

**MDS version 2.0
Item by Item
Self Study Guide and
Quick Reference**

R E V I S E D
AUGUST, 2006

MDS ITEM-BY-ITEM QUICK REFERENCE

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PREFACE

The attached quick reference tool for the MDS is the *revised draft* of an item-by-item guide to aid in consistent and accurate completion of the MDS forms utilized in Missouri.

This guide was originally developed in conjunction with the statewide committee formed at the request of the Department of Health and Senior Services in the spring of 1997. The goal was to “plan a statewide strategy to improve the accuracy and use of MDS data and provide direction for the development of MDS training and resource materials for providers of nursing home care.”

We have attempted to provide concise, specific direction to code each answer on the MDS. Directions cited come from several areas:

- References noted in the bottom left hand corner of each page and page references relate to Sections in “The Long-Term Care Resident Assessment Instrument User’s Manual for Version 2.0,” published by CMS (HFCA), December 2002.
- Other information regarding the MDS is available through the AHCA, AAHS, AHA or CMS Internet sites:
<http://www.ahca.org> OR <http://www.aahsa.org> OR <http://www.aha.org> OR <http://cms.hhs.gov/medicaid/mds20/default.asp>
- You will note additional guidance in italics within the content of the form (EX. *Focus is resident strength*). These are not a part of the version 2.0 forms, but added guidance from the manual to assist you in completing the form accurately.
- An “R” has been added to the answer blocks of certain MDS items to remind you of the 108 MDS elements that affect the RUGS-III classifications.
- A “QI” symbol ♦ has been added to the answer blocks to remind you of the MDS Items that affect your MDS QI-QM reports.

Prior to using the guide, refer to the MDS coding conventions attached, from Section 3.2 of the December 2002 User’s Manual.

Always try to code for the “best response.”

We hope you find this information useful. The next page lists the committee members who have worked on this draft. Special thanks go to Margie Riddle of Delmar Gardens Enterprises for formatting this complicated document.

Since the MDS/RAI will have periodic updates, you are urged to clarify and update instructions on an ongoing basis.

For further information, you may contact your health care association or the Department of Health and Senior Services, through their web site. The final draft is available through the University of Missouri-Columbia, S438 Sinclair School of Nursing, Columbia, MO 65211, ATTN: Jessica Mueller, (573) 882-0241. Should you find an error or have a suggestion to improve this guide, please contact Jessica with your suggestions.

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- * PLEASE NOTE that Health Care Financing Administration (HCFA) had a name change. The agency is now called CMS (Center for Medicare and Medicaid Services), but continues to use HCFA for older publications and websites

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Resident Assessment Instrument Self Study and Case Study for MDS Training

and

MDS Version 2.0 Item-by-Item Self Study Guide and Quick Reference

Acknowledgments

These tools were developed by members of the Statewide Committee to improve the reliability of MDS information for Missouri Nursing Homes.

The Committee was formed at the request of the Department of Health and Senior Services (formally the Division of Aging) by the University of Missouri Sinclair School of Nursing. A group of volunteer providers came together to develop a statewide educational strategy and teaching materials to improve the usefulness of the MDS and the quality of the information that can be derived from MDS data. *The Resident Assessment Instrument Self Study and Case Study for MDS Training* and the *MDS version 2.0 Item-by-Item Self Study Guide and Quick Reference* are now available for use in the state.

The Committee wants to acknowledge the leadership and hours of work of the following people who wrote and edited these materials:

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As Facilitator of the Committee, I want to thank all members for their hours in meeting and hours working on materials to help the Committee meet its mission. You are truly dedicated to improving the care and services to residents in Missouri nursing homes.

- Marilyn Rantz, PhD, RN, FAAN

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DEFINITIONS

Resident Assessment Instrument (RAI) Assessment

A structured approach for applying a problem identification process in Long Term Care. This assessment system provides a comprehensive, accurate, standardized, reproducible assessment of each resident's functional status, strengths, weaknesses, and preferences and offers guidance on further assessment once problems or needs have been identified. The RAI consists of 3 basic components: the Minimum Data Set (MDS), Resident Assessment Protocols (RAPs) and the Utilization Guidelines. Each component flows naturally into the next, leading to care plan development, implementation and evaluation. This is how the process looks as a pathway.



Minimum Data Set

A core set, of screening, clinical and functional status elements, including common definitions and coding categories, which forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies.

Resident Assessment Protocols (RAP's)

The RAP's are structured, problem-orientated frameworks for organizing MDA information, and examining additional clinically relevant information about an individual. RAP's help identify social, medical and psychological problems and form the basis for individualized care planning. The 18 RAP's are explained in detail in Appendix C (C-5 to C-104).

Triggers

Triggers are specific resident responses for one or a combination of MDS elements. The triggers identify residents who have or are at risk for developing specific functional problems and require further evaluation.

Trigger Legend

The Trigger legend summarizes all of the triggers for the 18 RAP's. It is not a required form that must be maintained in the resident's clinical record. Rather, it is a worksheet that may be used by the interdisciplinary team members to determine which RAP's are triggered from a completed MDS assessment.

RAP's Analysis

The RAP's analysis is performed in accordance with the Utilization Guidelines. The in-depth review assists the staff members to draw a conclusion to proceed or not to proceed to the plan of care. (See Chapter 4, page 4-1 – 4-24)

RAP Summary Sheet

The RAP Summary Sheet documents the decisions made during this evaluation process on whether or not to proceed to care planning. Information from Section V of the MDS is documented on the RAP Summary Form which:

- Identifies the location of information derived from RAP's about the residents status in the triggered area. As appropriate for the resident, information may include the nature of problems. Complications and risk factors, the need for referral to appropriate health professionals, and the reasons for deciding to proceed or not to proceed with care planning specific to the triggered problems.
- Provides a means for collecting data on triggered RAPs and documenting care plan decisions
- Provides a method for staff to certify the accuracy and completeness of the RAP assessment (i.e., signature and date).

Utilization Guidelines

Instructions concerning when and how to use the RAI, also known as the RAI Manual. These include instructions for completion of the RAI as well as structured frameworks for synthesizing MDS and other clinical information.

Common Definitions

Standardized instructions (Found in Chapter 3 for how to interpret each element specified in the MDS.

MDS Coding Conventions/Coding Categories

Levels of measurements for each element included in and used when preparing the MDS form.

Quarterly Review

Each state's includes, at a minimum, CMS's required Quarterly assessment items. Not all MDS items appear on the Quarterly assessment form. In Missouri the form is the 1997 RUGs-III Quarterly Assessment Form. The quarterly assessment is used to track the resident's status between comprehensive assessments, and to ensure monitoring of crucial indicators of the gradual onset of significant changes in resident assessments. The timing of these assessments are to be no less frequently than once every three months (92 days) to assure the continued accuracy of care planning.

Discharge Tracking

Includes Section Aa (Identification Information), a subset of codes from Item 8 (Reason for Assessment) and Item 9 (Signatures). The form also includes Section R related to discharge status and date, along with two items from Section AB, that are required only for individuals whose stay is less than 14 days. This form is completed whenever a resident is discharged from the facility for any reason other than a temporary visit, another type of therapeutic or social leave, or observational stays of less than 24 hours when the resident is not admitted to the hospital. This is the only form required at the time of discharge, when the resident physically leaves the facility.

Re-entry Tracking Form

Includes Section Aa (Identification Information), a subset of codes from Item 8 (Reason for Assessment) and Item 9 (Signatures). The reentry tracking form contains items from Section A related to the date and point of reentry. This form is completed whenever a resident re-enters the nursing home following temporary admission to a hospital or other health care setting, even if the resident's clinical record was not formally closed, or the resident discharged from the facility. This form must be completed for residents "re-entering" the facility in order to re-enter the resident into the database.

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 Re-entry Tracking form record that has been previously accepted in 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.

PPS – Prospective Payment System

A daily (per-diem) payment rate paid to skilled nursing facilities that is applicable to all covered skilled nursing and therapy services. The payment is deemed by the patient's care needs derived from MDS assessment items and definitions.

Resource Utilization Groups (RUGs) Patient Classification System

The Resource Utilization Groups (RUG-III) case-mix classification system was developed to capture resource use of nursing home patients and to provide an improved method of tracking the quality of care.

RUG-III is a 53-group model for classifying nursing home patients into homogeneous groups according to the amount and type of resources they use. The RUG-III groups are the basis for the payment indices used to establish equitable prospective payments levels for patients with different services use. Information regarding a patient's characteristics and care needs is derived from the MDS, a set of core screening and assessment items and item definitions.

Medicare Prospective Payment System Assessment Form (MPAF)

A SNF PPS assessment that is a shorter version of the MDS that may be used by skilled nursing facilities in the place of a full MDS for Medicare Assessments – the MPAF consists of a subset of the MDS items including items for resident identification, items necessary to complete the Resource Utilization Group (RUG-III) calculation, and the items needed to calculate the Quality Indicators and Quality Measures. The MPAF optional cannot be used when OBRA assessments are due.

Encoding Process

After completing the clinical assessment process, the facility has the next 7 days to encode (enter) all MDS responses in a computerized file and verify that all responses in the computer file match the responses on the paper form.

Editing Process

The facility is responsible for running encoded MDS data against CMS and State specific edits (software check system). Each MDS response must be within the required range and consistent with other item responses. An assessment is considered complete only if 100% of required edits are passed.

Locking Process

After passing the CMS edits and the record is accepted into the state database, a record is then “locked.” Individual MDS records must not contain any “fatal” information for the record to be accepted in the state database. At this point, the record cannot be changed by the facility. A facility must, at least on a monthly basis, electronically transmit to the State MDS database encoded, accurate and complete MDS assessments conducted during the previous months. It is recommended that facilities transmit at least every 2 weeks or more if a large volume of MDS’s is completed.

Validation Reports

Once data is received at the state agency, the MDS system will validate the file structure and data content. These validations are based on the MDS 2.0 record specification. The system generates two reports: an Initial Feedback Report and the Final Validation Report. Both reports are formatted as text files with column specifications so that they may be easily read, printed, or downloaded.

Initial Feedback Reports

Indicates that the MDS system has performed a basic validation check on your file and whether your submissions has been accepted or rejected. If rejected, the Initial Feedback Report includes the rejection error. The Initial Feedback Report should be received shortly after submitting the file while you remain online.

- the number of Records Processed will indicate the number of records per file that have been processed
- The number of Records Rejected, the number of Duplicate Records, the number of 0_00 Records, the number of Records with Errors, and the total Number of Errors are not displayed on the Initial Feedback Report. Once the entire file has been validated, these lines and the Report Detail will be completed in the Final Validation Report.
- It is not necessary to retain this report.

Final Validation Reports

Will be generated within 24 hours of submission of the file. The report is created after the MDS System performs data validation, timing checks, sequence checks, and calculated element validations. The timing and sequence of the MDS records are verified against customized State schedules. You will not receive a Final Validation Report if your Initial Feedback Report indicated that your batch has been rejected.

- Retain this report. The department of Health and Senior Services recommends 15 months retention consistent with retention of active MDS’ in the medical record.

MDS QI/QM's

MDS QI/QM's are derived from the Minimum Data Set are markers that may indicate the presence or absence of potentially poor care practices in nursing home care. The MDS QI/QM's are not absolute markers of care problems or poor quality; rather they indicate a need for further review of clinical care in the facility.

The new MDS QI/QM reports are similar to the MDS QI reports from the CHRSA system with a few variances. The new reports contain quality measures in addition to the quality indicators. The QM's are identical to those contained in the Nursing Home Compare public reporting system. The same QI's that are not duplicated by QM's are present in the report.

The reports can be retrieved through the CASPER system via the internet on the same site as MDS transmission. These reports are facility-specific and can be compared to state and national averages. The RUGs-III Quarterly QIs are generated into a report known as the Department of Health and Senior Services/University of Missouri Show-Me Reports and provides facility specific information longitudinally over 15 months (or 5 quarters). The Show-Me Reports provide facility specific data that is graphed according to expert-set thresholds and is most useful for quality improvement efforts at the facility level. At this time, the Show-Me Reports are exclusive to Missouri nursing homes.

Quality Measures

Quality Measures (QM's) are derived from the Minimum Data Set by the Centers for Medicare and Medicaid Services (CMS) Nursing Home Quality Initiative (NHQI). The measures are currently related to specific clinical areas of care. The Quality Measures are intended to provide a set of objective measures by which an individual may determine how well the nursing home is managing various aspects of care being provided to their residents. The public may view these reports at www.medicare.gov/nhcompare/home.asp.

DAVE (Data Assessment and Verification Program)

The objective of the DAVE program is to assess the accuracy and reliability of assessment data submitted by nursing homes. The review process is done as an off site review process using facility submitted medical records or by an on-site review. The information obtained is reported as nation wide trends. **A national rollout began in January 2004 with the original DAVE program. In the Spring of 2006, DAVE 2 began.**

STANDARD FORMAT FOR MDS ITEMS

To facilitate completion of Version 2.0 of the MDS assessment and to ensure consistent interpretation of items, this section presents the following types of information for many (**but not all**) items:

- Intent:*** Reason(s) for including the item (or set of items) in the MDS, including discussions of how the information will be used by clinical staff to identify resident problems and develop the plan of care.
- Definition:*** Explanation of key terms.
- Process:*** Sources of information and methods for determining the correct response for an item. Sources include:
- Discussion with facility staff – licensed and non-licensed staff members.
 - Resident interview observation.
 - Clinical records, facility records, transmittal records (at admission) – physician orders, laboratory data, medication records, treatment sheets, flow sheets (e.g. vital signs, weights, intake and output), care plans, and any similar documents in the facility record system.
 - Discussion with the resident’s family.
 - Attending physician.
- Coding:*** Proper method of recording each response, with explanations of individual response categories.
- Clarifications:*** ♦ Clarifications for MDS items provided by CMS. These clarifications apply to the MDS.

MDS CODING CONVENTIONS

The coding conventions to be used when preparing the MDS are as follows:

- Use a check mark for white boxes with lower case letters in the box or before the item description, if specified condition is met; otherwise these boxes remain blank (e.g., N4, General Activity Preferences – boxes a. – m.)
- Use a numeric response (a number or preassigned value) for blank white boxes (e.g., H1a, Bowel Incontinence.)
- Darkly shaded areas remain blank; they are on the form to set off boxes visually.

The convention of entering “0”: In assigning values for items that have an ordered set of responses (e.g., from independent to dependent), zero (“0”) is used universally to indicate the lack of a problem or that the resident is self-sufficient. For example, a resident whose ADL codes are almost all coded “0” is a self-sufficient resident; the resident whose ADLs have no “0” codes indicates a resident that receives help from others.

- **When completing hard copy forms to be used for data entry, capital letters may be easiest to read. Print legibly.**
- **Dates:** Where recording month, day, and year, enter two digits for the month and the day, but four digits for the year. For example, the third day of January in the year 2003 is recorded as:

0	1
---	---

Month

0	3
---	---

Day

2	0	0	3
---	---	---	---

Year

- **The standard no-information code is a “dash” (-).** This code indicates that all available sources of information have been exhausted; that is the information is not available, and despite exhaustive probing, it remains unavailable.
- **NONE OF THE ABOVE** is a response item to several items (e.g., MDS Item I2, Infections, box m.) **Check this item where none of the responses apply; it should not be used to signify lack of information about the item. If “none of the above” is not present and none of the items apply (i.e., H2 Bowel Elimination on MPAF), simply leave all the boxes blank.**
- **“Skip” Patterns - There are a few instances where scoring on one item will govern how scoring is completed for one or more additional items.** The instructions direct the assessor to “skip” over the next item (or several items) and go on to another (e.g., B1, Comatose, directs the assessor to “skip” to Section G. if B1 is answered “1” – “Yes.” **The intervening items from B2 - F3 would not be coded.** If B1 was recorded as “0” – “No,” then the assessor would continue with item B2.)

A useful technique for visually checking the proper use of the “skip” pattern instructions is to circle the “skip” instructions before going to the next appropriate item.

- **The “8” code is for use in MDS Section G., Physical Functioning and Structural Problems only.** The use of this code is limited to situations where the ADL activity was not performed and therefore an objective assessment of the resident’s performance is not possible. Its primary use is with bed-bound residents who neither transferred from bed nor moved between locations over the entire 7-day period of observation. When the “8” code is entered for self-performance, it should also be entered for support.
- **Coding for Section J:** Disease Diagnosis Specific instructions for entering ICD-9-CM codes apply to this section. See coding instructions in Chapter 3. Section I (pages 3-127 to 3-137.) Coders in Long Term Care should also refer to the most recent volumes of ICD-9-CM codes for guidance in assigning and reporting code numbers.

Medicaid and Medicare MDS Completion

Medicaid Certified Beds	Medicaid and Medicare Dual Certified Beds	Medicare Certified Beds
Complete, record, encode and transmit a MDS for every resident in a MEDICAID CERTIFIED bed. If the resident's care is being paid for by Medicaid: Follow ----- MDS REGULATORY completion schedule. If the resident's care is being paid for by another payor source: Follow----- MDS REGULATORY completion schedule	Complete, record, encode and transmit a MDS for every resident in a MEDICAID/ MEDICARE DUAL CERTIFIED bed. If the resident's care is being paid for by Medicaid: Follow ----- MDS REGULATORY completion schedule. If the resident's care is being paid for by Medicare Part A: Follow ----- MEDICARE MDS/PPS completion schedule. If the resident's care is being paid for by another payor source: Follow ----- MDS REGULAROTY completion schedule.	Complete, record, encode and transmit a MDS for every resident in a MEDICARE CERTIFIED bed. If the resident's care is being paid for by Medicare Part A: Follow ----- MEDICARE MDS/PPS completion schedule. If the resident's care is being paid for by another payor source: Follow ----- MDS REGULATORY completion schedule.

Provided by:
Sharon McGauly
Quality Improvement Consultations

MDS Regulatory and Medicare/PPS Assessments

MDS OBRA Assessments	MDS Medicare/PPS Assessments
<u>Assessment Type</u>	<u>Assessment Type</u>
• Admission (Initial) Assessment (Comprehensive) • Annual Reassessment (Comprehensive) • Significant Change in Status Reassessment (Comprehensive) • Quarterly Assessment (Three Page) • Significant Correction of a Prior Full Assessment • Significant Correction of a Prior Quarterly Assessment • Discharge Tracking Assessment • Re-entry Tracking Assessment	• 5 Day Assessment (Comprehensive or Full) • 14 Day Assessment (Comprehensive if not completed on the 5 day or Full) • 30 Day Assessment (Full) • 60 Day Assessment (Full) • 90 Day Assessment (Full) • Readmission/Return Assessment (Full) • Other Medicare Required Assessment (OMRA) (Full)

NURSING FACILITIES PRIVACY ACT STATEMENT – HEALTH CARE RECORDS

THIS FORM PROVIDES YOU THE ADVICE REQUIRED BY THE PRIVACY ACT OF 1974. THIS FORM IS NOT A CONSENT FORM TO RELEASE OR USE HEALTH CARE INFORMATION PERTAINING TO YOU.

1. **AUTHORITY FOR COLLECTION OF INFORMATION, INCLUDING SOCIAL SECURITY NUMBER AND WHETHER OR NOT DISCLOSURE IS MANDATORY OR VOLUNTARY. Sections 1819(f), 1919(f), 1819(b)(3)(A), 1919(b)(3)(A), and 1864 of the Social Security Act.** Medicare and Medicaid participating long-term care facilities are required to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity and health status. To implement this requirement, the facility must obtain information from every resident. This information also is used by the Federal Centers for Medicare & Medicaid Services (CMS) to ensure that the facility meets quality standards and provides appropriate care to all residents. For this purpose, as of June 22, 1998, all such facilities are required to establish a database of resident assessment information, and to electronically transmit this information to the CMS contractor in the State government, which in turn transmits the information to CMS. Because the law requires disclosure of this information to Federal and State sources as discussed above, a resident does not have the right to refuse consent to these disclosures. These data are protected under the requirements of the Federal Privacy Act of 1974 and the MDS Long-Term Care System of Records.

2. **PRINCIPAL PURPOSES FOR WHICH INFORMATION IS INTENDED TO BE USED** The information will be used to track changes in health and functional status over time for purposes of evaluating and improving the quality of care provided by nursing facilities that participate in Medicare or Medicaid. Submission of MDS information may also be necessary for the nursing facilities to receive reimbursement for Medicare services.

3. **ROUTINE USES** The primary use of this information is to aid in the administration of the survey and certification of Medicare/Medicaid long-term care facilities and to improve the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose. The information collected will be entered into the Long-Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1517. Information from this system may be disclosed, under specific circumstances (routine uses), which include: To the Census Bureau and to: (1) Agency contractors, or consultants who have been engaged by the Agency to assist in accomplishment of a CMS function, (2) another Federal or State agency, agency of a State government, an agency established by State law, or its fiscal agent to administer a Federal health program or a Federal/State Medicaid program and to contribute to the accuracy of reimbursement made for such programs, (3) to Quality Improvement Organizations (QIOs) to perform Title XI or Title XVIII functions, (4) to insurance companies, underwriters, third party administrators (TPA), employers, self-insurers, group health plans, health maintenance organizations (HMO) and other groups providing protection against medical expenses to verify eligibility for coverage or to coordinate benefits with the Medicare program, (5) an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, or the restoration of health, or payment related projects, (6) to a member of Congress or congressional staff member in response to an inquiry from a constituent, (7) to the Department of Justice, (8) to a CMS contractor that assists in the administration of a CMS-administered health benefits program or to a grantee of a CMS-administered grant program, (9) to another Federal agency or to an instrumentality of any governmental jurisdiction that administers, or that has the authority to investigate potential fraud or abuse in a health benefits program funded in whole or in part by Federal funds to prevent, deter, and detect fraud and abuse in those programs, (10) to national accrediting organizations, but only for those facilities that these accredit and that participate in the Medicare program

4. **EFFECT ON INDIVIDUAL OF NOT PROVIDING INFORMATION** The information contained in the Long-Term Care Minimum Data Set is generally necessary for the facility to provide appropriate and effective care to each resident. If a resident fails to provide such information, for example on medical history, inappropriate and potentially harmful care may result. Moreover, payment for such services by third parties, including Medicare and Medicaid, may not be available unless the facility has sufficient information to identify the individual and support a claim for payment.

Revised--December 2002

SECTION AA. IDENTIFICATION INFORMATION

This form must be submitted with every Full Assessment (admission, annual, significant change, and significant correction of prior full assessment) and Quarterly Assessment as well as assessments required for Medicare PPS. This form provides key information necessary to identify residents in a computerized environment. The discharge and re-entry tracking forms have been developed to contain the same items, therefore Section AA. Is not required to be submitted with either the discharge or re-entry tracking forms.

1. If the resident has no middle initial, leave 1b blank (pg. 3-6)

4. If the resident is unable to respond and no family member is available, or if the resident does not appear to fit into any of the categories, the assessor should assign the category they feel is most appropriate (pg. 3-6)

5 a.b. In rare instances, there will not be a Medicare or Social Security Number. When this occurs, another type of basic identification number (i.e., railroad retirement insurance number) may be substituted. Enter the number itself, one digit per box beginning with the left most box. A Medicare number always starts with a number and the first 9 characters must be digits (0-9) (pg. 3-6).

6. a. This number always starts with a **10** and is 9 digits long in Missouri. Some Medicare only facilities will not have a state number. If none, leave blank. (pg. 3-8)

6. b. The Federal number always starts with **26** and is 6 digits long in Missouri. There must always be a federal provider number (pg. 3-8)

7. A + is entered if the resident has applied for Medicaid but has not received a number yet. Enter a N if resident does not have Medicaid. **An N/A or blank is not an accepted response.**

8. a. Please note section A.8 on the Full Assessment requires the same responses.

8. b. Special codes for use with Medicare patients. It is possible to select a code from both 8a & 8b.

(a complete review of 8. Reasons for assessment is found on pages 3-9, 10)

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*				
		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 4. Hispanic 2. Asian/Pacific Islander 5. White, not of 3. Black, not of Hispanic origin Hispanic origin			
5.	SOCIAL SECURITY* AND MEDICARE NUMBERS*	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 ASSESSMENT	[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 Complete RAPS for Medicare 5 or 14 day assessment to comply with requirements for admission assessment AA8a			

Note: 8a 2, 3, 4, 5, and 10 are considered for QI/QM calculations.

Note: 8b 1 and 7 are used to calculate the Post Acute Care Sample.

SECTION AA. IDENTIFICATION INFORMATION - continued

9. Formal attestation statement and signature lines for individual staff completing any portion of the RAI to sign and certify the accuracy of the portion(s) they completed.

Item AA9 is used to record signatures, titles and dates of completion, as well as accuracy, for all parts of MDS assessments and tracking forms from Sections AA and A through W. All persons completing part of this assessment must sign their names in the appropriate locations at item AA9. To the right of the name, enter title and the letters that correspond to the sections of the MDS for which the assessor was responsible, and also enter the date on which the form is signed. (pg. 1-25, 26) (pg. 3-11)

NOTE: The label of MDS Item AA9 was revised, and formal attestation language has been added above the signature lines. The identical change was made to Item AA9 as it appears on all tracking forms (The Basic Assessment Tracking form, the Discharge Tracking form, the Reentry Tracking form, and MPAF). Item AA9 will be used to record signatures and dates of completion, as well as attestation of accuracy, for all parts of MDS full assessments, quarterly assessments, tracking forms, and MPAF, from section AA and A through V. Signatures should be included at Item AA9 for these sections of the MDS, including sections T, U, V, and W.

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 all 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.			

SECTION AB. DEMOGRAPHIC INFORMATION/FACE SHEET (Sections AB, AC, and AD)

This form is completed one time only except whenever additional information not originally known to the facility becomes available OR resident is readmitted after permanent discharge. If changes are made to the face sheet data, it is to be updated and transmitted with the next assessment. (pg. 3-12)

1. Enter the date when the person first becomes a resident in your facility. Use all boxes for date, i.e., 01-05-1998. The admission date does not change until the resident is discharged - return not anticipated (pg. 3-12, 13)

2. This area helpful in care planning: Signal issues, i.e., delirium (from acute stay), grief (loss of home), or need for home health resources related to relocation status and may suggest others to contact for additional information. Code 3 if admitted from a licensed Residential Care facility in Missouri. Code 4 Nursing Home also includes admissions from hospital swing beds. Refer to pgs. 3-14 and 3-15 for guidance to code "in other facility."

3. Check if the resident did not have a primary residence to return to while living in those settings. (pg. 3-17)

4. Establishes familiarity in how to address resident (i.e., Doctor) or for care planning purposes. If resident is under 18 or never employed, code NONE.

5. Code what resident currently speaks and understands.

6. Document a primary or secondary diagnosis of psychiatric illness or MR/DD that results in functional limitations in life activities (do not include dementia). See definition, next page, for guidance.

7. For any item 10b - 10f to be checked, condition must be documented in medical record. See definition, next page, for guidance.

8. Should reflect the date that form is completed or amended.

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	ZIP Code Prior to any nursing home stay.	
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 in nursing home Stay in other nursing home Other residential facility-board and care home, assisted living, group home MH/psychiatric setting MR/DD setting NONE OF ABOVE	
6.	LIFETIME OCCUPATION(S) [Put "/" between two occupations]	Occupation	
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) MR/DD with organic condition Down's syndrome Autism Epilepsy Other organic condition MR/DD with no organic condition	
11.	DATE BACKGROUND INFORMATION COMPLETED	Month Day Year	

Note: If information is updated, must complete all items. Exception is the requirement to complete AB5 a-f with the MPAF form (pg. 3-21).

This form remains in the chart throughout the course of stay

SECTION AB. DEMOGRAPHIC INFORMATION - Definitions

9. Mental Health History

To document a primary or secondary diagnosis of psychiatric illness or developmental disability, resident has **one** of the following:

- A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder, personality disorder; other psychotic disorder; or another mental disorder that may lead to chronic disability; but
- Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder;

AND

- The disorder results in functional limitations in major life activities that would be appropriate within the past 3 to 6 months for the individual's developmental stage;

AND

- The treatment history indicates that the individual has experienced either: (a) psychiatric treatment more intensive than outpatient care more than once in the past 2 years (e.g., partial hospitalization or inpatient hospitalization); or (b) within the last 2 years due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which formal supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

Review the resident's record only. For a "Yes" response to be entered, there must be written documentation (i.e. verbal reports from the resident or resident's family are not sufficient).

10. Conditions Related to MR/DD Status (Mental Retardation/Developmental Disabilities)

To document conditions associated with mental retardation or developmental disabilities.

For item 10e, "Other organic condition related to MR/DD" - examples of diagnostic conditions include congenital rubella, prenatal infection, congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macrencephaly, meningomyelocele, congenital hydrocephalus, etc.

Review the resident's record only. For any item (10b through 10f) to be checked, the condition must be documented in the clinical record.

Check all conditions related to MR/DD status that were present before age 22. When age of onset is not specified, assume that the condition meets this criterion AND is likely to continue indefinitely.

- If an MR/DD condition is not present, check item 10a ("Not Applicable - No MR/DD") and skip to item AB-11.
- If an MR/DD condition is present, check each condition that applies.
- If an MR/DD condition is present but the resident does not have any of the specific conditions listed, check item 10f ("MR/DD with No Organic Condition")

SECTION AC. CUSTOMARY ROUTINE

This is one of the most important sections of the MDS in relation to accommodation of needs and is used to individualize care plans. It gives clues to resident's functional level prior to any nursing home admission.

* Check actual routines and usual lifestyle in community rather than their future preferences and goals (this differs from MDS SECTION F Psychosocial, i.e. F3c "Resident perceives that daily routine is very different")

This is a good opportunity to begin to build relationships through interview. For interview tips, refer to User's Manual Chapter 3, Section AC (pg. 3-24 - 25) and appendix D. (Guidelines for Interviewing Resident)

If an individual item in a particular category is not known, code **NA**.

Check None of the Above (**h, l, r, and x**) only if no items are marked in each section.

y. Check here only if information is unavailable for **all items** in entire section (all other boxes in Section AC must be blank to code here). For assistance, review definitions Chapter 3, Customary Routine, Section AC (pg. 3-22 - 27).

SECTION AC. CUSTOMARY ROUTINE

CUSTOMARY ROUTINE <i>(In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home)</i>	<i>(Check all that apply. If all information UNKNOWN, check last box only.)</i>	
	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>Kosher, vegetarian, hates hot dogs, etc</i>	i.
	Eats between meals all or most days <i>Do not code simple likes and dislikes</i>	j.
	Use of alcoholic beverage(s) at least weekly <i>(At least one per week)</i>	k.
	NONE OF ABOVE	l.
	ADL PATTERNS	
	In bedclothes much of day	m.
	Wakens to toilet all or most nights <i>(At least once during the night)</i>	n.
	Has irregular bowel movement pattern <i>Unpredictable or irregular- do not note if resident prefers a different pattern.</i>	o.
	Showers for bathing	p.
	Bathing in PM <i>Includes bath or shower.</i>	q.
	NONE OF ABOVE	r.
	INVOLVEMENT PATTERNS	
	Daily contact with relatives/close friends <i>Includes in person, by phone or regular email.</i>	s.
Usually attends church, temple, synagogue (etc.) <i>Even if on TV.</i>	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

The RN Assessment Coordinator must enter his or her signature on the date it is completed.

Must enter signature, title, sections they completed, and date on the day this MDS face sheet is complete. (pg. 3-27, 28)

Only sign if you completed any part of Section AB or AC, include your title and sections completed.

The FACE SHEET must remain in active chart throughout resident=s entire stay.

This verbage is the same as Item AA9 - formal attestation statement and signature line as found on the Basic Assessment Tracking Form.

If, for some technical reason, such as computer or printer breakdown, the Background (face sheet) Information at Admission cannot be signed on the date it is completed, it is appropriate to use the actual date it is signed. It is recommended that staff document the reason for the discrepancy in the clinical record. (pg 3-27)

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.		

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

The full assessment form contains Sections A through W. The full assessment must be completed on admission, annually, with significant change and significant correction of prior full assessment. Section T is required for residents whose stay is covered by Medicare or any time a full assessment is required. MDS's completed for Medicare reimbursement (PPS) only may be submitted as either a full MDS assessment or the short MPAF.

3. a. This is a critical concept and often misunderstood. The ARD is the common date on which the MDS observation period ends. (Refers to the end or last of observations for the MDS items. It also is referred to as the end of the look back period. Refer to Chapter 3, Section A.3 and your facility policy). This establishes the common observation period for all members of the interdisciplinary team.

Anything that happens after the ARD will not be captured on that MDS. Refer to pgs. 3-29 to 3-31.

3. b. Enter a (00) in this item. See Chapter 5 for information on the correction process.

4. a. If not hospitalized within the last 90 days, leave blank.

7. Check with business office for all payment sources that cover the daily per diem or ancillary services for the resident's stay in the nursing facility over the last 30 days. Don't rely on medical records alone to complete this section as the resident's clinical condition may trigger different sources of payment over time. Refer to pg. 3-33, 34 for guidance.

7. a. Check this item if Medicaid is pending.

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 3. Widowed 5. Divorced 2. Married 4. Separated																						
6.	MEDICAL RECORD NO.																							
7.	CURRENT PAYMENT SOURCES FOR N.H. STAY	(Billing Office to indicate; check all that apply in last 30 days) <table border="0"> <tr> <td>Medicaid per diem</td> <td>☐</td> <td>VA per diem</td> <td>☐</td> </tr> <tr> <td>Medicare per diem</td> <td>☐</td> <td>Self or family pays for full per diem</td> <td>☐</td> </tr> <tr> <td>Medicare ancillary part A</td> <td>☐</td> <td>Medicaid resident liability or Medicare co-payment</td> <td>☐</td> </tr> <tr> <td>Medicare ancillary part B</td> <td>☐</td> <td>Private insurance per diem (including co-payment)</td> <td>☐</td> </tr> <tr> <td>CHAMPUS per diem</td> <td>☐</td> <td>Other per diem</td> <td>☐</td> </tr> </table>			Medicaid per diem	☐	VA per diem	☐	Medicare per diem	☐	Self or family pays for full per diem	☐	Medicare ancillary part A	☐	Medicaid resident liability or Medicare co-payment	☐	Medicare ancillary part B	☐	Private insurance per diem (including co-payment)	☐	CHAMPUS per diem	☐	Other per diem	☐
Medicaid per diem	☐	VA per diem	☐																					
Medicare per diem	☐	Self or family pays for full per diem	☐																					
Medicare ancillary part A	☐	Medicaid resident liability or Medicare co-payment	☐																					
Medicare ancillary part B	☐	Private insurance per diem (including co-payment)	☐																					
CHAMPUS per diem	☐	Other per diem	☐																					

NOTE: The day of admission is counted as day one when calculating the Resident Assessment Instrument (RAI) due date.

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION - continued

8. a.

1. An initial comprehensive assmt including RAPs, completed within 14 days of a patient's admission. In some instances, the same assmt that is completed and electronically transmitted to meet PPS requirements, may also be used to meet the OBRA clinical requirements. The facility may use either the Medicare 5 day or the Medicare 14 day assmt (whichever one included the RAPs) to meet both the requirements for PPS, and the clinical requirement for completing and transmitting an Initial Admission assmt. The OBRA clinical requirements for MDS completion do not provide a grace period for completion of the Initial Admission assmt to correspond with the grace period that the PPS rules allow for the Medicare 14 day assmt.

PLEASE NOTE that the code for Initial Admission assmt is also used when an individual returns to the facility subsequent to a prior discharge where return was not anticipated.

2. A comprehensive reassmt required within 12 months (366 days) of the most recent full assmt. If a resident has a significant change in status at the time of the annual, code 8a=3. DO NOT code as an Annual assmt. The MDS schedule "restarts" and the next comprehensive assessment would be due within 366 days of the significant change assessment. (pg. 2-5)

3. A comprehensive reassmt prompted by a "major change" that is not self-limited, that impacts on more than one area of the resident's clinical status, and that requires interdisciplinary review or revision of the care plan to ensure that appropriate care is given. When there is a significant change, the assmt must be completed by the end of the 14th calendar day following the determination that a significant change has occurred. (refer to Chapter 2, pgs. 2-7 to 2-13).

PLEASE NOTE: For instances in which the resident continues to make steady progress under the current course of care, reassmt is only required when the condition has stabilized. With a terminal condition, a full reassmt is optional. Refer to the next page for additional comments.

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. Discharge prior to completing initial assessment 9. Reentry 10. Significant correction of prior quarterly assessment 0. NONE OF ABOVE
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4. A comprehensive assmt completed at the facility's prerogative, because the previous assmt was inaccurate or completed incorrectly. This differs from a significant change in status assmt, in which there has been an actual change in the resident's health status (refer to pgs. 2-13 to 2-14).

5. The subset of MDS items required by the State, which must be completed no less frequently than once every 3 months (92 days) (i.e., between required full assmts). Ensures that changes in the resident's status are noted, and incorporated into the care plan, so that it remains current and appropriate in meeting the needs of the resident. If a significant change in status is noted at the time of a resident's quarterly review assmt, replace with a significant change in status assmt. Use code 8a=3. Do not code as a Quarterly review assmt. The requirements for PPS specify that a Medicare 90 day assmt must be completed for each patient whose stay is still covered under Medicare. To minimize burden on facility staff, the full assmt that is completed at day 90 of a Medicare Part A stay to meet PPS requirements, may also be used to meet the clinical requirements for completion of a Quarterly Review Assmt, as long as it is completed no later than 92 days after completion of the prior assmt. In this case, the Reason for Assmt would be coded both as a Quarterly Review Assmt (8a=5), and as a Medicare 90 day assmt (8b=4).

6. and **7.** These are not codes used on this form; they are used on the "Discharge Tracking Form" only.

8. Use this code when a resident is discharged during the first 14 days of residency AND an admission assmt has not been completed. A subset of information contained on the *Discharge Tracking Form* must be completed for all individuals admitted to the facility regardless of length of stay. This form must also be completed following a resident's transfer to another facility, or death.

9. This is not a code used on this form; it is used on the Re-entry Tracking Form only.

10. A quarterly review assmt completed at the facility's prerogative, because the previous quarterly review assmt was inaccurate or completed incorrectly.

0. Use this code when none of the codes in 8a apply, but the facility is required to complete an assmt for Medicare PPS or by the State. If 0 is checked at 8a, a code must be selected at 8b.

Be consistent. Responses here must be the same as in Section AA.8.a. It is possible to select a code from both 8a & 8b.

Additional Comments on Significant Change Assessment

Facilities have an ongoing responsibility to assess the resident's status and intervene to assist the resident to attain or maintain the highest practicable level of physical, mental, and psychosocial well-being. Staff have the responsibility of deciding whether a change they have noted (either an improvement or decline) is significant.

A "significant change" is defined as a major change in the resident's status that:

- Is not self-limiting;
- Impacts on more than one area of the resident's health status; and
- Requires interdisciplinary review and/or revision of the care plan.

The following indicate conditions under which a significant change reassessment is required. The terms referenced are based on items (and definitions) found in Version 2.0 of the MDS. Other situations can apply; this list is not exhaustive, and other situations may also meet significant change definition. [Note C in an end stage disease status, a full reassessment is optional, depending on a clinical determination of whether or not the resident would benefit from the reassessment.]

A significant change may occur at any point during the resident's stay, although facilities may most commonly identify that a significant change has occurred while constructing the resident's scheduled quarterly review. Over a six-month period, depending on the resident population, one in five residents typically decline in two or more of these areas. The goal of the significant change reassessment is to ensure that residents are being appropriately monitored and necessary changes in care instituted. Also see discussion in Chapter 2.

SIGNIFICANT CHANGE CRITERIA*

A significant change assessment is required if a decline (or improvement) change is consistently noted in two or more areas of decline, or two or more areas of improvement.

DECLINE

- Any **decline in ADL physical functioning** where a resident is **newly** coded as 3, 4, or 8 (Extensive assistance; Total dependency; Activity did not occur.) **(Item G1a)**
- Increase in number of areas where Behavioral symptoms are coded as not easily altered (increase in number of code 1's for E4B)
- **Resident's** decision making **changes** from 0 or 1 to 2 or 3. **(Item B4)**
- **Resident's** incontinence **pattern changes** from 0 or 1 to 2, 3, or 4 **(Item H1a or b)**, or placement of an indwelling catheter. **(Item H3d)**
- Emergence of sad or anxious mood as a problem that is not easily altered. **(Item E2)**
- Emergence of an unplanned weight loss problem (5% change in 30 days or 10% **change** in 180 days.) **(Item K3a)**
- Begin to use a trunk restraint or a chair that prevents rising **for a resident when it was not used before.** **(Item P4c, e)**
- Emergence of a condition/disease **in which** resident is judged to be unstable. **(Item J5a)**
- Emergence of a pressure ulcer at Stage II or higher, when no ulcers were previously present at that stage or higher. **(Item M2a)**
- Overall deterioration **of resident's condition; resident** receives more support, (e.g., in performing ADLs, or in decision making). **(Item Q2 = 2)**

IMPROVEMENT

- Any **improvement in ADL physical functioning** where a resident is **newly** coded as 0, 1, or 2, when previously scored as a 3, 4, or 8. **(Item G1a)**
- Decrease in number of areas where Behavioral symptoms of sad or anxious mood are coded as not easily altered. **(Item E2, E4B)**
- **Resident's** decision making **changes** from 2 or 3 to 0 or 1. **(Item B4)**
- **Resident's** incontinence **pattern changes** from 2, 3, or 4 to 0 or 1. **(Item H1a or b)**
- Overall improvement of **resident's condition; resident** receives fewer supports. **(Item Q2 = 1)**

*This is not an exhaustive list.

(pg. 2-8, 9)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION - continued

All of the following codes, with the exception of 8.b.6. designate only assmts required under Medicare PPS for residents whose stay is covered by Medicare. Grace periods apply to Medicare PPS assmts only. The schedule for PPS assmts is distinct from the OBRA clinical assmt requirements.

8.b.

1. The first assmt in the Part A stay. The assmt reference date will fall within the first 5 days of the stay (unless one of the grace days is being used). May be either a full assmt, MPAF, or, if used as the required OBRA Initial Admission Assmt (AA8a=01), complete a comprehensive assmt.
2. The third scheduled assmt in a Part A stay. The assmt reference date will fall on any day 21 through 29 of the stay unless one of the grace days is being used.
3. The fourth scheduled assmt in a Part A stay. The assmt reference date will fall on any day 50 through 59 (unless grace days are used).
4. The fifth scheduled assmt of the Part A stay. The assmt reference date will fall on any day 80 through 89 of the stay (unless one of the grace days is being used). If this assmt is also the required Quarterly Assmt (AA8a=4), it must be **completed** within the 92 days of the prior comprehensive assmt.
5. This is coded when a beneficiary is discharged from a SNF stay to another inpatient setting and is then readmitted to the SNF. The Readmission/Return assmt reference date must fall within the first 5 days of the new stay.
6. DO NOT USE in Missouri.
7. The second scheduled assmt in a Part A stay. Must have an assmt reference date that falls on any day 11 through 14 (unless a grace day is used). May be a full assmt or MPAF unless this assmt is also the OBRA Initial Admission Assmt (AA8a=01) in which case it must be a comprehensive assmt and must be completed by day 14. (No grace days allowed)
8. This assmt type is performed on the 8th, 9th, or 10th day after all of the beneficiary's rehabilitative therapy services are discontinued. This is only required if the beneficiary is still in the facility in a Part A stay. (pg. 2-31)

NOTE that it is possible to select a code from both 8a and 8b (e.g., Item 8a coded 3) (Significant Change in Status assmt), and Item 8b coded 3 (60-day assmt).

8	REASONS FOR ASSESSMENT	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		(R)
9	RESPONSIBILITY/LEGAL GUARDIAN	(Check all that apply) Legal guardian a. Durable power attorney/financial Other legal oversight b. Family member responsible Durable power of attorney/health care c. Patient responsible for self NONE OF ABOVE		d. e. f. g.
10	ADVANCED DIRECTIVES	(For those items with supporting documentation in the medical record, check all that apply) Refer to Chapter 3, pgs. 3-37 to 3-40 Living will a. Feeding restrictions Do not resuscitate b. Medication restrictions Do not hospitalize c. Other treatment restrictions Organ donation d. NONE OF ABOVE Autopsy request e.		f. g. h. i.

9. May have multiple answers. To check in this area, must have documentation in the medical record; if no legal documentation is available, assume that the resident is the responsible party. See definitions pgs. 3-36 to 3-37.

10. Check all that apply. If none of the directives are verified by documentation in the medical record, check NONE OF THE ABOVE.

To clarify Item 10, you may refer to Missouri Long Term Care Facility Regulations and Licensure Law 13 CSR-15-18.010 or Federal Regulations at F152 and F156.

EXAMPLE:

If resident was Discharged - return anticipated, complete a Full Assmt if no significant change. Complete a Comprehensive Assmt if resident had a significant change. If resident was Discharged - return not anticipated, complete a Comprehensive Assmt, treat as an initial admission.

SECTION B. COGNITIVE PATTERNS

Determines the resident's ability to remember, think coherently, and organize daily self-care activities, as these areas are crucial factors in care planning. With aphasic residents, use your best clinical judgment to assess nonverbal clues. Check with caregivers for their observations at different times of day or during differing activities. Be cognizant of possible cultural differences that may affect your perception of the resident's response (pg. 3-41, 42).

1. Refer to pg. 3-42 to 3-43, for guidance re: physician's diagnosis of coma or persistent vegetative state. To check YES, must be documented in clinical record by physician.

2. a. & b. Use a "-" if the information is not available because it cannot be assessed (pgs. 3-43 to 3-45).

3. Ability to recall within environmental setting.

4. Focus on whether the resident is actively making decisions about tasks or activities of daily living and not whether the staff may believe they are capable of doing so. The intent of this item is to record residents performance not staff support.

5. Delirium is often manifested behaviorally and often caused by a treatable illness. See examples, pg. 3-49.

6. Reflect changes in B1-B5 above; may be permanent or temporary changes, causes may be known or unknown. If new admission, note changes prior to admission. Refer to pg. 3-50.

SECTION B. COGNITIVE PATTERNS

1. COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No ☐ 1. Yes ☐ (If yes, skip to Section G)	☐
2. MEMORY a1= ☐	(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 ☐ Location of own room ☐ b. ☐ Staff names/faces ☐ c. NONE OF ABOVE are recalled ☐ d. ☐ e. ☐	☐
4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING 1, 2, 3 = ☐	(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

Documents the resident's ability to hear (with assistive devices, if used), understand, and communicate with others. Evaluate resident's ability to hear with environmental adjustments as necessary. (i.e., reducing noise volume on T.V. or radio, installing amplification device on T.V.) (pg. 3-51)

1. Refer to last 7 days if time frame not indicated.

1.2 Includes use of hearing enhanced telephone

3. Denotes the ability to express self or communicate both verbally and nonverbally. (Expressive ability)

4. Ability to express requests, needs, opinions, urgent problems and social conversation by any method—even in writing.

5. Reflects quality of speech only (not content or appropriateness).

6. Denotes ability to understand others. Measures ability to hear messages and also to process and understand language. Able to comprehend by any method, orally, by writing, or in sign language, or by braille. (Receptive Ability)

Note: Problem understanding others may be due to functional problems or that the resident uses a different language

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING	(With hearing appliance, if used) 0. <i>HEARS ADEQUATELY</i> —normal talk, TV, phone 1. <i>MINIMAL DIFFICULTY</i> when not in quiet setting 2. <i>HEARS IN SPECIAL SITUATIONS ONLY</i> —speaker has to adjust tonal quality and speak distinctly 3. <i>HIGHLY IMPAIRED</i> —absence of useful hearing		
2. COMMUNICATION DEVICES/ TECHNIQUES	(Check all that apply during last 7 days) Hearing aid, present and used Hearing aid, present and not used regularly Other receptive comm. techniques used (e.g., lip reading) <i>NONE OF ABOVE</i>		a. b. c. d.
3. MODES OF EXPRESSION	(Check all used by resident to make needs known) Speech Writing messages to express or clarify needs American sign language or Braille	a. Signs/gestures/sounds b. Communication board c. Other <i>NONE OF ABOVE</i>	d. e. f. g.
4. MAKING SELF UNDERSTOOD	(Expressing information content—however able) 0. <i>UNDERSTOOD</i> 1. <i>USUALLY UNDERSTOOD</i> —difficulty finding words or finishing thoughts 2. <i>SOMETIMES UNDERSTOOD</i> —ability is limited to making concrete requests 3. <i>RARELY/NEVER UNDERSTOOD</i>		®
5. SPEECH CLARITY	(Code for speech in the last 7 days) 0. <i>CLEAR SPEECH</i> —distinct, intelligible words 1. <i>UNCLEAR SPEECH</i> —slurred, mumbled words 2. <i>NO SPEECH</i> —absence of spoken words		
6. ABILITY TO UNDERSTAND OTHERS	(Understanding verbal information content—however able) 0. <i>UNDERSTANDS</i> 1. <i>USUALLY UNDERSTANDS</i> —may miss some part/intent of message 2. <i>SOMETIMES UNDERSTANDS</i> —responds adequately to simple, direct communication 3. <i>RARELY/NEVER UNDERSTANDS</i>		
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		

May use speech/language pathologist to consult regarding ability to express or receive information.

SECTION D. VISION PATTERNS

Records resident's visual abilities and limitations assuming adequate lighting and assistance of visual appliances, if used.

1. Refer to last 7 days if time frame not indicated.

NOTE: Residents with cognitive impairments may not be able to participate in vision screening if they are unable to follow directions or are unable to tell you what they see. However, many such residents appear to "track" or follow moving objects in their environment with their eyes. For residents who appear to do this, use code 3, Highly Impaired. This is the best assessment you can do under the circumstances.

2. Related to diseases common in the aged. Some of these may be treatable, others may be managed by interventions to maintain or improve visual ability. Check all that apply or **NONE OF ABOVE**.

3. Appliances must be used regularly to code here.

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 <i>NONE OF ABOVE</i>	a. b. c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

SECTION E: MOOD AND BEHAVIOR PATTERNS

Mood distress is a serious condition and is associated with significant morbidity. The elderly respond readily to treatment for mood distress. Therefore, it is very important to identify the signs and symptoms.

1. Record the frequency of indicators observed, irrespective of the assumed cause of the behavior. It is important to note that coding the presence of indicators does not automatically mean the resident has a diagnosis of depression or anxiety.

Distress may be expressed nonverbally and observed in these areas during usual routines.

Observe changes in usual patterns of behavior.

Note: if an indicator of depression occurs twice in the last 30 days (not 2 times each week) it should be coded as "1" to indicate that the indicator of depression was exhibited up to 5 days a week, but less than 6 days a week. It does not need to occur each week to be coded (pg. 3-63)

An indicator of depression that occurs in the beginning of the 30 day period should be coded as occurring up to 5 days a week, but less than 6 days a week (pg. 3-63).

2. This item is looking at the last 7 days. During that specific period of time, were there depressed, sad, or anxious indicators? If so, could they be altered?

3. Reflects changes in number, frequency, or intensity of expressions or signs of distress.

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" ♦	(R)	
		b. Repetitive questions—e.g., "Where do I go; What do I do?"	(R)	
		c. Repetitive verbalizations—e.g., calling out for help, ("God help me") ♦	(R)	
		d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received	(R)	
		e. Self deprecation—e.g., "I am nothing; I am of no use to anyone" ♦	(R)	
		f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others ♦	(R)	
		g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack ♦	(R)	
		h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions ♦	(R)	
		i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues	(R)	
		SLEEP-CYCLE ISSUES		
		j. Unpleasant mood in morning	(R)	♦
		k. Insomnia/change in usual sleep pattern	(R)	
		SAD, APATHETIC, ANXIOUS APPEARANCE		
		l. Sad, pained, worried facial expressions—e.g., furrowed brows	(R)	
		m. Crying, tearfulness ♦	(R)	
		n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking	(R)	♦
		LOSS OF INTEREST		
		o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends	(R)	♦
		p. Reduced social interaction	(R)	♦
2.	MOOD PERSISTENCE 1,2= ♦	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		

SECTION E. MOOD AND BEHAVIOR PATTERNS -- continued

4. Identifies frequency and alterability of behavioral symptoms that cause distress to the resident or that may be distressing or disruptive to other residents and staff.

a. WANDERING - see Section E, 4 for definition. Do not include pacing here (refer to Eln, previous page -repetitive physical movements).

b. Includes residents or staff

c. Includes residents or staff

e. RESISTS CARE - does not include exercise of rights to refuse care, i.e., informed choice. See pg. 3-66, 67.

5. Considers numbers, frequency, intensity or alterability of behavior. Asks for a snapshot of “today” as compared to 90 days ago (or since last assessment if less than 90 days) of the status of behaviors noted under E4. Please note however that behavioral symptoms for the entire 90 day period should be reviewed for care planning purposes.

PLEASE NOTE: Once frequency and alterability of individual behaviors has been determined, or assessed, subsequent documentation in the record should reflect the status of behavior and response to interventions.

4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequency in last 7 days Across all three shifts 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 Across all three shifts 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) (R) ☐ b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at) (R) ☐ c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused) (R) ☐ 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) (R) ☐ e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating) (R) ☐
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

Determines resident's emotional adjustment to the facility, general attitude, adaptation to surroundings and change in relationship patterns. The residents strength(s) or problem(s)/need(s) can both be identified in this section. For care planning purposes, what is checked is as important as what is not checked.

Discrepancies can exist between how the resident sees him/herself and how he/she actually behaves.

Check all that apply in the last 7 days.

1. Assess degree resident is involved in nursing home life, takes initiative in participation, including solitary pursuits.

2. Indicates quality and nature of resident's interpersonal contacts with others.

3. Documents resident's recognition or acceptance of feelings regarding previous roles or status now that they are living in a nursing home. (May reflect resident's strength).

SECTION F. PSYCHOSOCIAL WELL-BEING

1. SENSE OF INITIATIVE/ INVOLVE- MENT	At ease interacting with others	a.
	At ease doing planned or structured activities	b.
	At ease doing self-initiated activities <i>Focus is resident strength.</i>	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 RELATION- SHIPS	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.

Note: F1. Process for F1a-b – If resident not at ease interacting with others and/or doing planned and/or structured activities, it should be coded regardless of the suspected reason and regardless of whether or not this is the residents normal status.

Refer to definitions pgs. 3-71 to 3-72.

SECTION G: PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

Most nursing home residents are at risk for physical decline due to multiple chronic illnesses and/or other factors impacting self-sufficiency. A resident's potential for maximum functionality may often be greatly underestimated by family, staff and the residents themselves. All residents are candidates for nursing-based rehabilitative care that focuses on maintaining and/or increasing self-involvement in ADLs. Individualized plans of care can be successfully developed only when the resident's self-performance has been accurately assessed and the amount and type of support being provided to the resident by others has been evaluated.

Each of these ADL Self-Performance codes is exclusive; there is no overlap between categories. Changing from one self-performance category to another demands an increase or decrease in the number of times that help is provided. Thus, to move from independent to supervision to limited assistance, non-weight-bearing supervision or physical assistance **MUST** increase from one to two times up to three or more times during the least seven days. (See examples 3-83 to 3-89.)

G1(A) 0-4 Three or more times is an important part of determination of movement to the next level of dependency. See Chapter 3, Section G & ADL self performance diagram (See pg 21 of handouts. See pg 22 of handouts for further explanation.)

(A) Measures what the resident actually did according to a performance-based scale. Performance may vary by time of day, so observe over 24 hour periods.

(B) To promote highest level of function, must identify what resident actually does for self, noting when assistance is received and clarifying type of assistance provided.

NOTE: Since this section is in two parts, each using its own scale, it may help you to **complete all of Section A first**, then Section B - to avoid confusion.

Review ADL Self Performance definitions and coding instructions pgs.3-76 to 3-82. See coding example pgs. 3-83 to 3-102.

*Code 8 is limited to situations where the activity was not performed, by the resident or staff over the last 7 days. Therefore, an objective assessment of the resident's performance is not possible; when 8 is coded for **self-performance**, it should also be entered for support. Do not confuse a resident who is totally dependent in an ADL activity (Code 4 - Total Dependence) with the activity itself not occurring, i.e., a resident who is tube fed.

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			
	* 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)		(A)	(B)
	0. No setup or physical help from staff		SELF-PERF	SUPPORT
	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.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed	(R)	(R)
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	(R)	(R)
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)	(R)	
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	(R)	(R)
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)		

SECTION G: PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS, CONT'D.

Bathing is the only ADL activity for which the ADL self performance codes in item G1A do not apply. This is due to the frequency of baths carried out over a 7-day period. The ADL - Support Provided Codes given in item G1B, still apply. See pgs. 3-91 to 3-92.

2. Column (A) evaluates how the resident takes a full body bath, shower or sponge bath including transfers in and out of tub or shower. Score maximum amount of assistance resident received during bathing. The definition does not include the washing of back or hair.

Column (B) identifies the maximum level of support provided in bathing activities using the ADL Support Scale in Item G1B.

3. Residents with impaired sitting and standing balance are at a greater risk for falls. This evaluates resident's balance abilities so that appropriate interventions can be implemented to prevent injuries.

Records resident's ability to balance while standing (without assistance from a device or person) and balance while sitting (without using any type of support).

See method for testing in manual, Chapter 3, Section G, Item 3. "DO NOT attempt to test residents who cannot stand by themselves." Code these residents as **3** (pg 102-104).

NOTE: The resident may decline balance test, but every attempt should be made to determine why the resident refuses. A short notation should be made on the MDS form regarding why the resident refused (pgs. 3-102 to 3-103).

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	(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			
	(see training manual)	Refer to pgs. 3-102 to 3-107 a. Balance while standing b. Balance while sitting—position, trunk control			
4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION	(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 For (A) - Code 1 or 2 if unilateral or bilateral amputee (See pg. 3-109) i.e. spine, jaw or other		(A)	(B)
	(see training manual)	Refer to pgs. 3-107 to 3-111 ♦			

4. Identifies presence of (A) functional limitation or that interferes with daily functioning or (B) loss of voluntary movement which places the resident at risk of injury. Voluntary movement is defined as intentional and purposeful functional movement.

See manual for assessing process, Chapter 3, Section G, Item 4. (pg 3-107 to 3-109)

This is a screening item to determine a need for a more intensive evaluation. It does not need to be performed by a physical therapist, but by a member of any clinical discipline in accordance with instructions. (pg 3-107)

4. a. It is proper to actively assist resident with cognitive impairment in ROM exercise to assess for limitations (See pg. 3-108). First determine if there is a limitation in active or active-assisted ROM. Then determine if the limitation in ROM interferes with function or place the resident at risk for injury.

SECTION G: PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS, CONT'D.

5. Identifies the type(s) of appliances, devices, or personal assistance that resident uses (on and off the unit) during the last 7 days.

5. a. Cane/walker/crutch, includes resident pushing wheelchair, or merry walker.

5. b. Wheeled self includes hand-propelled or motorized wheelchair, resident is responsible for self-mobility.

5. c. Other person wheeled is another person pushing the resident.

5. d. Check here even if ambulatory but primarily dependent on wheelchair to get around. A merry walker is viewed as a walker if used to aid ambulation (pg. 3-111 and 3-199, 200).

6. Records type(s) of assistive devices resident uses for transferring and bed mobility during the last 7 days.

6. a. If resident bedfast in bed or recliner but out of room, location is crucial in coding here. If out of room most of day, do NOT check. The concept of bedfast is meant to capture residents who spend 22 hours or more in a bed or recliner in their own room regardless of their level of function.

7. Some residents become overwhelmed and anxious with expectations for greater independence. Identifies residents who are more involved and independent in personal care tasks because they have received help in breaking tasks down into smaller steps to make tasks easier.

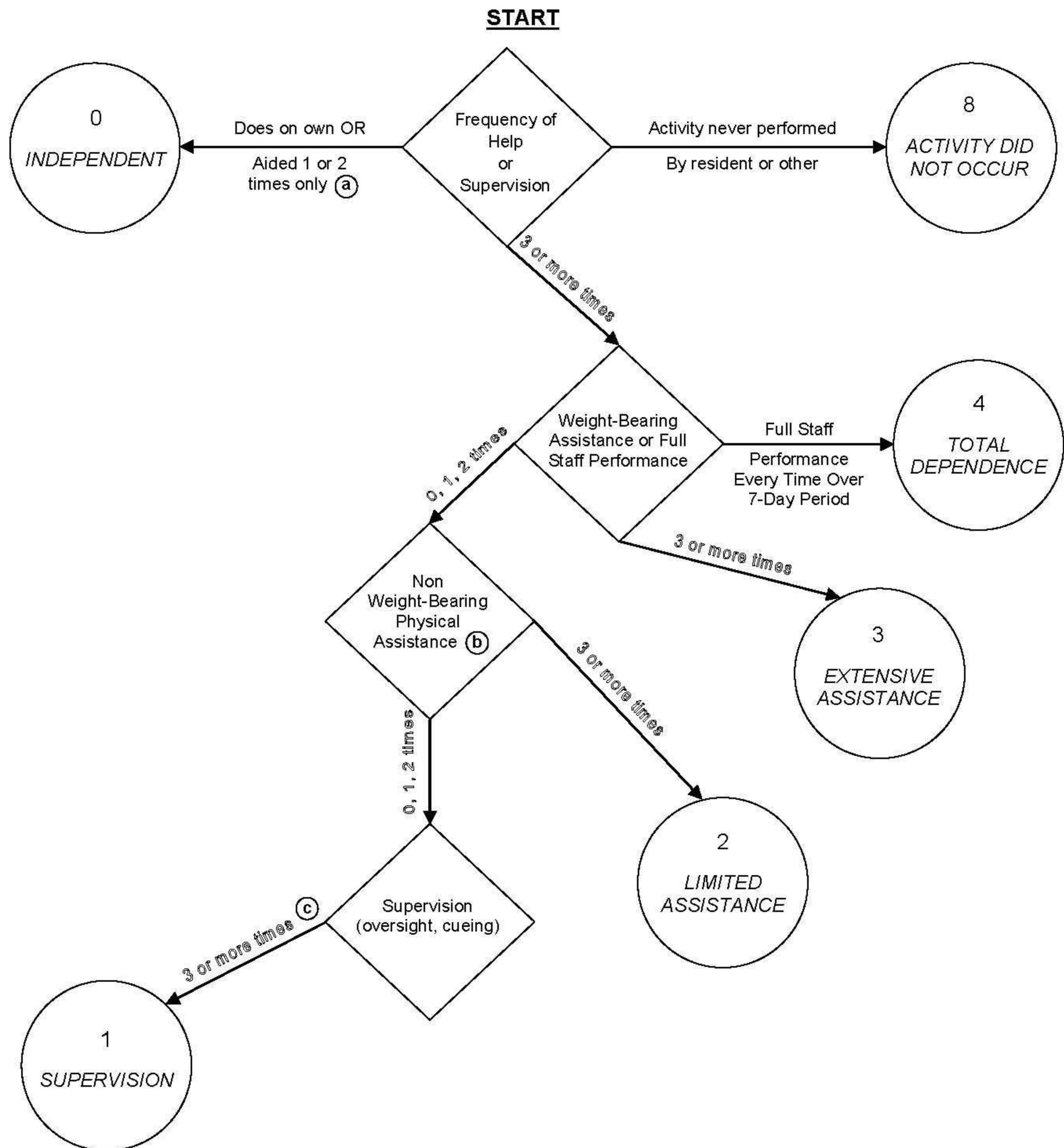
Provides residents with directions for performing each step in an ADL activity through verbal cues, and/or physical cues. This information may be documented in nursing notes or therapy notes, or assessed by observing nurse assistant with resident during care.

8. Evaluates resident's functional status to determine if he or she is capable of greater independence and involvement in self-care. Identify any variances in resident's independence over all shifts during the last 7 days.

9. Documents any changes occurring in resident's overall self-performance and the amount/type of support received by staff as compared to status 90 days ago, or since the last assessment. Review medical record and Section G from last assessment and compare findings.

5.	MODES OF LOCOMOTION	(Check all that apply during last 7 days)		
Refer to pg. 3-111		a.	Wheelchair primary mode of locomotion	d.
		b.		
		c.	NONE OF ABOVE	e.
6.	MODES OF TRANSFER	(Check all that apply during last 7 days) (Not bath lift)		
Refer to pg. 3-112		a.	Lifted mechanically in bed or chair	d.
		b.	Transfer aid (e.g., slide board, trapeze, cane, walker, brace)	e.
		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. Examples p 3-114. 0. No 1. Yes		
8.	ADL FUNCTIONAL REHABILITATION POTENTIAL	Resident believes he/she is capable of increased independence in at least some ADLs Direct care staff believe resident is capable of increased independence in at least some ADLs Resident able to perform tasks/activity but is very slow Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings NONE OF ABOVE		a. b. c. d. 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		

SCORING ADL SELF PERFORMANCE



- a. Can include one or two events where received supervision, non weight-bearing assistance, or weight-bearing assistance.
- b. Can include one or two episodes of weight-bearing assistance, e.g., two events with non weight-bearing assistance plus two of weight-bearing assistance would be coded as a "2".
- c. Can include one or two episodes where physical help received, e.g., two episodes of supervision, one of weight-bearing assistance and one of non weight-bearing assistance would be coded as a "1".

ADL SELF-PERFORMANCE

MDS SECTION G 1(A)

- 0 - Independent
- 1 - Supervision (stand by assistance)
- 2 - Limited assistance (contact guard)
- 3 - Extensive assistance (min-mod-max assistance)
- 4 - Total dependence
- 5 - Activity did not occur

MDS SECTION G 1(B)

- 0 - No setup or physical help from staff
- 1 - Setup help only
- 2 - One person physical assist
- 3 - Two or more physical assist
- 4 - ADL activity itself did not occur

SECTION H: CONTINENCE IN LAST 14 DAYS

This section differs from other ADL items as the period of review is extended to 14 days. This time frame is viewed as the minimum required to assess an accurate picture of bowel patterns.

NOTE: See process instructions -- continence patterns over last 14 days, pgs. 3-119 to 3-120.

- 1.** This item refers to control of urinary bladder function and/or bowel movement, distinct from ADL status and need for assist. Code one response for (a) Bowel Continence level and one response for (b) Bladder Continence.

Use 5 point scale in User's Manuals Chapter 3, Section H, Question 1. (pg 3-121)

- 2.** Records effectiveness of the resident's bowel function during the last 14 days. Refer to pg. 3-120.

- 3.** Review medical record, consult with staff and residents, and check all incontinence appliances used and/or incontinence programs in place over last 14 days.

3. a. There are 3 key ideas in H3a: 1) schedule, 2) toileting, and 3) program. Changing wet garments is not included in this concept.

3. b. A retraining program where the resident is taught to consciously delay urinating. Residents are encouraged to void on a schedule rather than based on their urge to void.

SECTION H. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL CATEGORIES (Code for resident's PERFORMANCE OVER ALL SHIFTS)			
0. <i>CONTINENT</i> —Complete control [includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool] <i>may include changing own pads</i> does not include toilet ability (G1A)			
1. <i>USUALLY CONTINENT</i> —BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly			
2. <i>OCCASIONALLY INCONTINENT</i> —BLADDER, 2 or more times a week but not daily; BOWEL, once a week			
3. <i>FREQUENTLY INCONTINENT</i> —BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week			
4. <i>INCONTINENT</i> —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	3,4= ☐ 2,3= ☐	
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	3,4= ☐ 2,3= ☐	
2. BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days	a. Diarrhea ☐ b. Fecal impaction ☐ c. Constipation ☐ d. NONE OF ABOVE ☐ e.	

3. APPLIANCES AND PROGRAMS	Any scheduled toileting plan ☐ habit or prompted voiding ☐ Bladder retraining program ☐	a. ☐ Did not use toilet room/ commode/urinal /bedpan ☐ b. ☐ Pads/briefs used ☐ c. ☐ Enemas/irrigation /ostomy irrigations ☐ d. ☐ Ostomy present ☐ e. ☐ NONE OF ABOVE ☐	f. ☐ g. ☐ h. ☐ i. ☐ 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 ☐	

3. e. Intermittent catheterization by a licensed nurse or the resident.

3. g. Do not include routine use of pads on beds if resident rarely incontinent.

4. Document changes in the resident's urinary continence status compared to 90 days ago or since the last assessment. Compare self-control categories, appliances or program changes.

SECTION I: DISEASE DIAGNOSES

The disease conditions require a physician documented diagnosis in the clinical record, pgs. 3-127 to 3-130. In general, coded items should be conditions that drive the current plan of care.

1. The focus of the MDS is to generate an updated, accurate picture of the resident's health status. Therefore, this section documents the presence of diseases that have a relationship to the resident's current overall status. Do not include conditions/diagnoses that have been resolved or no longer affect the resident's functioning or care plan. Utilize a review of the clinical records, clinical monitoring of the resident by a licensed nurse, interview of the resident and review of diagnoses with the resident's physician.

2. Documents the presence of infections that have a relationship to the resident's current overall status. Do not include infections that have been resolved or no longer affect the resident's functioning or care plan. There should be supportive documentation in the medical record from a physician.

2. C. This item is an exception to the 7 day rule. If UTI in last 30 days, code even if no longer receiving treatment or monitoring during assessment period.

3. Identifies conditions not listed in Item I1 and I2 that affect the resident's current ADL status, mood and behavioral status, medical treatments, nursing monitoring, or risk of death. Include more specific designations for general disease categories listed above. Enter the description of the diagnosis including an ICD-9 code. **NOTE:** Consult most recent version of the full set of volumes of ICD-9-CM codes. Vcodes may be used if they affect the resident's current ADL status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (pg. 3-137)

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)	
See pgs. 3-127 to 3-130	ENDOCRINE/METABOLIC/NUTRITIONAL		Hemiplegia/Hemiparesis v. (R)
	Diabetes mellitus a. (R)		Multiple sclerosis w. (R)
	Hyperthyroidism b.		Paraplegia x.
	Hypothyroidism c.		Parkinson's disease y.
	HEART/CIRCULATION		Quadruplegia z. (R)
	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. (R)		OTHER	
Cerebral palsy s. (R)		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)	
See definitions pgs. 3-135 to 3-136	Antibiotic resistant infection (e.g., Methicillin resistant staph) a.		Septicemia g. (R)
	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. (R)		Viral hepatitis k.
	Respiratory infection f.		Wound infection l.
			NONE OF ABOVE m.
3. OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES			
See pg 3-137	a. ♦		
	b.		
	c.		
	d.		
	e.		

May consult the medical record and/or the physician or resident to solicit input on inaccurate or missed diagnosis or infections.

SECTION J: HEALTH CONDITIONS

This section records conditions that could effect the resident's health or functional status and identifies risk factors for illness, accidents and decline. This section also records the frequency and intensity of signs and symptoms of pain. This information can be used to identify indicators of pain as well as to monitor the resident's response to pain management interventions for care planning purposes.

1. **a.** Record specific problems or symptoms that affect or have the potential to affect a resident's health or functional status, and identify risk factors for illness, accident or functional decline. Check all that apply or **NONE OF ABOVE** if none apply.

NOTE: review clinical signs of dehydration pg. 3-138.

2. **a.** Frequency of pain as described or manifested by resident.

2. **b.** Severity of pain as described or manifested by resident. **NOTE:** Code for presence or absence of pain, regardless of pain management efforts, i.e. breakthrough pain.

3. For MDS assessment purposes, pain refers to any type of physical pain or discomfort in any part of the body. Pain is whatever the resident says it is, or may depend on observation and assessment because the resident will not or cannot verbalize.

4. Determines resident's risk of future falls or injuries. Check all conditions that apply. If no conditions apply, check **NONE OF ABOVE**. See fall definition, pgs. 3-146 to 3-147.

5. Used to determine if resident's disease or health conditions present over the last 7 days are acute, unstable, or deteriorating.

5. **a.** denotes changing and variable nature of resident's condition. Reflects degree of difficulty in balance between treatment for multiple conditions.

5. **b.** usually sudden onset, time-limited course, requiring physician evaluation and significant increase in licensed nurse monitoring.

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	
		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	
		Delusions	
		Dizziness/Vertigo	f.
		Edema	g.
		Fever defined as 2.4 deg. F greater than baseline	h. (R)
		Hallucinations	i. (R)
		Internal bleeding	j. (R)
		Recurrent lung aspirations in last 90 days	k.
		Shortness of breath (X-rays not necessary)	l.
		Syncope (fainting)	m.
		Unsteady gait	n.
		Vomiting	o. (R)
		NONE OF ABOVE	p.

Review definitions
pgs. 3-138 to 3-140

Review intent and
coding, pgs. 3-140 to
3-143

see definitions pg. 3-144

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	b. INTENSITY of pain
		0. No pain (skip to J4)	1. Mild pain
		1. Pain less than daily	2. Moderate pain
		2. Pain daily	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	
		Bone pain	
		Chest pain while doing usual activities	
		Headache	
		Hip pain	
		Incisional pain	
		Joint pain (other than hip)	
		Soft tissue pain (e.g., lesion, muscle)	
		Stomach pain	
		Other	
4.	ACCIDENTS	(Check all that apply)	
		Fell in past 30 days	
		Fell in past 31-180 days	
		Hip fracture in last 180 days	
		Other fracture in last 180 days	
		NONE OF ABOVE	
5.	STABILITY OF CONDITIONS	(last 7 days)	
		Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating)	
		Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem	
		End-stage disease, 6 or fewer months to live	
		NONE OF ABOVE	

(interferes with
routine sleep)

(last 7 days)
See pg 3-147,
148 and 2-11

5. **c.** Substantiate by well documented disease diagnosis and deteriorating clinical course. A doctor's certification that the resident has 6 months or less to live must be present in the medical record (pg. 3-147.)

SECTION K: ORAL/NUTRITIONAL STATUS

NOTE: Expanded information and new guidance provided; see pgs. 3-149 to 3-152.

1. Record any oral problems such as chewing or swallowing problems or mouth pain present in the last 7 days even when successful interventions have been introduced (pg. 3-149).

2. Round height and weights up to the nearest whole inch and whole pound respectively. Record height in inches; if last height recorded more than one year ago, measure again. Record most recent weight. (If weight is less than 100 lbs, use leading zero to fill all boxes, i.e., 097) If taken more than one month ago, weigh again. If the resident has experienced a decline in intake at meals, snacks, or fluid intake, weigh again. Use same scale and weigh at consistent time each month a.m. or p.m.

3. Record the variations in the resident's weight over time. When calculating percentage of loss or gain, do not round up the resident's weight. If there is no weight to compare to, enter **the unknown code [-]**. (pg 3-151)

4. Identifies specific problems, conditions, and risk factors for functional decline present in the last 7 days that could affect the resident's health or functional status. See expanded process, pg. 3-153.

Check all conditions that apply. If no conditions apply, check **NONE OF ABOVE**.

5. a. Include only fluid administered for nutrition or hydration. See pg 3-153 for examples to be included and excluded. See further clarification on pg 3-154 regarding hypodermoclysis and subcutaneous ports in hydration therapy.

5. b. Presence of any type of tube that can deliver food, fluids, or meds directly into the GI system.

5. c. Mechanically altered diet is not automatically considered a therapeutic diet. Enteral feeding formulas are not coded here.

5. e. Therapeutic diet: A diet ordered to manage problematic health conditions. Code entered feeding formulas here when they meet the definition.

SECTION K. ORAL/NUTRITIONAL STATUS

1. ORAL PROBLEMS	Chewing problem	<i>(ask resident and observe at meals)</i>	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			
	b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days			
4. NUTRITIONAL PROBLEMS	Complains about the taste of many foods	a.	Leaves 25% or more of food uneaten at most meals (2 of 3 meals)	c.
	Regular or repetitive complaints of hunger (2 of 3 days)	b.	NONE OF ABOVE	d.
5. NUTRITIONAL APPROACHES	(Check all that apply in last 7 days)			
	Parenteral/IV continuous or intermittent	a. ☒	Dietary supplement between meals don't include snacks as part of daily routine	f.
	Feeding tube	b. ☒	Plate guard, stabilized built-up utensil, etc. to facilitate self-performance in eating	g.
	Mechanically altered diet soft pureed, ground, or thickened	c.	On a planned weight change program	h.
	Syringe (oral feeding)	d.	NONE OF ABOVE	i.
	Therapeutic diet ordered to manage health condition i.e. NAS supplement during meals	e.		
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	b. Code the average fluid intake per day by IV or tube in last 7 days		
consider oral intake	0. None	3. 51% to 75%	☒	
	1. 1% to 25%	4. 76% to 100%	☒	
	2. 26% to 50%			
	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		

5. h. Documented purpose and goal is to facilitate weight gain or loss, i.e., double portions, high/low calorie

6. DO NOT answer this question if neither item K5a or K5b is checked. Record the proportion of calories received and the average fluid intake, through parenteral or tube feeding in the last 7 days. (Amount actually received, not ordered.) See new process instructions, pg. 3-156.

6. a. Review Intake Record. If resident took no food or fluids by mouth, or just sips, stop here and code "4". If more substantial oral intake consult with dietician to derive a calorie count received from parenteral or tube feedings (pg. 3-155).

To calculate, see Chapter 3, pg. 3-156.

6. b. Divide the weeks total intake by 7.

NOTE: A weight change of:

5% in 1 month is significant; over 5% is severe

7.5% in 3 months is significant; over 7.5% is severe

10% in 6 months is significant; over 10% is severe

SECTION L: ORAL/DENTAL STATUS

Documents the resident's oral and dental status as well as any problematic conditions such as tooth decay or cavities. Check all that apply.

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 abscesses; 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

For purposes of the MDS, code skin ulcers in terms of what is actually seen during the look-back period. If necrotic eschar/slough is present, code as Stage 4 until debrided to allow staging. If there are more than 9 ulcers at any one Stage, enter 9 in the appropriate box.

1. Record the number of skin ulcers, at each ulcer stage, on any part of the body. Skin ulcers that develop because of circulation or pressure to be coded here. Review medical record, talk with direct care staff and do a full body examination using the ulcer staging scale definitions in the User's Manual, Chapter 3, Section M, Item 1. See definitions and clarifications, pgs. 3-159 to 3-160.

2. Record the highest stage for 2 types of skin ulcers, Pressure and Stasis, that were present in the last 7 days using the ulcer staging scale definitions in the User's Manual, Chapter 3, Section M, Item 1. Skin tears/shears are coded in item M4 unless pressure was a contributing factor, pg 3-159.

3. Determine if the resident previously had an ulcer that was resolved or cured during the last 90 days by reviewing clinical records including the last Quarterly Assessment, pg 3-165.

4. Document the presence of skin problems or lesions (other than pressure or ulcers caused by circulation conditions) and conditions that are risk factors for more serious problems, pgs. 3-165 to 3-166.

5. Document any specific or generic skin treatment the resident has received in the last 7 days, pgs. 3-167 to 3-168.

6. Document the presence of foot problems and care to resident's feet in the last 7 days.

NOTE: For MDS purposes only, you must reverse stage ulcers, which may be contrary to documentation practices of the Pressure Ulcer Advisory Board and AHRQ Guidelines. Documentation in the record should reflect good clinical practice.

NOTE: A debrided skin ulcer is not a surgical wound. A skin ulcer that is repaired with a skin flap is now a surgical wound. If the graft fails, it is still a surgical wound.

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.	(R)
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	(R)
		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.	(R)
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	(R)
2.	TYPE OF ULCER (Cause is pressure or venous insufficiency)	(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	(R)
		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 (risk factor for developing subsequent ulcers) 0.No 1.Yes	
4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT	(Check all that apply during last 7 days) Abrasions, bruises Burns (second or third degree) Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster Skin desensitized to pain or pressure -- (test in absence of) Skin tears or cuts (other than surgery) documentation in record.) Surgical wounds NONE OF ABOVE	a. b. (R) c. (R) d. e. f. g. (R) h.
5.	SKIN TREATMENTS	(Check all that apply during last 7 days) Pressure relieving device(s) for chair (not 2" egg crate) Pressure relieving device(s) for bed (not 2" egg crate) Turning/repositioning program (continuous/consistent) Nutrition or hydration intervention to manage skin problems Ulcer care (any intervention at any stage, including hydrotherapy) Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE (Bath soaks, elbow pads)	a. (R) b. (R) c. (R) d. (R) e. (R) f. (R) g. (R) h. (R) i. j.
6.	FOOT PROBLEMS AND CARE (doesn't include ankle)	(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 Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days (by nurse or pdiatrist, not CNA) Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE	a. b. (R) c. (R) d. e. f. (R) g.

SECTION N: ACTIVITY PURSUIT LEVEL

This section includes the amount and types of interests and activities that the resident currently pursues, or activities the resident would like to pursue that are not currently available in the facility.

1. Identifies those periods in a typical day over the last 7 days when resident was awake all or most of the time.

--the resident who is awake most of the time could be encouraged to become more involved in activities-solitary or group)

--the resident who naps a lot may be bored or depressed and may benefit from more activity involvement

--See explanation on intent of coding, pg. 3-170.

2. Determines the proportion of free time a resident, while awake, was actually involved in activity pursuits such as caring for plants, reading, visiting family, making phone calls, one on one or therapeutic recreation activities. Does not have to be structured activities. DO NOT include time spent in treatments, ADL activities, or nursing care. Eating is not to be counted as an activity. (pg 3-172)

3. Determines activity settings that resident prefers and/or appears to be at ease. Observe and interview resident, family and staff.

4. Determines which activities listed the resident would prefer to participate in. (Resident activity preferences) Do not limit choices by whether the resident currently engages in the activity or whether the activity is currently offered.

5. Determines if the resident has an interest in pursuing activities not offered at the facility (or off the nursing unit), or not made available to the resident. Code for residents preferences in daily routines/activities. Residents who resist attendance/ involvement in activities offered at the facility are also included in this category in order to determine possible reasons for their lack of involvement. (pg 3-175)

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 7a -12p	a. (R)	Evening 5p-10p (or HS) c. (R)
	Afternoon 12p - 5p	b. (R)	NONE OF ABOVE d.
(If resident is comatose, code as "none of the above.")			
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.	Outside facility d.
	Inside NH/off unit	c.	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.	Trips/shopping g.
	Crafts/arts	b.	Walking/wheeling outdoors h.
	Exercise/sports	c.	Watching TV i.
	Music	d.	Gardening or plants j.
	Reading/writing	e.	Talking or conversing k.
	Spiritual/religious activities	f.	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. Count the number of different medications (not the number of doses or different dosages) administered by any route at any time during the last 7 days. Include any routine, prn, and stat doses given. Medications include topical preparations, ointments, creams used in wound care, eye drops, vitamins, and suppositories. Topical preparations that are used for preventive skin care (i.e., moisturizers, moisture barriers) are not coded here. Antigens and vaccines are counted here. Include any medication that the resident administers to self, if known. Antigens and vaccines are also counted here (pg. 3-176).

2. Identifies whether the resident is currently receiving medications that were initiated in the last 90 days. If the resident received new medication(s) in the last 90 days but they were discontinued prior to this assessment period, code 0 (no new medication).

3. Record the number of days during the past seven days that the resident received any type of medication, antigen, or vaccine, by subcutaneous, intramuscular or intradermal injection.

4. Record the number of days that the resident received antipsychotics, antianxiety, antidepressants, hypnotics, or diuretics given by any route in any setting over the last 7 days. Determine if a specific long acting medication is still active based on physician, pharmacist or PDR input. See Appendix E for list of drugs by category. Code medications according to a drug's pharmacological classification, not how it is used. Combination products, such as Corzide (which contains a diuretic and a betablocker) are counted as **one** medication. (pg 3-177)

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 ☐	

NOTE: Pg. 3-178. If B₁₂ injections are given once per month, but outside the assessment period (i.e., prior) Code Under O.1. Code B₁₂ injections under O.3. if given during observation period.

NOTE: To record IV fluids, refer to Section K5a
To record IV medications, refer to Section P1c

For new admissions, may use documentation from referring facility, if clearly recorded. If transfer records are not clear or do not reference that the resident received one of these medications, record 0 (not used) in the corresponding box. If the resident did not use any medications from a drug category, enter 0.

DO NOT code services that were provided solely in conjunction with a surgical or diagnostic procedure, the immediate post-operative recovery period, or post-procedure recovery period (pg. 3-182).

1. b. Record therapies that occurred after admission or readmission to the facility, ordered by a physician and performed by a qualified therapist. May include therapy done inside or outside facility. Record actual treatment time, not documentation time. Include only therapies based on a therapist's assessment and treatment plan that is documented in the resident's clinical record. Include only medically necessary therapies (see pg. 3-187).

3. **a.** Clarification. See pg. 3-192.

3. **k.** Other: includes activities to improve or maintain resident self-performance in functioning, i.e., self-care with diabetes, self-administration of meds, ostomy care)

1.	SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE—Check treatments or programs received during the last 14 days TREATMENTS Chemotherapy by any route Dialysis Anywhere IV medication /IV/drip Intake/output at least 24 hours Over 3 consecutive shifts Monitoring acute medical condition by licensed nurse Ostomy care with assistance Oxygen therapy continuous or intermittent Radiation Suctioning Tracheostomy care Transfusions blood or blood products 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 c. Speech - language pathology and audiology services d. Occupational therapy e. Physical therapy (includes hydrotherapy) f. Respiratory therapy (By R.T. or trained nurse) g. Psychological therapy (by any licensed mental health professional)	include if weaned off in last Ventilator or respirator 14 days PROGRAMS Alcohol/drug treatment program Alzheimer's/dementia special care unit Hospice care Pediatric unit Respite care Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) NONE OF ABOVE	i. ☐ m. n. o. p. q. r. s.
	Record IV meds not IV fluids			
	See new instructions, pg. 3-182			
	Use leading zeros to fill in all boxes			
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 support group by facility social worker or outside facility Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage Reorientation—e.g., cueing Individual or group designed to reduce disorientation in confused residents NONE OF ABOVE	a. ☐ b. ☐ c. ☐ d. ☐ e. ☐ f. ☐	
	Does not include group recreation or leisure			
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	☐ ☐ ☐ ☐ ☐ ☐
	By Nursing			

NOTE: Passive Rom = the caregiver moves the body part around a fixed point or joint through the resident's available range of motion; resident provides no assist. Active Rom = exercises performed by resident, with cueing or supervision by staff, planned, scheduled and documented in medical record. If resident needs assistance with final stretch, still considered active ROM. See examples, pgs. 3-196 to 3-197.

SECTION P: SPECIAL TREATMENTS AND PROCEDURES - continued

A physical restraint is any manual method or physical or mechanical device, material or equipment attached to, or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's own body -- Includes, but is not limited to, any article, device or garment that interferes with free movement of resident, or that resident is unable to remove easily. "Freedom of movement" is defined as the ability of the resident to move around within the context of the resident's functional capacity, as assessed by the facility. Ask the question, "Does the item prevent the resident from performing an action they are otherwise capable of performing?" Code only those devices categorized as a restraint. See coding instructions pgs. 3-198 to 3-202.

4. Record frequency over last 7 days with which resident was restrained by any listed device, day or night. See definitions pg. 3-198 and clarifications pg 3-199 to 3-202.

5. If resident is a new admission to facility include admissions during period prior to admission.

6. A visit to an ER **not** accompanied by an overnight hospital stay. Exclude prior scheduled visits for physician evals, transfusions, chemotherapy, etc.

7. Exam may be performed in facility or physician office. Frequency of visits may be indicative of clinical complexity. Does **not** include exams conducted in the emergency room. Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist working in collaboration with the physician qualifies (pg. 3-204).

8. Includes written, phone, fax, or consultation orders for new or altered treatment. Do not include admission orders, return admission orders, or order renewals without change. Change in condition orders on day of admission are counted, see pg. 3-205.

Note: See coding changes pgs. 3-205 to 3-206.

4. DEVICES AND RE-STRAINTS	(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 <i>Merry walker, lap buddy, bean bags</i>	
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)	(R)
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)	(R)
9. ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission)? 0. No 1. Yes	

9. Only record lab tests performed after admission, not during hospitalization. *Abnormal as compared to standard values not what is abnormal for resident. Enter 0. (No) if there was no abnormal lab value noted or if no lab work was done (do not use Code 8 here - Code 8 is only used in Section G).

SECTION Q: DISCHARGE POTENTIAL AND OVERALL STATUS

Identifies residents who are potential candidates for discharge within the next 3 months. Discharge can be to home, another community setting, another care facility or residential setting. A prognosis of death should not be considered as an expected discharge.

1. a. Ask resident of plans directly if new admission. The longer a resident lives in a facility, the harder it is to ask about preferences. Use careful judgment here to avoid unrealistic expectations. This section provides data on discharge potential. Depending on resident's clinical status and circumstances, additional assessments to determine why the resident is not a candidate for discharge at this time and what care plan can be implemented to improve discharge potential may be warranted.

2. Monitors resident's overall progress over time. If new admit, include changes prior to admission.

SECTION R. ASSESSMENT INFORMATION

2. a. The RN Assessment Coordinator signs and dates at Items R2a and R2b when all other assessors have finished their portions of MDS Sections A-W. The RN Assessment Coordinator's signature certifies overall completion of portions of the MDS Section A-W in the record, not the accuracy of all portions of the assessment. (Date should be no earlier than assessment reference date (A3a). Starts clock dates for next assessment.) This date should be later than or the same as the completion dates in AA9 a-f for Sections A-W.

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE	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 (<i>Spouse, family member or significant other</i>) 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	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					

Note: Federal regulations require the RN Assessment Coordinator to sign and thereby certify that the assessment is complete. Use the actual date the MDS was completed, reviewed, and signed (see pg. 3-212).

SECTION T: THERAPY SUPPLEMENT FOR MEDICARE PPS

Code ordered therapies under Sections P & T. These sections are not mutually exclusive. Therapy can occur inside or outside of facility as long as staff meets qualifiers. Section T is completed for all full PPS assessments or MPAF. Communication with therapies and nursing aides on all shifts is critical to complete Section T2

1.**a.** Record therapy ordered by a physician that provides therapeutic stimulation beyond the general activity program. Orders must include frequency, duration and scope of treatment by a state licensed or nationally certified therapeutic recreation specialist or assistant.

1.**b.** This section recognizes ordered and scheduled PT, OT, and ST services during the early days of the resident's stay. Provides an overall picture of the amount of therapy that a resident will likely receive through the 15th day of admission.

1.**c.d.** Estimates total number of days therapy provided and total number of minutes therapy anticipated. To estimate, need physicians order, clinical knowledge of resident's condition and tolerance of therapy, the amount already provided and number of days.

SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1. SPECIAL TREATMENTS AND PROCEDURES <i>Use leading zero's to fill all boxes.</i>	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)			
			DAYS	MIN
	(A) = # of days administered for 15 minutes or more		(A)	(B)
	(B) = total # of minutes provided in last 7 days			
	Skip unless this is a Medicare 5 day or 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?			

Note: Calculate the expected number of days through day 15, even if the resident is discharged prior to day 15. This calculation includes days of therapy already delivered. See examples, pg. 3-216.

Note: Do not include evaluation in minutes. Do not count the evaluation day unless treatment is rendered in addition to the evaluation.

Note: When the physician orders a limited number of days of therapy, then the projection is based on the actual number of days of therapy ordered (pg. 3-216).

2. Therapy is often implemented to improve a resident's ability to walk. It is important to monitor the gait pattern and walking progress for residents and how functional walking is integrated into the resident's ADLs on the nursing unit. Monitor distance, amount of time taken to walk the distance, the amount of assistance and support received. View in combination with Section G.

2. a.-e. Captures information based on the same one episode when resident walked the farthest without sitting down - captures the single highest level of independence in observation period whether in therapy or on the nursing unit, any time on all shifts.

3. Case mix group - may be calculated by vendor software. Medicare: the first 3 boxes contain the Medicare case mix group (RUGS classification) and the last 2 boxes are the current CMS Medicare case mix version "07".

State: leave blank at this time for Missouri. Missouri is not currently a case mix state (see pg. 3-223).

NOTE: Sections T1a, T2 and T3 are required with every full assessment for Medicare Part A payment under PPS.

NOTE: Section T1b, T1c, and T1d are required only with the Medicare 5 day or readmission/return assessments.

SECTION W: Supplemental MDS Items

Section W must be completed for all residents on all assessment types with ARD and all discharge tracking forms with discharge dates from October 1 through June 30.

1. The facility is encouraged to begin using this number once it has been assigned by CMS.

2. a. Code 'yes' if the resident received the Influenza vaccine, administered in your facility.

b. Code why the resident did not receive the vaccine in your facility

3. See flow chart, pg. 3-244, on determining who needs pneumococcal vaccine.

a. Enter 1 if PPV status is up-to-date. Enter 0 if not up-to-date and complete **W3b** for reason is not up-to-date.

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 5. 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 not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered

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 1 st 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 ASSESSMENT	[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											

SECTION AB. DEMOGRAPHIC INFORMATION

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

1.	DATE OF ENTRY	<i>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</i> Month Day Year											
2.	ADMITTED FROM (A1ENTRY)	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 hospital, MR/DD facility 7. Rehabilitation hospital 8. Deceased 9. Other Encode within 7 days after "event" (discharge) b. Optional State Code											
4.	DISCHARGE DATE	<i>Date of death or discharge</i> Month Day Year											

Section AB - Demographic Information

Complete only for stays less than 14 days, when AA8a = 8. See definitions on pg 3-213, 214 under section R3.

9. Formal attestation statement and signature lines for individual staff completing any portion of the accompanying assessment or tracking form. Used to record signatures and dates of completion, as well as accuracy.

NOTE: Make sure all identification information on these subsets is the same as the information on corresponding sections. Also, the requirement for completing this form applies regardless of a facility's policy and procedure for discharge, or opening and closing records and regardless of how long the individual was a resident of the facility.

Retention of form in active record is 15 months.

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 all 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.											

In a computerized system this form must be completed and submitted to state database when resident dies or leaves the facility and is actually admitted to another healthcare facility, regardless of whether the facility formally discharges the resident. **Encode within 7 days after "event" (discharge).** Exception is for temporary visit home, therapeutic or social leave, or observational stays of less than 24 hours when resident is not admitted to hospital. See manual pgs. 2-23 to 2-24.

8. a. Primary reason for assessment has only 3 discharge codes, 6, 7 or 8 to complete whenever the resident is formally discharged from the facility. Code return anticipated based on the information at time of discharge.

The following exceptions to CMS's requirements for Discharge and Reentry are allowable, but are not federally required:

1. A "temporary" Discharge Tracking form using code 7 (return anticipated) can be followed by a "permanent" Discharge Tracking form using code 6 (return not anticipated) at the facility's option. This option can be used if, after the temporary discharge, the facility gains knowledge that the resident will not return. This may be required in some states for Medicaid program purposes. This is **not required** in Missouri at this time, but is **recommended** by state RAI coordinator.
2. When an Initial Admission assessment is required, but the resident is discharged before Day 14 of the stay and the Initial Admission assessment has not been completed, then a Discharge Tracking form using code 8 ("discharged prior to completing initial assessment") can be completed in lieu of the Initial Admission assessment.

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 *			
		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 ASSESSMENT	[Note—Other codes do not apply to this form] a. Primary reason for assessment 9. Reentry		

Provides key information to uniquely identify each resident. Must be completed whenever a resident re-enters the nursing facility following a temporary admission to a hospital or other health care setting, or if the resident was discharged. **Encode within 7 days after “event” (reentry).** See manual, pg. 2-25.

The state system must receive this information to enter the resident back into the state database.

Section AA - Identification Information

Contains Items 1-9. Item 8, reasons for assessment has only one choice - 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 all 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	Date
	a.	

Section A - Identification and Background Information

Contains Items A4a, 4b and 6.

Item 4b. Has choices 1-8, to identify where the resident is admitted from at reentry.

NOTE: Make sure all identification information on these subsets is the same as the information on corresponding sections.

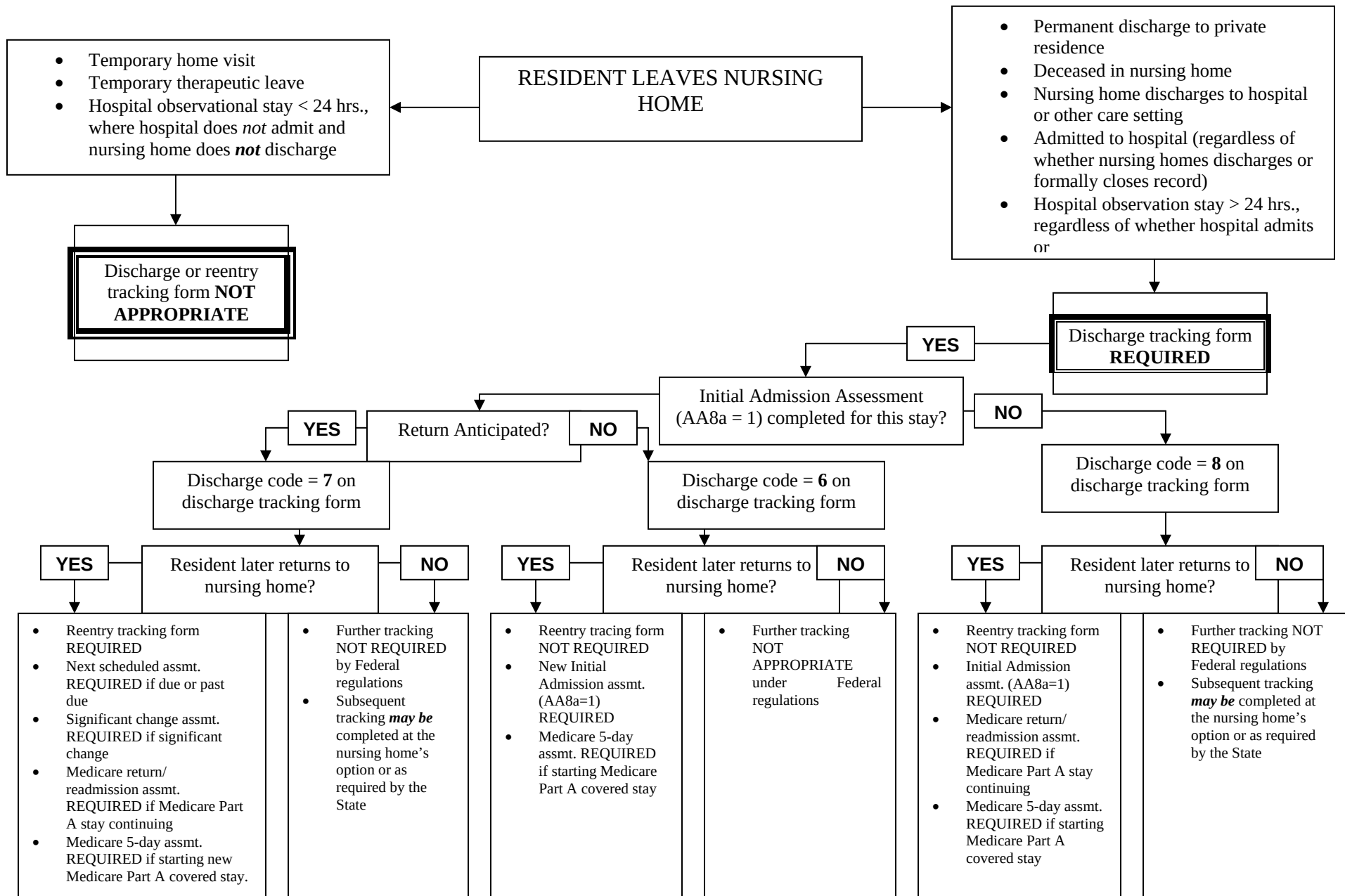
There are two conditions under which other forms accompany the re-entry tracking form. If the resident re enters a facility following a temporary admission to a hospital or other healthcare setting and also meets significant change criteria, a comprehensive assessment must be completed, along with a basic assessment tracking form. If no significant change, a full assessment form must be completed along with the basic assessment tracking form.

9. Formal attestation statement and signature lines for individual staff completing any portion of the accompanying assessment or tracking form. Used to record signatures and dates of completion, as well as accuracy.

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.	

MDS 2.0 Discharge and Reentry Flowchart



Maximum Time Frames for MDS Completion, Data Entry, Editing, and Transmission

RECORD TYPE	COMPLETE BY:	ENCODE AND EDIT BY:	CARE PLAN COMPLETION:	SUBMIT TO STATE BY:
<i>Comprehensive Assessment (MDS & RAPs)</i>	VB2	*VB2 + 7 Days	**VB4 + 7 Days	31 Days after Care Plan Completion Date
<i>Full Assessment without RAPs</i>	R2b	R2b + 7 Days	N/A	31 Days after Assessment Completion Date
<i>Quarterly Assessment</i>	R2b	R2b + 7 Days	N/A	31 Days after Assessment Completion Date
<i>Discharge Tracking Form</i>	R4 + 7 Days	R4 + 7 Days	N/A	31 Days after Form Completion Date
<i>Reentry Tracking Form</i>	A4a + 7 Days	A4a + 7 Days	N/A	31 Days after Form Completion Date
<i>Special Instructions</i>		*For comprehensive assessments, encode and edit MDS and RAP trigger information at VA(a) (RAP Summary - check if triggered)	**For comprehensive assessments, encode and edit care plan decisions at VA(b) (RAP Summary - Care Planning Decision)	

MDS Item VB2 = Date of the RN Coordinator's signature on the RAP summary sheet (section V), indicating RAP analysis is complete.

MDS Item VB4 = Date of the signature of person completing care planning decision on RAP summary sheet (section V), indicating which RAPs are addressed in the care plan.

MDS Item R2b = Date of RN assessment coordinator's signature, indicating that the MDS is complete.

MDS Item R4 = Date of death or discharge.

MDS Item A4a = Date of 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 form 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. Discharge - return not anticipated 7. Discharge - return anticipated 8. Discharged prior to completing initial assessment REENTRY TRACKING (Complete Prior Date item Prior A4a ONLY) 9. Reentry 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 for 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			

The MDS Correction Request Form contains the minimum amount of information necessary to locate erroneous MDS records that have been accepted into the State MDS database.

The Prior Record Section must be completed EXACTLY as it appears in the erroneous record, even if the information is wrong. The information is necessary to locate the record in the State database.

Prior AA3 - Do not leave any boxes blank, if month or day is a single digit, fill in the first box with a 0.

Prior Date - Complete ONLY ONE.

If prior erroneous record is an assessment, complete A3a, Assessment Reference Date.
If prior erroneous record is a Discharge Tracking Form, complete R4, Discharge Date.
If prior erroneous record is a Reentry Tracking Form, complete A4a, Date of Reentry.
Fill in all boxes, if month or date is a single digit, fill in first box with a 0.

Refer to RAI Manual Chapter 5.

Reference: Provider Instructions for MDS Correction Policy, Chapter 3, Item-by-Item Guide to the MDS Version 2.0 Correction Request Form, Pages 3-1 to 3-11, March, 2000, which may be accessed at <http://www.qtso.com/download/mds/mdscorrectionpolicy.pdf>

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)	1
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: _____	

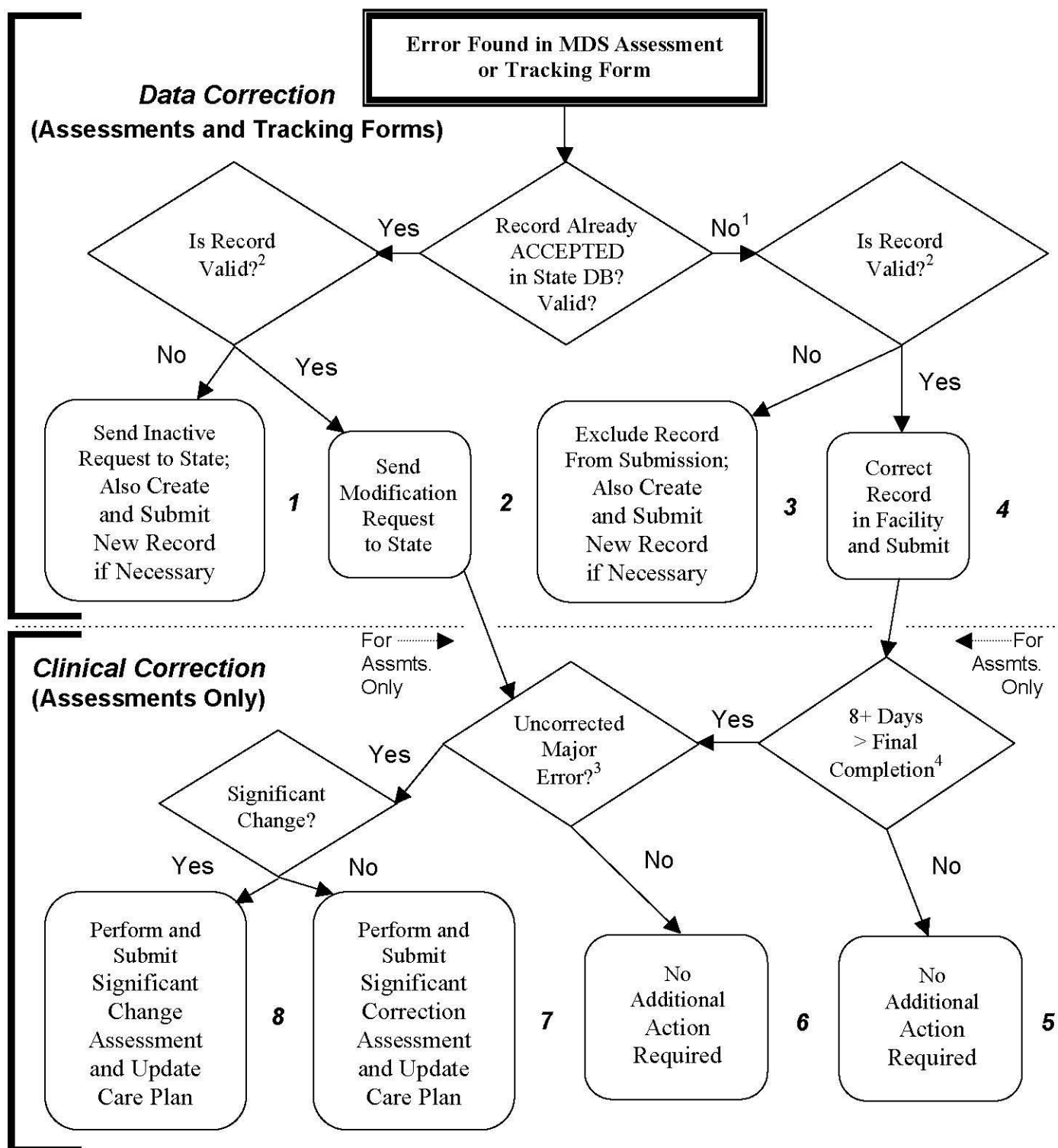
RN COORDINATOR ATTESTATION OF COMPLETION

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.		

Correction Attestation Section**AT1** - Denotes the number of successive correction requests.**AT2** - Identifies whether correction request is being submitted to MODIFY or INACTIVATE a prior erroneous form.**AT3** - Identifies the reason(s) for the error(s) that require modification of erroneous assessment or tracking from previously submitted and accepted by the State database.**AT4** - Identifies the reason(s) requiring inactivation of an invalid assessment or tracking form previously submitted and accepted by the State database.**AT5** - To identify the facility staff attesting to the completion and accuracy of the corrected information.**AT6** - This date must be within 14 days of detecting an error in an MDS record that resides in the State MDS database. Fill in all boxes.**AT7** - To identify the date the attesting facility staff certified the completion and accuracy of the corrected information.**NOTE: The date at AT6 must be the same or later than the dates at AT7.**

Detailed instructions for determining when and how to use this form can be found in the "LTC Provider Instructions for Making Automated Corrections using the MDS Correction Request Form". This manual can be downloaded from www.qtso.com/mdsdownload.htm

CORRECTION POLICY FLOWCHART



¹Record has not been data entered, has not been submitted, or has been submitted and rejected.

²The record is **valid** if **event occurred**, **resident** and **reasons for assessment are correct**, and **submission is required**.

³The assessment in error contains a Major error that has not been corrected by a subsequent assessment.

⁴Final completion is Item VB4 for a comprehensive and R2b for all other assessments.