

Resident _____

Numeric Identifier _____

MINIMUM DATA SET (MDS) — VERSION 2.0
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

Attachment 4.19D
Page 10 of 24

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 <div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> — <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> — <div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> </div> <p style="font-size: small; margin-top: 5px;">Month Day Year</p>
2. ADMITTED FROM (AT ENTRY)	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> 0. No 1. Yes 2. In other facility
4. ZIP CODE OF PRIOR PRIMARY RESIDENCE	<div style="border: 1px solid black; width: 100px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div>
5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	<p>(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above)</p> <ul style="list-style-type: none"> 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 "I" between two occupations]	<div style="border: 1px solid black; width: 100%; height: 20px; display: flex; align-items: center; justify-content: center;"> </div>
EDUCATION (Highest Level Completed)	<ul style="list-style-type: none"> <li style="width: 50%;">1. No schooling <li style="width: 50%;">5. Technical or trade school <li style="width: 50%;">2. 8th grade/less <li style="width: 50%;">6. Some college <li style="width: 50%;">3. 9-11 grades <li style="width: 50%;">7. Bachelor's degree <li style="width: 50%;">4. High school <li style="width: 50%;">8. Graduate degree
8. LANGUAGE	<p>(Code for correct response)</p> <p>a. Primary Language</p> <p>0. English 1. Spanish 2. French 3. Other</p> <p>b. If other, specify <div style="border: 1px solid black; width: 100px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div></p>
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	<p>(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely)</p> <ul style="list-style-type: none"> Not applicable—no MR/DD (Skip to AB11) a. MR/DD with organic condition b. <ul style="list-style-type: none"> Down's syndrome Autism Epilepsy Other organic condition related to MR/DD MR/DD with no organic condition f.
11. DATE BACKGROUND INFORMATION COMPLETED	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> — <div style="border: 1px solid black; width: 20px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> — <div style="border: 1px solid black; width: 30px; height: 20px; display: flex; align-items: center; justify-content: center;"> </div> </div> <p style="font-size: small; margin-top: 5px;">Month Day Year</p>

SECTION AC. CUSTOMARY ROUTINE

1. CUSTOMARY ROUTINE	(Check all that apply. If all information UNKNOWN, check last box only.)
(In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home)	
CYCLE OF DAILY EVENTS	
Stays up late at night (e.g., after 9 pm)	a.
Naps regularly during day (at least 1 hour)	b.
Goes out 1+ days a week	c.
Stays busy with hobbies, reading, or fixed daily routine	d.
Spends most of time alone or watching TV	e.
Moves independently indoors (with appliances, if used)	f.
Use of tobacco products at least daily	g.
NONE OF ABOVE	h.
EATING PATTERNS	
Distinct food preferences	i.
Eats between meals all or most days	j.
Use of alcoholic beverage(s) at least weekly	k.
NONE OF ABOVE	l.
ADL PATTERNS	
In bedclothes much of day	m.
Wakens to toilet all or most nights	n.
Has irregular bowel movement pattern	o.
Showers for bathing	p.
Bathing in PM	q.
NONE OF ABOVE	r.
INVOLVEMENT PATTERNS	
Daily contact with relatives/close friends	s.
Usually attends church, temple, synagogue (etc.)	t.
Finds strength in faith	u.
Daily animal companion/presence	v.
Involved in group activities	w.
NONE OF ABOVE	x.
UNKNOWN—Resident/family unable to provide information	y.

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:			
a. Signature of RN Assessment Coordinator			Date
b. Signatures	Title	Sections	Date
c.			Date
d.			Date
e.			Date
f.			Date
g.			Date

= When box blank, must enter number or letter = When letter in box, check if condition applies

TN # 98-10 APPROVAL DATE SEP 29 1998
MDS 2.0 01/30/98
SUPERSEDES
TN # 94-24 EFFECTIVE DATE 7/1/98

Numeric Identifier

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

Attachment 4.19D
Page 11 of 24

(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	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
3. ASSESSMENT REFERENCE DATE	a. Last day of MDS observation period <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 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) <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year			
5. MARITAL STATUS	1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated			
6. MEDICAL RECORD NO.	<input type="text"/>			
7. CURRENT PAYMENT SOURCES FOR N.H. STAY	(Billing Office to indicate; check all that apply in last 30 days) Medicaid per diem a. VA per diem f. Medicare per diem b. Self or family pays for full per diem g. Medicare ancillary part A c. Medicaid resident liability or Medicare co-payment h. Medicare ancillary part B d. Private insurance per diem (including co-payment) i. CHAMPUS per diem e. Other per diem j.			
8. REASONS FOR ASSESSMENT	a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment 9. Reentry 10. Significant correction of prior quarterly assessment 0. NONE OF ABOVE b. Codes for assessments required for Medicare PPS or the State 1. Medicare 5 day assessment 2. Medicare 30 day assessment 3. Medicare 60 day assessment 4. Medicare 90 day assessment 5. Medicare readmission/return assessment 6. Other state required assessment 7. Medicare 14 day assessment 8. Other Medicare required assessment			
9. RESPONSIBILITY/LEGAL GUARDIAN	(Check all that apply) Durable power attorney/financial Legal guardian a. Family member responsible d. Other legal oversight b. Patient responsible for self e. Durable power of attorney/health care c. NONE OF ABOVE f.			
10. ADVANCED DIRECTIVES	(For those items with supporting documentation in the medical record, check all that apply) Living will a. Feeding restrictions f. Do not resuscitate b. Medication restrictions g. Do not hospitalize c. Other treatment restrictions h. Organ donation d. NONE OF ABOVE i. Autopsy request e.			

SECTION B. COGNITIVE PATTERNS

1. COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (If yes, skip to Section G)	
2. MEMORY	(Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem	

3. MEMORY/RECALL ABILITY	(Check all that resident was normally able to recall during last 7 days) Current season a. That he/she is in a nursing home d. Location of own room b. NONE OF ABOVE are recalled e. Staff names/faces c.		
4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING	(Made decisions regarding tasks of daily life) 0. INDEPENDENT—decisions consistent/reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions		
5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/AWARENESS	(Code for behavior in the last 7 days.) (Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time). 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out) e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)		
6. CHANGE IN COGNITIVE STATUS	Resident's cognitive status, skills, or abilities have changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated		

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING	(With hearing appliance, if used) 0. HEARS ADEQUATELY—normal talk, TV, phone 1. MINIMAL DIFFICULTY when not in quiet setting 2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly 3. HIGHLY IMPAIRED/absence of useful hearing		
2. COMMUNICATION DEVICES/TECHNIQUES	(Check all that apply during last 7 days) Hearing aid, present and used 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. American sign language or Braille c. Other f. NONE OF ABOVE g.		
4. MAKING SELF UNDERSTOOD	(Expressing information content—however able) 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY/NEVER UNDERSTOOD		
5. SPEECH CLARITY	(Code for speech in the last 7 days) 0. CLEAR SPEECH—distinct, intelligible words 1. UNCLEAR SPEECH—slurred, mumbled words 2. NO SPEECH—absence of spoken words		
6. ABILITY TO UNDERSTAND OTHERS	(Understanding verbal information content—however able) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part/intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY/NEVER UNDERSTANDS		
7. CHANGE IN COMMUNICATION/HEARING	Resident's ability to express, understand, or hear information has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated		

= When box blank, must enter number or letter = When letter in box, check if condition applies

APPROVAL DATE
TN # 98-10
SUPERSEDES
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EFFECTIVE DATE 7/1/98
SEP 29 1998

Resident
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) Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes NONE OF ABOVE	a. b. 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. WANDERING (moved with no rational purpose, seemingly obvious 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)	(A) (B)

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

1. SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others At ease doing planned or structured activities At ease doing self-initiated activities Establishes own goals Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) Accepts invitations into most group activities NONE OF ABOVE	a. b. c. d. e. f. g.
2. UNSETTLED RELATIONSHIPS	Cover/open conflict with or repeated criticism of staff Unhappy with roommate Unhappy with residents other than roommate Openly expresses conflict/anger with family/friends Absence of personal contact with family/friends Recent loss of close family member/friend Does not adjust easily to change in routines NONE OF ABOVE	a. b. c. d. e. f. g. h.
3. PAST ROLES	Strong identification with past roles and life status Expresses sadness/anger/empty feeling over lost roles/status Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community NONE OF ABOVE	a. b. c. 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 last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days 2. LIMITED ASSISTANCE —Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days 3. EXTENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: —Weight-bearing support — Full staff performance during part (but not all) of last 7 days 4. TOTAL DEPENDENCE —Full staff performance of activity during entire 7 days 5. ACTIVITY DID NOT OCCUR during entire 7 days		
(B) ADL SUPPORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)	0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+ persons physical assist	8. ADL activity itself did not occur during entire 7 days	(A) (B) SELF-PERF 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)		

SEP 29 1998

TN # 98-10 APPROVAL DATE 2.0 01/30/98

SUPERSEDES

TN # 94-24 EFFECTIVE DATE 7/1/98

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Resident	
2. BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) Code for most dependent in self-performance and support. (A) BATHING SELF-PERFORMANCE codes appear below (A) (B)
3. TEST FOR BALANCE (see training manual)	(Code for ability during test in the last 7 days) 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test, or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help a. Balance while standing b. Balance while sitting—position, trunk control
4. FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)	(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury) (A) RANGE OF MOTION (B) VOLUNTARY MOVEMENT 0. No limitation 0. No loss 1. Limitation on one side 1. Partial loss 2. Limitation on both sides 2. Full loss a. Neck b. Arm—including shoulder or elbow c. Hand—including wrist or fingers d. Leg—including hip or knee e. Foot—including ankle or toes f. Other limitation or loss
5. MODES OF LOCOMOTION	(Check all that apply during last 7 days) Cane/walker/crutch a. Wheelchair primary mode of locomotion d. Wheeled self b. Other person wheeled c. NONE OF ABOVE e.
6. MODES OF TRANSFER	(Check all that apply during last 7 days) Bedfast all or most of time a. Lifted mechanically d. Bed rails used for bed mobility or transfer b. Transfer aid (e.g., slide board, trapeze, cane, walker, brace) e. Lifted manually c. NONE OF ABOVE f.
7. TASK SEGMENTATION	Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them 0. No 1. Yes
8. ADL FUNCTIONAL REHABILITATION POTENTIAL	Resident believes he/she is capable of increased independence in at least some ADLs 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
BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days a. Diarrhea b. Fecal impaction c. NONE OF ABOVE d. Constipation e.

3. APPLIANCES AND PROGRAMS	Did resident use scheduled toileting plan a. External (condom) catheter b. Indwelling catheter c. Intermittent catheter d. Pads/briefs used e. Enemas/irrigation f. Ostomy present g. NONE OF ABOVE
4. CHANGE IN URINARY CONTINENCE	Resident's urinary continence has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

SECTION I. DISEASE DIAGNOSES

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

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

SECTION J. HEALTH CONDITIONS

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

SUPERSEDES

TN # 94-24

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

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE—Check treatments or programs received during the last 14 days	
	TREATMENTS	Ventilator or respirator a. PROGRAMS b. Alcohol/drug treatment program c. Alzheimer's/dementia special care unit d. Hospice care e. Pediatric unit f. Respite care g. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) h. r. i. s. j. k. NONE OF ABOVE
	Chemotherapy	
	Dialysis	
	IV medication	
	Intake/output	
	Monitoring acute medical condition	
	Ostomy care	
	Oxygen therapy	
	Radiation	
Suctioning		
Tracheostomy care		
Transfusions		
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 DAYS MIN		
(B) = total # of minutes provided in last 7 days (A) (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	
	Evaluation by a licensed mental health specialist in last 90 days	
	Group therapy	
	Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage	
	Reorientation—e.g., cueing	
NONE OF ABOVE		
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:	
	d. Bed mobility	i. Amputation/prosthesis care
	e. Transfer	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. 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

SEP 29 1998

TN # 98-10 APPROVAL DATE

SUPERSEDES

TN # 94-24 EFFECTIVE DATE 7/1/98

Numenc identifier

Resident _____

SECTION S. STATE OF OHIO SUPPLEMENT

1. VENT ANNING INDICATOR	Resident was started on a vent weaning program in the last 14 days. (If yes, section P1L must be checked. If No, skip to S3) 0. No 1. Yes																																																																		
2. VENT WEANING START DATE	Date vent weaning program started <table border="1"> <tr> <td> </td><td> </td><td>-</td><td> </td><td> </td><td>-</td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td>Month</td><td>Day</td><td></td><td>Year</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>			-			-						Month	Day		Year																																																			
		-			-																																																														
Month	Day		Year																																																																
3. TRACH SUCTIONING DAILY FREQUENCY	Code the frequency of tracheal suctioning during the last 14 days 0. None 1. 1-4 times daily 2. 5-8 times daily 3. 9-12 times daily 4. 13 or more times daily 5. pm																																																																		
4. INFECTIOUS DISEASES	Check all diseases that were present during the last 90 days or since last assessment Vancomycin Resistant Enterococcus (VRE) a. Methicillin Resistant Staphylococcus aureus (MRSA) b. Salmonellosis c. Shigellosis d. Campylobacteriosis e. E. coli O157:H7 f. Legionellosis g. Meningococcal Disease h. Giardiasis i. Cryptosporidiosis j. Streptococcal Pneumoniae, invasive k. Influenza l. None of the above m.																																																																		
5. VACCINES	Record date resident received vaccine during the last 90 days. (If not received, skip to S6) a. Influenza vaccine <table border="1"> <tr> <td> </td><td> </td><td>-</td><td> </td><td> </td><td>-</td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td>Month</td><td>Day</td><td></td><td>Year</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table> b. Pneumonia vaccine <table border="1"> <tr> <td> </td><td> </td><td>-</td><td> </td><td> </td><td>-</td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td>Month</td><td>Day</td><td></td><td>Year</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table> c. Hepatitis vaccine <table border="1"> <tr> <td> </td><td> </td><td>-</td><td> </td><td> </td><td>-</td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td>Month</td><td>Day</td><td></td><td>Year</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>			-			-						Month	Day		Year										-			-						Month	Day		Year										-			-						Month	Day		Year							
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OXYGEN THERAPY	Record status during the last 14 days a. Number of days oxygen received (If 0 skip to S7) b. Primary source of oxygen 1. Concentrator 2. Liquid 3. Gas c. Average daily use of oxygen 1. <1 hour per day 2. 1-6 hours per day 3. 7-12 hours per day 4. 13-18 hours per day 5. 19-24 hours per day 6. Unknown d. Flow rate of oxygen 1. 1-2 liters per minute 2. 3-4 liters per minute 3. 5-6 liters per minute 4. >6 liters per minute																																																																		

7. SUICIDAL TENDENCIES	Resident demonstrated observable signs of suicidal thoughts/actions during the last 30 days 0. No 1. Yes																													
8. THERAPIES	Enter the number of days and total minutes each of these was administered (for at least 10 minutes) in the last 7 days. (Enter 0 if none) NOTE - If totals are the same as coded in Section P1b, skip to S9 A = Total number of days administered for 10 minutes or more B = Total number of minutes provided in last 7 days <table border="1"> <thead> <tr> <th rowspan="2"></th> <th colspan="2">DAYS</th> <th colspan="2">MINUTES</th> </tr> <tr> <th>A</th> <th>B</th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>a. Speech - language pathology & audiology</td> <td></td><td></td><td></td><td></td> </tr> <tr> <td>b. Occupational therapy</td> <td></td><td></td><td></td><td></td> </tr> <tr> <td>c. Physical therapy</td> <td></td><td></td><td></td><td></td> </tr> <tr> <td>d. Respiratory therapy</td> <td></td><td></td><td></td><td></td> </tr> </tbody> </table>		DAYS		MINUTES		A	B			a. Speech - language pathology & audiology					b. Occupational therapy					c. Physical therapy					d. Respiratory therapy				
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9. PHYSICIAN ORDERS	In the prior 30-day period/ since the resident was admitted how many times has the physician (authorized assistant or practitioner) changed the resident's orders? Do not count order renewals without changes																													
10. MEDICAID MCO	Resident is enrolled in a Medicaid Managed Care Organization 0. No 1. Yes																													
11. MEDICARE MCO	Resident is enrolled in a Medicare Managed Care Organization 0. No 1. Yes																													
12. RESIDENT IDENTIFIER CODE	Record alternate resident identifier code if resident does not have a Social Security Number. See instructions. (If SSN is coded in Section AAsa, skip to S13) <table border="1"> <tr> <td> </td><td> </td> </tr> </table>																													
13. ODHS DOCUMENT NUMBER	Record 11 digit ODHS assigned document number ONLY if AAsa and AAs are coded 4 or 10. (If coded other than 4 or 10, skip to S14) <table border="1"> <tr> <td> </td><td> </td> </tr> </table>																													
14. SPECIAL CODES	Record special reimbursement codes as appropriate a. <table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table> b. <table border="1"><tr><td> </td><td> </td><td> </td><td> </td></tr></table>																													

SEP 29 1998

TN # 98-10 APPROVAL DATE SEP 29 1998
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TN # 94-24 EFFECTIVE DATE 7/1/98

Resident _____

Numeric Identifier _____

SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

Attachment 4.19D
Page 17 of 24

<p>1. SPECIAL TREATMENTS AND PROCEDURES</p>	<p>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)</p> <table border="1" style="float: right;"> <tr> <th colspan="2">DAYS</th> <th colspan="2">MIN</th> </tr> <tr> <td>(A)</td> <td></td> <td>(B)</td> <td></td> </tr> </table> <p>(A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in last 7 days</p> <p>Skip unless this is a Medicare 5 day or Medicare readmission/return assessment.</p> <p>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</p> <p>If not ordered, skip to item 2</p> <p>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.</p> <p>d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?</p>	DAYS		MIN		(A)		(B)					
DAYS		MIN											
(A)		(B)											
<p>2. WALKING WHEN MOST SELF SUFFICIENT</p>	<p>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:</p> <ul style="list-style-type: none"> • 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 <p>Skip to item 3 if resident did not walk in last 7 days</p> <p>(FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)</p> <p>a. Furthest distance walked without sitting down during this episode.</p> <table border="0"> <tr> <td>0. 150+ feet</td> <td>3. 10-25 feet</td> </tr> <tr> <td>1. 51-149 feet</td> <td>4. Less than 10 feet</td> </tr> <tr> <td>2. 26-50 feet</td> <td></td> </tr> </table> <p>b. Time walked without sitting down during this episode.</p> <table border="0"> <tr> <td>0. 1-2 minutes</td> <td>3. 11-15 minutes</td> </tr> <tr> <td>1. 3-4 minutes</td> <td>4. 16-30 minutes</td> </tr> <tr> <td>2. 5-10 minutes</td> <td>5. 31+ minutes</td> </tr> </table> <p>c. Self-Performance in walking during this episode.</p> <p>0. INDEPENDENT—No help or oversight</p> <p>1. SUPERVISION—Oversight, encouragement or cueing provided</p> <p>2. LIMITED ASSISTANCE—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance</p> <p>3. EXTENSIVE ASSISTANCE—Resident received weight bearing assistance while walking</p> <p>d. Walking support provided associated with this episode (code regardless of resident's self-performance classification).</p> <p>0. No setup or physical help from staff</p> <p>1. Setup help only</p> <p>2. One person physical assist</p> <p>3. Two+ persons physical assist</p> <p>e. Parallel bars used by resident in association with this episode.</p> <p>0. No 1. Yes</p>	0. 150+ feet	3. 10-25 feet	1. 51-149 feet	4. Less than 10 feet	2. 26-50 feet		0. 1-2 minutes	3. 11-15 minutes	1. 3-4 minutes	4. 16-30 minutes	2. 5-10 minutes	5. 31+ minutes
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2. 5-10 minutes	5. 31+ minutes												
<p>3. CASE MIX GROUP</p>	<p>Medicare <input type="checkbox"/> <input type="checkbox"/></p> <p>State <input type="checkbox"/> <input type="checkbox"/></p>												

SEP 29 1998

TN # 98-10 APPROVAL DATE 09/29/98
SUPERSEDES
TN # 94-24 EFFECTIVE DATE 7/1/98

