A) BATHING SELF-PERFORMANCE codes appear below 0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur during entire 7 days *(Bathing support codes are as defined in Item 1, code B above)*	(A)	(B)
3.	TEST FOR BALANCE (see training manual)	*(Code for ability during test in the last 7 days)* 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help		
		a. Balance while standing		
		b. Balance while sitting—position, trunk control		
4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)	*(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury)* (A) *RANGE OF MOTION* 0. No limitation 1. Limitation on one side 2. Limitation on both sides (B) *VOLUNTARY MOVEMENT* 0. No loss 1. Partial loss 2. Full loss	(A)	(B)
		a. Neck		
		b. Arm—Including shoulder or elbow		
		c. Hand—Including wrist or fingers		
		d. Leg—Including hip or knee		
		e. Foot—Including ankle or toes		
		f. Other limitation or loss		
5.	MODES OF LOCOMOTION	*(Check all that apply during last 7 days)* Cane/walker/crutch a. 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.		
	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		
	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. Bladder retraining program b. External (condom) catheter c. Indwelling catheter d. Intermittent catheter e. Did not use toilet room/commode/urinal f. Pads/briefs used g. Enemas/irrigation h. Ostomy present i. *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 Diabetes mellitus a. Hyperthyroidism b. Hypothyroidism c. HEART/CIRCULATION Arteriosclerotic heart disease (ASHD) d. Cardiac dysrhythmias e. Congestive heart failure f. Deep vein thrombosis g. Hypertension h. Hypotension i. Peripheral vascular disease j. Other cardiovascular disease k. MUSCULOSKELETAL Arthritis l. Hip fracture m. Missing limb (e.g., amputation) n. Osteoporosis o. Pathological bone fracture p. NEUROLOGICAL Alzheimer's disease q. Aphasia r. Cerebral palsy s. Cerebrovascular accident (stroke) t. Dementia other than Alzheimer's disease u. Hemiplegia/Hemiparesis v. Multiple sclerosis w. Paraplegia x. Parkinson's disease y. Quadriplegia z. Seizure disorder aa. Transient ischemic attack (TIA) bb. Traumatic brain injury cc. PSYCHIATRIC/MOOD Anxiety disorder dd. Depression ee. Manic depression (bipolar disease) ff. Schizophrenia gg. PULMONARY Asthma hh. Emphysema/COPD ii. SENSORY Cataracts jj. Diabetic retinopathy kk. Glaucoma ll. Macular degeneration mm. OTHER Allergies nn. Anemia oo. 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. 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.		
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 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. Dizziness/Vertigo f. Edema g. Fever h. Hallucinations i. Internal bleeding j. Recurrent lung aspirations in last 90 days k. Shortness of breath l. Syncope (fainting) m. Unsteady gait n. Vomiting o. *NONE OF ABOVE* p.		

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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 last 30 days; or 10 % or more in last 180 days 0. No 1. Yes	
		b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes	
4.	NUTRITIONAL PROBLEMS	Complains about the taste of many foods	a.
		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 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	

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

			Number at Stage
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.]*	
		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 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 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.

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

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

	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)		

2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS

(Check all interventions or strategies used in last 7 days—no matter where received)

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

3. NURSING REHABILITATION/ RESTORATIVE CARE

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

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

4. DEVICES AND RESTRAINTS

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

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

5.	HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay in last 90 days (or since last assessment if less than 90 days). *(Enter 0 if no hospital admissions)*
6.	EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days). *(Enter 0 if no ER visits)*
7.	PHYSICIAN VISITS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? *(Enter 0 if none)*
8.	PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change. (Enter 0 if none)*
9.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission)? 0. No 1. Yes

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0. No 1. Yes
		b. Resident has a support person who is positive towards discharge 0. No 1. Yes
		c. Stay projected to be of a short duration— discharge projected within 90 days (do not include expected discharge due to death) 0. No 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. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:

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

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

c. Other Signatures	Title	Sections	Date
d.			Date
e.			Date
f.			Date
g.			Date
h.			Date

AFFIDAVIT

State of MISSOURI)
) ss.
County of _____)

I, _____(Name of Son or Daughter)_____, first being duly sworn, on my oath, state that I have resided in the home of _____(Name of Institutionalized Recipient)_ , my parent, for at least two years immediately before his/her admission to a nursing facility, intermediate care facility for the mentally retarded, or other medical institution on ___(Date of Admission to Facility)___ . I swear that I have resided in the home on a continuous basis since that time, and can establish to the Department of Social Service's satisfaction that I have been providing care which permitted _____(Name of Institutionalized Recipient)___, my parent, to reside at home rather than in an institution.

_____(Signature of Son or Daughter)_____

Subscribed and sworn to before me this _____ day of _____, ____. I am commissioned as a Notary Public within the County of _____, State of Missouri, and my commission expires __/__/__.

_____

Notary Public

State Plan TN# 96-11 Effective Date April 1, 1996
Supersedes TN# NA Approval Date AUG 0 1 1996