

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

### BASIC ASSESSMENT TRACKING FORM

#### SECTION AA. IDENTIFICATION INFORMATION

|                                                                     |                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            |                  |                   |                                   |             |                           |                                  |                                  |  |  |  |  |  |       |     |      |  |  |  |  |  |  |  |                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| <b>1.</b>                                                           | <b>RESIDENT NAME<sup>Ⓞ</sup></b>                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            |                  |                   |                                   |             |                           |                                  |                                  |  |  |  |  |  |       |     |      |  |  |  |  |  |  |  |                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                                                                     |                                                                                                                               | <b>a. (First)</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | <b>b. (Middle Initial)</b> | <b>c. (Last)</b> | <b>d. (Jr/Sr)</b> |                                   |             |                           |                                  |                                  |  |  |  |  |  |       |     |      |  |  |  |  |  |  |  |                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>2.</b>                                                           | <b>GENDER<sup>Ⓞ</sup></b>                                                                                                     | 1. Male                      2. Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                            |                  |                   |                                   |             |                           |                                  |                                  |  |  |  |  |  |       |     |      |  |  |  |  |  |  |  |                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>3.</b>                                                           | <b>BIRTHDATE<sup>Ⓞ</sup></b>                                                                                                  | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td colspan="8" style="text-align: center;">Year</td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                            |                  |                   |                                   |             |                           |                                  |                                  |  |  |  |  |  | Month | Day | Year |  |  |  |  |  |  |  |                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                                                                     |                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            |                  |                   |                                   |             |                           |                                  |                                  |  |  |  |  |  |       |     |      |  |  |  |  |  |  |  |                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Month                                                               | Day                                                                                                                           | Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                            |                  |                   |                                   |             |                           |                                  |                                  |  |  |  |  |  |       |     |      |  |  |  |  |  |  |  |                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>4.</b>                                                           | <b>RACE/<sup>Ⓞ</sup><br/>ETHNICITY</b>                                                                                        | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">1. American Indian/Alaskan Native</td> <td style="width: 50%;">4. Hispanic</td> </tr> <tr> <td>2. Asian/Pacific Islander</td> <td>5. White, not of Hispanic origin</td> </tr> <tr> <td>3. Black, not of Hispanic origin</td> <td></td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                            |                  |                   | 1. American Indian/Alaskan Native | 4. Hispanic | 2. Asian/Pacific Islander | 5. White, not of Hispanic origin | 3. Black, not of Hispanic origin |  |  |  |  |  |       |     |      |  |  |  |  |  |  |  |                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. American Indian/Alaskan Native                                   | 4. Hispanic                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            |                  |                   |                                   |             |                           |                                  |                                  |  |  |  |  |  |       |     |      |  |  |  |  |  |  |  |                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2. Asian/Pacific Islander                                           | 5. White, not of Hispanic origin                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            |                  |                   |                                   |             |                           |                                  |                                  |  |  |  |  |  |       |     |      |  |  |  |  |  |  |  |                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. Black, not of Hispanic origin                                    |                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            |                  |                   |                                   |             |                           |                                  |                                  |  |  |  |  |  |       |     |      |  |  |  |  |  |  |  |                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>5.</b>                                                           | <b>SOCIAL SECURITY<sup>Ⓞ</sup><br/>AND<br/>MEDICARE<br/>NUMBERS<sup>Ⓞ</sup></b><br>[C in 1 <sup>st</sup> box if non med. no.] | <table style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="10"><b>a. Social Security Number</b></td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="10"><b>b. Medicare number (or comparable railroad insurance number)</b></td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> |                            |                  |                   | <b>a. Social Security Number</b>  |             |                           |                                  |                                  |  |  |  |  |  |       |     |      |  |  |  |  |  |  |  | <b>b. Medicare number (or comparable railroad insurance number)</b> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>a. Social Security Number</b>                                    |                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            |                  |                   |                                   |             |                           |                                  |                                  |  |  |  |  |  |       |     |      |  |  |  |  |  |  |  |                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| <b>b. Medicare number (or comparable railroad insurance number)</b> |                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            |                  |                   |                                   |             |                           |                                  |                                  |  |  |  |  |  |       |     |      |  |  |  |  |  |  |  |                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| <b>6.</b>                                                           | <b>FACILITY PROVIDER NO.<sup>Ⓞ</sup></b>                                                                                      | <table style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="10"><b>a. State No.</b></td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="10"><b>b. Federal No.</b></td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>                                                            |                            |                  |                   | <b>a. State No.</b>               |             |                           |                                  |                                  |  |  |  |  |  |       |     |      |  |  |  |  |  |  |  | <b>b. Federal No.</b>                                               |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>a. State No.</b>                                                 |                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            |                  |                   |                                   |             |                           |                                  |                                  |  |  |  |  |  |       |     |      |  |  |  |  |  |  |  |                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| <b>b. Federal No.</b>                                               |                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            |                  |                   |                                   |             |                           |                                  |                                  |  |  |  |  |  |       |     |      |  |  |  |  |  |  |  |                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| <b>7.</b>                                                           | <b>MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient]<sup>Ⓞ</sup></b>                                             | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                            |                  |                   |                                   |             |                           |                                  |                                  |  |  |  |  |  |       |     |      |  |  |  |  |  |  |  |                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| <b>8.</b>                                                           | <b>REASONS FOR ASSESSMENT</b>                                                                                                 | <p>[Note—Other codes do not apply to this form]</p> <p><b>a. Primary reason for assessment</b></p> <ol style="list-style-type: none"> <li>1. Admission assessment (required by day 14)</li> <li>2. Annual assessment</li> <li>3. Significant change in status assessment</li> <li>4. Significant correction of prior full assessment</li> <li>5. Quarterly review assessment</li> <li>10. Significant correction of prior quarterly assessment</li> <li>0. NONE OF ABOVE</li> </ol> <p><b>b. Codes for assessments required for Medicare PPS or the State</b></p> <ol style="list-style-type: none"> <li>1. Medicare 5 day assessment</li> <li>2. Medicare 30 day assessment</li> <li>3. Medicare 60 day assessment</li> <li>4. Medicare 90 day assessment</li> <li>5. Medicare readmission/return assessment</li> <li>6. Other state required assessment</li> <li>7. Medicare 14 day assessment</li> <li>8. Other Medicare required assessment</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                            |                  |                   |                                   |             |                           |                                  |                                  |  |  |  |  |  |       |     |      |  |  |  |  |  |  |  |                                                                     |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| <b>9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |          |      |
| 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>a.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |      |
| <b>b.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |      |
| <b>c.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |      |
| <b>d.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |      |
| <b>e.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |      |
| <b>f.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |      |
| <b>g.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |      |
| <b>h.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |      |
| <b>i.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |      |
| <b>j.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |      |
| <b>k.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |      |
| <b>l.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |          |      |

**GENERAL INSTRUCTIONS**

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

Ⓞ = Key items for computerized resident tracking  
 = When box blank, must enter number or letter    **a.**  = When letter in box, check if condition applies

## MINIMUM DATA SET (MDS) — VERSION 2.0

### FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

#### BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

#### SECTION AB. DEMOGRAPHIC INFORMATION

|     |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-----|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1.  | <b>DATE OF ENTRY</b>                                            | 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<br><div style="text-align: center;"> <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> — <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> — <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/><br/>                     Month                  Day                  Year                 </div> |
| 2.  | <b>ADMITTED FROM (AT ENTRY)</b>                                 | 1. Private home/apt. with no home health services<br>2. Private home/apt. with home health services<br>3. Board and care/assisted living/group home<br>4. Nursing home<br>5. Acute care hospital<br>6. Psychiatric hospital, MR/DD facility<br>7. Rehabilitation hospital<br>8. Other                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| 3.  | <b>LIVED ALONE (PRIOR TO ENTRY)</b>                             | 0. No<br>1. Yes<br>2. In other facility                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 4.  | <b>ZIP CODE OF PRIOR PRIMARY RESIDENCE</b>                      | <input style="width: 40px; height: 20px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 5.  | <b>RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY</b>               | (Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above)<br>Prior stay at this nursing home <span style="float: right;">a.</span><br>Stay in other nursing home <span style="float: right;">b.</span><br>Other residential facility—board and care home, assisted living, group home <span style="float: right;">c.</span><br>MH/psychiatric setting <span style="float: right;">d.</span><br>MR/DD setting <span style="float: right;">e.</span><br>NONE OF ABOVE <span style="float: right;">f.</span>                                                                                                                                                                                                            |
| 6.  | <b>LIFETIME OCCUPATION(S) [Put "/" between two occupations]</b> | <input style="width: 100%; height: 20px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 7.  | <b>EDUCATION (Highest Level Completed)</b>                      | 1. No schooling<br>2. 8th grade/less<br>3. 9-11 grades<br>4. High school<br>5. Technical or trade school<br>6. Some college<br>7. Bachelor's degree<br>8. Graduate degree                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 8.  | <b>LANGUAGE</b>                                                 | (Code for correct response)<br>a. Primary Language<br>0. English    1. Spanish    2. French    3. Other<br>b. If other, specify <input style="width: 40px; height: 20px;" type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| 9.  | <b>MENTAL HEALTH HISTORY</b>                                    | Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem?<br>0. No                  1. Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| 10. | <b>CONDITIONS RELATED TO MR/DD STATUS</b>                       | (Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely)<br>Not applicable—no MR/DD (Skip to AB11) <span style="float: right;">a.</span><br>MR/DD with organic condition <span style="float: right;">b.</span><br>Down's syndrome <span style="float: right;">c.</span><br>Autism <span style="float: right;">d.</span><br>Epilepsy <span style="float: right;">e.</span><br>Other organic condition related to MR/DD <span style="float: right;">f.</span><br>MR/DD with no organic condition                                                                                                                                                                                       |
| 11. | <b>DATE BACKGROUND INFORMATION COMPLETED</b>                    | <div style="text-align: center;"> <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> — <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> — <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/><br/>                     Month                  Day                  Year                 </div>                                                                                                                                                                                                                                                      |

#### SECTION AC. CUSTOMARY ROUTINE

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

#### SECTION AD. FACE SHEET SIGNATURES

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |          |      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|------|
| <b>SIGNATURES OF PERSONS COMPLETING FACE SHEET:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |          |      |
| 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 D. VISION PATTERNS**

|                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                |
|-------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|
| 1. <b>VISION</b>                          | (Ability to see in adequate light and with glasses if used)<br>0. <b>ADEQUATE</b> —sees fine detail, including regular print in newspapers/books<br>1. <b>IMPAIRED</b> —sees large print, but not regular print in newspapers/books<br>2. <b>MODERATELY IMPAIRED</b> —limited vision; not able to see newspaper headlines, but can identify objects<br>3. <b>HIGHLY IMPAIRED</b> —object identification in question, but eyes appear to follow objects<br>4. <b>SEVERELY IMPAIRED</b> —no vision or sees only light, colors, or shapes; eyes do not appear to follow objects |                |
| 2. <b>VISUAL LIMITATIONS/DIFFICULTIES</b> | 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)<br><br>Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes<br><br><i>NONE OF ABOVE</i>                                                                                                                                                                                                                           | a.<br>b.<br>c. |
| 3. <b>VISUAL APPLIANCES</b>               | Glasses; contact lenses; magnifying glass<br>0. No<br>1. Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                |

**SECTION E. MOOD AND BEHAVIOR PATTERNS**

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

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

**SECTION F. PSYCHOSOCIAL WELL-BEING**

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

**SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS**

|                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                   |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------|
| 1. (A) <b>ADL SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)</b>                                        | 0. <b>INDEPENDENT</b> —No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days<br><br>1. <b>SUPERVISION</b> —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<br><br>2. <b>LIMITED ASSISTANCE</b> —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<br><br>3. <b>EXTENSIVE ASSISTANCE</b> —While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:<br>—Weight-bearing support<br>— Full staff performance during part (but not all) of last 7 days<br><br>4. <b>TOTAL DEPENDENCE</b> —Full staff performance of activity during entire 7 days<br><br>8. <b>ACTIVITY DID NOT OCCUR</b> during entire 7 days | (A) (B)           |
| (B) <b>ADL SUPPORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)</b> | 0. No setup or physical help from staff<br>1. Setup help only<br>2. One person physical assist<br>3. Two+ persons physical assist<br><br>8. ADL activity itself did not occur during entire 7 days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | SELF-PERF SUPPORT |
| a. <b>BED MOBILITY</b>                                                                                                                                             | How resident moves to and from lying position, turns side to side, and positions body while in bed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   |
| b. <b>TRANSFER</b>                                                                                                                                                 | How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                   |
| c. <b>WALK IN ROOM</b>                                                                                                                                             | How resident walks between locations in his/her room                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                   |
| d. <b>WALK IN CORRIDOR</b>                                                                                                                                         | How resident walks in corridor on unit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                   |
| e. <b>LOCOMOTION ON UNIT</b>                                                                                                                                       | How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                   |
| f. <b>LOCOMOTION OFF UNIT</b>                                                                                                                                      | 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. <b>DRESSING</b>                                                                                                                                                 | How resident puts on, fastens, and takes off all items of <b>street clothing</b> , including donning/removing prosthesis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                   |
| h. <b>EATING</b>                                                                                                                                                   | How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                   |
| i. <b>TOILET USE</b>                                                                                                                                               | How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                   |
| j. <b>PERSONAL HYGIENE</b>                                                                                                                                         | How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                   |

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

**SECTION H. CONTINENCE IN LAST 14 DAYS**

|    |                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                      |
|----|------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. | <b>CONTINENCE SELF-CONTROL CATEGORIES</b><br>(Code for resident's PERFORMANCE OVER ALL SHIFTS) | 0. CONTINENT—Complete control [includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                      |
|    |                                                                                                | 1. USUALLY CONTINENT—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly<br>2. OCCASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not daily; BOWEL, once a week<br>3. FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week<br>4. INCONTINENT—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time |                                                                                                                                                                      |
| a. | <b>BOWEL CONTINENCE</b>                                                                        | Control of bowel movement, with appliance or bowel continence programs, if employed                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                      |
|    |                                                                                                | <b>BLADDER CONTINENCE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                       | Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., Foley) or continence programs, if employed |
| 2. | <b>BOWEL ELIMINATION PATTERN</b>                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Bowel elimination pattern regular—at least one movement every three days                                                                                             |

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

**SECTION I. DISEASE DIAGNOSES**

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

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

**SECTION J. HEALTH CONDITIONS**

|    |                                                                                                               |                                                                                        |    |                                            |    |
|----|---------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------|----|--------------------------------------------|----|
| 1. | <b>PROBLEM CONDITIONS</b><br>(Check all problems present in last 7 days unless other time frame is indicated) | <b>INDICATORS OF FLUID STATUS</b>                                                      |    | Dizziness/Vertigo                          | f. |
|    |                                                                                                               | Weight gain or loss of 3 or more pounds within a 7 day period                          | a. | Edema                                      | g. |
| 2. | <b>PROBLEM CONDITIONS</b><br>(Check all problems present in last 7 days unless other time frame is indicated) | Inability to lie flat due to shortness of breath                                       | b. | Fever                                      | h. |
|    |                                                                                                               | Dehydrated; output exceeds input                                                       | c. | Hallucinations                             | i. |
| 3. | <b>PROBLEM CONDITIONS</b><br>(Check all problems present in last 7 days unless other time frame is indicated) | Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days | d. | Internal bleeding                          | j. |
|    |                                                                                                               | <b>OTHER</b>                                                                           | e. | Recurrent lung aspirations in last 90 days | k. |
|    |                                                                                                               | Delusions                                                                              |    | Shortness of breath                        | l. |
|    |                                                                                                               |                                                                                        |    | Syncope (fainting)                         | m. |
|    |                                                                                                               |                                                                                        |    | Unsteady gait                              | n. |
|    |                                                                                                               |                                                                                        |    | Vomiting                                   | o. |
|    |                                                                                                               |                                                                                        |    | NONE OF ABOVE                              | p. |

**SECTION M. SKIN CONDITION**

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

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

**SECTION K. ORAL/NUTRITIONAL STATUS**

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

**SECTION N. ACTIVITY PURSUIT PATTERNS**

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

**SECTION L. ORAL/DENTAL STATUS**

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

|                                        |                                                                                                            |  |
|----------------------------------------|------------------------------------------------------------------------------------------------------------|--|
| 5. PREFERENCES CHANGE IN DAILY ROUTINE | Code for resident preferences in daily routines<br>0. No change      1. Slight change      2. Major change |  |
|                                        | a. Type of activities in which resident is currently involved                                              |  |
|                                        | b. Extent of resident involvement in activities                                                            |  |

**SECTION O. MEDICATIONS**

|                                           |                                                                                                             |  |             |
|-------------------------------------------|-------------------------------------------------------------------------------------------------------------|--|-------------|
| 1. NUMBER OF MEDICATIONS                  | (Record the number of different medications used in the last 7 days; enter "0" if none used)                |  |             |
| 2. NEW MEDICATIONS                        | (Resident currently receiving medications that were initiated during the last 90 days)<br>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 | a. Antipsychotic                                                                                            |  | d. Hypnotic |
|                                           | b. Antianxiety                                                                                              |  | e. Diuretic |
|                                           | c. Antidepressant                                                                                           |  |             |
|                                           |                                                                                                             |  |             |

**SECTION P. SPECIAL TREATMENTS AND PROCEDURES**

| 1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | a. SPECIAL CARE—Check treatments or programs received during the last 14 days                                                                                                                                                                    |                                                                                                                                  |                         |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|-------------------------|-------------------------------|--|-----|--|--|-----|-----|-----|-----|-------------------------------------------------------|--|--|--|--|-------------------------|--|--|--|--|---------------------|--|--|--|--|------------------------|--|--|--|--|-----------------------------------------------------------------------|--|--|--|--|--|
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | TREATMENTS                                                                                                                                                                                                                                       | Ventilator or respirator                                                                                                         | l.                      |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Chemotherapy                                                                                                                                                                                                                                     | a. PROGRAMS                                                                                                                      |                         |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Dialysis                                                                                                                                                                                                                                         | b. Alcohol/drug treatment program                                                                                                | m.                      |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | IV medication                                                                                                                                                                                                                                    | c. Alzheimer's/dementia special care unit                                                                                        | n.                      |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Intake/output                                                                                                                                                                                                                                    | d. Hospice care                                                                                                                  | o.                      |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Monitoring acute medical condition                                                                                                                                                                                                               | e. Pediatric unit                                                                                                                | p.                      |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Ostomy care                                                                                                                                                                                                                                      | f. Respite care                                                                                                                  | q.                      |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Oxygen therapy                                                                                                                                                                                                                                   | g. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) | r.                      |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Radiation                                                                                                                                                                                                                                        | h. NONE OF ABOVE                                                                                                                 | s.                      |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
| Suctioning                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                  |                                                                                                                                  |                         |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
| Tracheostomy care                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                  |                                                                                                                                  |                         |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
| Transfusions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                  |                                                                                                                                  |                         |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
| b. THERAPIES - Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily)<br>[Note—count only post admission therapies]                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                  |                                                                                                                                  |                         |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
| (A) = # of days administered for 15 minutes or more<br>(B) = total # of minutes provided in last 7 days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                  |                                                                                                                                  |                         |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
| <table border="1"> <thead> <tr> <th></th> <th colspan="2">DAYS</th> <th colspan="2">MIN</th> </tr> <tr> <th></th> <th>(A)</th> <th>(B)</th> <th>(A)</th> <th>(B)</th> </tr> </thead> <tbody> <tr> <td>a. Speech - language pathology and audiology services</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>b. Occupational therapy</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>c. Physical therapy</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>d. Respiratory therapy</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>e. Psychological therapy (by any licensed mental health professional)</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> |                                                                                                                                                                                                                                                  |                                                                                                                                  |                         | DAYS                          |  | MIN |  |  | (A) | (B) | (A) | (B) | a. Speech - language pathology and audiology services |  |  |  |  | b. Occupational therapy |  |  |  |  | c. Physical therapy |  |  |  |  | d. Respiratory therapy |  |  |  |  | e. Psychological therapy (by any licensed mental health professional) |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | DAYS                                                                                                                                                                                                                                             |                                                                                                                                  | MIN                     |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (A)                                                                                                                                                                                                                                              | (B)                                                                                                                              | (A)                     | (B)                           |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
| a. Speech - language pathology and audiology services                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                  |                                                                                                                                  |                         |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
| b. Occupational therapy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                  |                                                                                                                                  |                         |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
| c. Physical therapy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                  |                                                                                                                                  |                         |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
| d. Respiratory therapy                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                  |                                                                                                                                  |                         |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
| e. Psychological therapy (by any licensed mental health professional)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                  |                                                                                                                                  |                         |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
| 2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (Check all interventions or strategies used in last 7 days—no matter where received)                                                                                                                                                             |                                                                                                                                  |                         |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Special behavior symptom evaluation program                                                                                                                                                                                                      |                                                                                                                                  | a.                      |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Evaluation by a licensed mental health specialist in last 90 days                                                                                                                                                                                |                                                                                                                                  | b.                      |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Group therapy                                                                                                                                                                                                                                    |                                                                                                                                  | c.                      |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage                                                                                                             |                                                                                                                                  | d.                      |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Reorientation—e.g., cueing                                                                                                                                                                                                                       |                                                                                                                                  | e.                      |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | NONE OF ABOVE                                                                                                                                                                                                                                    |                                                                                                                                  | f.                      |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
| 3. NURSING REHABILITATION/ RESTORATIVE CARE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.) |                                                                                                                                  |                         |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | a. Range of motion (passive)                                                                                                                                                                                                                     |                                                                                                                                  | f. Walking              |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | b. Range of motion (active)                                                                                                                                                                                                                      |                                                                                                                                  | g. Dressing or grooming |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | c. Splint or brace assistance                                                                                                                                                                                                                    |                                                                                                                                  | h. Eating or swallowing |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | TRAINING AND SKILL PRACTICE IN:                                                                                                                                                                                                                  |                                                                                                                                  |                         | i. Amputation/prosthesis care |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | d. Bed mobility                                                                                                                                                                                                                                  |                                                                                                                                  | j. Communication        |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | e. Transfer                                                                                                                                                                                                                                      |                                                                                                                                  | k. Other                |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                  |                                                                                                                                  |                         |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                  |                                                                                                                                  |                         |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                  |                                                                                                                                  |                         |                               |  |     |  |  |     |     |     |     |                                                       |  |  |  |  |                         |  |  |  |  |                     |  |  |  |  |                        |  |  |  |  |                                                                       |  |  |  |  |  |

|                                 |                                                                                                                                                                                                                                                    |  |
|---------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 4. DEVICES AND RESTRAINTS       | (Use the following codes for last 7 days:)<br>0. Not used<br>1. Used less than daily<br>2. Used daily                                                                                                                                              |  |
|                                 | Bed rails                                                                                                                                                                                                                                          |  |
|                                 | a. — Full bed rails on all open sides of bed                                                                                                                                                                                                       |  |
|                                 | b. — Other types of side rails used (e.g., half rail, one side)                                                                                                                                                                                    |  |
|                                 | c. Trunk restraint                                                                                                                                                                                                                                 |  |
|                                 | d. Limb restraint                                                                                                                                                                                                                                  |  |
|                                 | e. Chair prevents rising                                                                                                                                                                                                                           |  |
| 5. HOSPITAL STAY(S)             | Record number of times resident was admitted to hospital with an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no hospital admissions)                                                               |  |
| 6. EMERGENCY ROOM (ER) VISIT(S) | Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no ER visits)                                                                                    |  |
| 7. PHYSICIAN VISITS             | In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter 0 if none)                                                       |  |
| 8. PHYSICIAN ORDERS             | In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter 0 if none) |  |
| 9. ABNORMAL LAB VALUES          | Has the resident had any abnormal lab values during the last 90 days (or since admission)?<br>0. No      1. Yes                                                                                                                                    |  |

**SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS**

|                                 |                                                                                                                                                                                                                                                                                          |  |
|---------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. DISCHARGE POTENTIAL          | a. Resident expresses/indicates preference to return to the community<br>0. No      1. Yes                                                                                                                                                                                               |  |
|                                 | b. Resident has a support person who is positive towards discharge<br>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)<br>0. No      1. Within 30 days      2. Within 31-90 days      3. Discharge status uncertain                                                            |  |
| 2. OVERALL CHANGE IN CARE NEEDS | Resident's overall self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days)<br>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 |
|                                                                | c. Significant other: | 0. No | 1. Yes |
| 2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:            |                       |       |        |
| a. Signature of RN Assessment Coordinator (sign on above line) |                       |       |        |
| b. Date RN Assessment Coordinator signed as complete           |                       |       |        |
|                                                                | Month                 | Day   | Year   |

**SECTION T.THERAPY SUPPLEMENT FOR MEDICARE PPS**

| 1.              | SPECIAL TREATMENTS AND PROCEDURES | <p>a. RECREATION THERAPY—Enter number of days and total minutes of recreation therapy administered (for at least 15 minutes a day) in the last 7 days (Enter 0 if none)</p> <table border="1"> <thead> <tr> <th colspan="2">DAYS</th> <th colspan="2">MIN</th> </tr> <tr> <th>(A)</th> <th>(B)</th> <th>(A)</th> <th>(B)</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>(A) = # of days administered for 15 minutes or more<br/>                     (B) = total # of minutes provided in last 7 days</p> <p><i>Skip unless this is a Medicare 5 day or Medicare readmission/return assessment.</i></p> <p>b. ORDERED THERAPIES—Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service?<br/>                     0. No                      1. Yes</p> <p><i>If not ordered, skip to item 2</i></p> <p>c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.</p> <p>d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | DAYS         |               | MIN            |                      | (A)           | (B) | (A)            | (B)              |                |                  |                 |                |
|-----------------|-----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------|---------------|----------------|----------------------|---------------|-----|----------------|------------------|----------------|------------------|-----------------|----------------|
|                 |                                   | DAYS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |              | MIN           |                |                      |               |     |                |                  |                |                  |                 |                |
| (A)             | (B)                               | (A)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (B)          |               |                |                      |               |     |                |                  |                |                  |                 |                |
|                 |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |               |                |                      |               |     |                |                  |                |                  |                 |                |
| 2.              | WALKING WHEN MOST SELF SUFFICIENT | <p>Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0,1,2, or 3 AND at least one of the following are present:</p> <ul style="list-style-type: none"> <li>Resident received physical therapy involving gait training (P.1.b.c)</li> <li>Physical therapy was ordered for the resident involving gait training (T.1.b)</li> <li>Resident received nursing rehabilitation for walking (P.3.f)</li> <li>Physical therapy involving walking has been discontinued within the past 180 days</li> </ul> <p><i>Skip to item 3 if resident did not walk in last 7 days</i></p> <p><b>(FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)</b></p> <p>a. Furthest distance walked without sitting down during this episode.</p> <table border="0"> <tr> <td>0. 150+ feet</td> <td>3. 10-25 feet</td> </tr> <tr> <td>1. 51-149 feet</td> <td>4. Less than 10 feet</td> </tr> <tr> <td>2. 26-50 feet</td> <td></td> </tr> </table> <p>b. Time walked without sitting down during this episode.</p> <table border="0"> <tr> <td>0. 1-2 minutes</td> <td>3. 11-15 minutes</td> </tr> <tr> <td>1. 3-4 minutes</td> <td>4. 16-30 minutes</td> </tr> <tr> <td>2. 5-10 minutes</td> <td>5. 31+ minutes</td> </tr> </table> <p>c. Self-Performance in walking during this episode.</p> <p>0. INDEPENDENT—No help or oversight<br/>                     1. SUPERVISION—Oversight, encouragement or cueing provided<br/>                     2. LIMITED ASSISTANCE—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance<br/>                     3. EXTENSIVE ASSISTANCE—Resident received weight bearing assistance while walking</p> <p>d. Walking support provided associated with this episode (code regardless of resident's self-performance classification).</p> <p>0. No setup or physical help from staff<br/>                     1. Setup help only<br/>                     2. One person physical assist<br/>                     3. Two+ persons physical assist</p> <p>e. Parallel bars used by resident in association with this episode.</p> <p>0. No                      1. Yes</p> | 0. 150+ feet | 3. 10-25 feet | 1. 51-149 feet | 4. Less than 10 feet | 2. 26-50 feet |     | 0. 1-2 minutes | 3. 11-15 minutes | 1. 3-4 minutes | 4. 16-30 minutes | 2. 5-10 minutes | 5. 31+ minutes |
| 0. 150+ feet    | 3. 10-25 feet                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |               |                |                      |               |     |                |                  |                |                  |                 |                |
| 1. 51-149 feet  | 4. Less than 10 feet              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |               |                |                      |               |     |                |                  |                |                  |                 |                |
| 2. 26-50 feet   |                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |               |                |                      |               |     |                |                  |                |                  |                 |                |
| 0. 1-2 minutes  | 3. 11-15 minutes                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |               |                |                      |               |     |                |                  |                |                  |                 |                |
| 1. 3-4 minutes  | 4. 16-30 minutes                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |               |                |                      |               |     |                |                  |                |                  |                 |                |
| 2. 5-10 minutes | 5. 31+ minutes                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |              |               |                |                      |               |     |                |                  |                |                  |                 |                |
| 3.              | CASE MIX GROUP                    | <p>Medicare <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>State <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |              |               |                |                      |               |     |                |                  |                |                  |                 |                |

## MINIMUM DATA SET (MDS) - VERSION 2.0

### FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

#### SECTION W. SUPPLEMENTAL MDS ITEMS

|                                                                                                                                     |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>1.</b>                                                                                                                           | <b>National<br/>Provider<br/>ID</b>   | Enter for all assessments and tracking forms, if available.<br><div style="text-align: center; border: 1px solid black; width: 100px; height: 15px; margin: 5px auto;"></div>                                                                                                                                                                                                                                                                                      |  |
| 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. |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
| <b>2.</b>                                                                                                                           | <b>Influenza<br/>Vaccine</b>          | a . Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)?<br><br>0. No (If No, go to item W2b)<br>1. Yes (If Yes, go to item W3)<br><br>b. If Influenza vaccine not received, state reason:<br>1. Not in facility during this year's flu season<br>2. Received outside of this facility<br>3. Not eligible<br>4. Offered and declined<br>5. Not offered<br>6. Inability to obtain vaccine |  |
| <b>3.</b>                                                                                                                           | <b>Pneumo-<br/>coccal<br/>Vaccine</b> | a. Is the resident's PPV status up to date?<br>0. No (If No, go to item W3b)<br>1. Yes (If Yes, skip item W3b)<br><br>b. If PPV not received, state reason:<br>1. Not eligible<br>2. Offered and declined<br>3. Not offered                                                                                                                                                                                                                                        |  |

**SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY**

Numeric Identifier \_\_\_\_\_

|                  |                     |
|------------------|---------------------|
| Resident's Name: | Medical Record No.: |
|------------------|---------------------|

1. Check if RAP is triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
  - Describe:
    - Nature of the condition (may include presence or lack of objective data and subjective complaints).
    - Complications and risk factors that affect your decision to proceed to care planning.
    - Factors that must be considered in developing individualized care plan interventions.
    - Need for referrals/further evaluation by appropriate health professionals.
  - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
  - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

| A. RAP PROBLEM AREA                                | (a) Check if triggered   | Location and Date of RAP Assessment Documentation | (b) Care Planning Decision—check if addressed in care plan |
|----------------------------------------------------|--------------------------|---------------------------------------------------|------------------------------------------------------------|
| 1. DELIRIUM                                        | <input type="checkbox"/> |                                                   | <input type="checkbox"/>                                   |
| 2. COGNITIVE LOSS                                  | <input type="checkbox"/> |                                                   | <input type="checkbox"/>                                   |
| 3. VISUAL FUNCTION                                 | <input type="checkbox"/> |                                                   | <input type="checkbox"/>                                   |
| 4. COMMUNICATION                                   | <input type="checkbox"/> |                                                   | <input type="checkbox"/>                                   |
| 5. ADL FUNCTIONAL/<br>REHABILITATION POTENTIAL     | <input type="checkbox"/> |                                                   | <input type="checkbox"/>                                   |
| 6. URINARY INCONTINENCE AND<br>INDWELLING CATHETER | <input type="checkbox"/> |                                                   | <input type="checkbox"/>                                   |
| 7. PSYCHOSOCIAL WELL-BEING                         | <input type="checkbox"/> |                                                   | <input type="checkbox"/>                                   |
| 8. MOOD STATE                                      | <input type="checkbox"/> |                                                   | <input type="checkbox"/>                                   |
| 9. BEHAVIORAL SYMPTOMS                             | <input type="checkbox"/> |                                                   | <input type="checkbox"/>                                   |
| 10. ACTIVITIES                                     | <input type="checkbox"/> |                                                   | <input type="checkbox"/>                                   |
| 11. FALLS                                          | <input type="checkbox"/> |                                                   | <input type="checkbox"/>                                   |
| 12. NUTRITIONAL STATUS                             | <input type="checkbox"/> |                                                   | <input type="checkbox"/>                                   |
| 13. FEEDING TUBES                                  | <input type="checkbox"/> |                                                   | <input type="checkbox"/>                                   |
| 14. DEHYDRATION/FLUID MAINTENANCE                  | <input type="checkbox"/> |                                                   | <input type="checkbox"/>                                   |
| 15. DENTAL CARE                                    | <input type="checkbox"/> |                                                   | <input type="checkbox"/>                                   |
| 16. PRESSURE ULCERS                                | <input type="checkbox"/> |                                                   | <input type="checkbox"/>                                   |
| 17. PSYCHOTROPIC DRUG USE                          | <input type="checkbox"/> |                                                   | <input type="checkbox"/>                                   |
| 18. PHYSICAL RESTRAINTS                            | <input type="checkbox"/> |                                                   | <input type="checkbox"/>                                   |

- B.** \_\_\_\_\_
1. Signature of RN Coordinator for RAP Assessment Process
  
  
  3. Signature of Person Completing Care Planning Decision

2.  —  —

Month                      Day                      Year

  

4.  —  —

Month                      Day                      Year

## RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

Key:

- = One item required to trigger
- ② = Two items required to trigger
- \* = One of these three items, plus at least one other item required to trigger
- ⓐ = When both ADL triggers present, maintenance takes precedence

**Proceed to RAP Review once triggered**

| MDS ITEM   | CODE                                        | Delirium | Cognitive Loss/Dementia | Visual Function | Communication | ADL-Rehabilitation Trigger A | ADL-Maintenance Trigger A ⓐ | Urinary Incontinence Trigger B ⓐ | Psychosocial Well-Being | Mood State | Behavioral Symptoms | Activities Trigger A | Activities Trigger B | Falls | Nutritional Status | Feeding Tubes | Dehydration/Fluid Maintenance | Dental Care | Pressure Ulcers | Psychotropic Drug Use | Physical Restraints |     |            |
|------------|---------------------------------------------|----------|-------------------------|-----------------|---------------|------------------------------|-----------------------------|----------------------------------|-------------------------|------------|---------------------|----------------------|----------------------|-------|--------------------|---------------|-------------------------------|-------------|-----------------|-----------------------|---------------------|-----|------------|
| B2a        | Short term memory                           | 1        | ●                       |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     | B2a |            |
| B2b        | Long term memory                            | 1        | ●                       |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | B2b        |
| B4         | Decision making                             | 1,2,3    | ●                       |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | B4         |
| B4         | Decision making                             | 3        |                         |                 |               | ●                            |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | B4         |
| B5a to B5f | Indicators of delirium                      | 2        | ●                       |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 | ●                     |                     |     | B5a to B5f |
| B6         | Change in cognitive status                  | 2        | ●                       |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 | ●                     |                     |     | B6         |
| C1         | Hearing                                     | 1,2,3    |                         |                 | ●             |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | C1         |
| C4         | Understood by others                        | 1,2,3    |                         |                 | ●             |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | C4         |
| C6         | Understand others                           | 1,2,3    |                         | ●               | ●             |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | C6         |
| C7         | Change in communication                     | 2        |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 | ●                     |                     |     | C7         |
| D1         | Vision                                      | 1,2,3    |                         | ●               |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | D1         |
| D2a        | Side vision problem                         | 1,2,3    |                         | ●               |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | D2a        |
| E1a to E1p | Indicators of depression, anxiety, sad mood | 1,2      |                         |                 |               |                              |                             | ●                                |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | E1a to E1p |
| E1n        | Repetitive movement                         | 1,2      |                         |                 |               |                              |                             | ●                                |                         |            |                     |                      |                      |       |                    |               |                               |             |                 | ●                     |                     |     | E1n        |
| E1o        | Withdrawal from activities                  | 1,2      |                         |                 |               |                              |                             | ●                                |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | E1o        |
| E2         | Mood persistence                            | 1,2      |                         |                 |               |                              |                             | ●                                |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | E2         |
| E3         | Change in Mood                              | 2        | ●                       |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 | ●                     |                     |     | E3         |
| E4aA       | Wandering                                   | 1,2,3    |                         |                 |               |                              |                             |                                  |                         |            |                     |                      | ●                    |       |                    |               |                               |             |                 |                       |                     |     | E4aA       |
| E4aA- E4eA | Behavioral symptoms                         | 1,2,3    |                         |                 |               |                              |                             |                                  | ●                       |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | E4aA- E4eA |
| E5         | Change in behavioral symptoms               | 1        |                         |                 |               |                              |                             |                                  | ●                       |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | E5         |
| E5         | Change in behavioral symptoms               | 2        | ●                       |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 | ●                     |                     |     | E5         |
| F1d        | Establishes own goals                       | 1        |                         |                 |               |                              |                             | ●                                |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | F1d        |
| F2a to F2d | Unsettled relationships                     | 1        |                         |                 |               |                              |                             | ●                                |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | F2a to F2d |
| F3a        | Strong id. past roles                       | 1        |                         |                 |               |                              |                             | ●                                |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | F3a        |
| F3b        | Lost roles                                  | 1        |                         |                 |               |                              |                             | ●                                |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | F3b        |
| F3c        | Daily routine different                     | 1        |                         |                 |               |                              |                             | ●                                |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | F3c        |
| G1aA- G1jA | ADL self performance                        | 1,2,3,4  |                         |                 |               | ●                            |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | G1aA- G1jA |
| G1aA       | Bed mobility                                | 2,3,4,8  |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               | ●           |                 |                       |                     |     | G1aA       |
| G2A        | Bathing                                     | 1,2,3,4  |                         |                 |               | ●                            |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | G2A        |
| G3b        | Balance while sitting                       | 1,2,3    |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       | ●                   |     | G3b        |
| G6a        | Bedfast                                     | 1        |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             | ●               |                       |                     |     | G6a        |
| G6a,b      | Resident, staff believes capable            | 1        |                         |                 |               | ●                            |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       | ●                   |     | G6a,b      |
| H1a        | Bowel incontinence                          | 1,2,3,4  |                         |                 |               |                              |                             | ●                                |                         |            |                     |                      |                      |       |                    |               |                               |             | ●               |                       |                     |     | H1a        |
| H1b        | Bladder incontinence                        | 2,3,4    |                         |                 |               |                              |                             | ●                                |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | H1b        |
| H2b        | Constipation                                | 1        |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       | ●                   |     | H2b        |
| H2d        | Fecal impaction                             | 1        |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       | ●                   |     | H2d        |
| H3c,d,e    | Catheter use                                | 1        |                         |                 |               |                              |                             | ●                                |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | H3c,d,e    |
| H3g        | Use of pads/briefs                          | 1        |                         |                 |               |                              |                             | ●                                |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | H3g        |
| I1         | Hypertension                                | 1        |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       | ●                   |     | I1         |
| I1         | Peripheral vascular disease                 | 1        |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             | ●               |                       |                     |     | I1         |
| I1ee       | Depression                                  | 1        |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       | ●                   |     | I1ee       |
| I1j        | Cataracts                                   | 1        |                         | ●               |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | I1j        |
| I1ll       | Glaucoma                                    | 1        |                         | ●               |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     |     | I1ll       |
| I2         | UTI                                         | 1        |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       | ●                  |               |                               |             |                 |                       |                     |     | I2         |
| I3         | Dehydration diagnosis                       | 2,7,6,5  |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       | ●                  |               |                               |             |                 |                       |                     |     | I3         |
| J1a        | Weight fluctuation                          | 1        |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       | ●                  |               |                               |             |                 |                       |                     |     | J1a        |
| J1c        | Dehydrated                                  | 1        |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       | ●                  |               |                               |             |                 |                       |                     |     | J1c        |
| J1d        | Insufficient fluid                          | 1        |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       | ●                  |               |                               |             |                 |                       |                     |     | J1d        |
| J1f        | Dizziness                                   | 1        |                         |                 |               |                              |                             |                                  |                         |            |                     |                      | ●                    |       |                    |               |                               |             |                 |                       | ●                   |     | J1f        |
| J1h        | Fever                                       | 1        |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       | ●                  |               |                               |             |                 |                       |                     |     | J1h        |
| J1i        | Hallucinations                              | 1        |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       | ●                   |     | J1i        |
| J1j        | Internal bleeding                           | 1        |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       | ●                  |               |                               |             |                 |                       |                     |     | J1j        |
| J1k        | Lung aspirations                            | 1        |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       | ●                   |     | J1k        |
| J1m        | Syncope                                     | 1        |                         |                 |               |                              |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       | ●                   |     | J1m        |

# RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPs (FOR MDS VERSION 2.0)

- Key:**
- = One item required to trigger
  - ② = Two items required to trigger
  - \* = One of these three items, plus at least one other item required to trigger
  - ⓐ = When both ADL triggers present, maintenance takes precedence

**Proceed to RAP Review once triggered**

| MDS ITEM  | CODE                            | Delirium | Cognitive Loss/Dementia | Visual Function | Communication | ADL-Rehabilitation Trigger A ⓐ | ADL-Maintenance Trigger B ⓐ | Urinary Incontinence Trigger B ⓐ | Psychosocial Well-Being | Mood State | Behavioral Symptoms | Activities Trigger A | Activities Trigger B | Falls | Nutritional Status | Feeding Tubes | Dehydration/Fluid Maintenance | Dental Care | Pressure Ulcers | Psychotropic Drug Use | Physical Restraints |           |
|-----------|---------------------------------|----------|-------------------------|-----------------|---------------|--------------------------------|-----------------------------|----------------------------------|-------------------------|------------|---------------------|----------------------|----------------------|-------|--------------------|---------------|-------------------------------|-------------|-----------------|-----------------------|---------------------|-----------|
| J1n       | Unsteady gait                   |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     | J1n       |
| J4a,b     | Fall                            |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      | ●     |                    |               |                               |             |                 | ●                     |                     | J4a,b     |
| J4c       | Hip fracture                    |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 | ●                     |                     | J4c       |
| K1b       | Swallowing problem              |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 | ●                     |                     | K1b       |
| K1c       | Mouth pain                      |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     | K1c       |
| K3a       | Weight loss                     |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       | ●                  |               |                               |             |                 |                       |                     | K3a       |
| K4a       | Taste alteration                |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       | ●                  |               |                               |             |                 |                       |                     | K4a       |
| K4c       | Leave 25% food                  |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       | ●                  |               |                               |             |                 |                       |                     | K4c       |
| K5a       | Parenteral/IV feeding           |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       | ●                  |               |                               |             |                 |                       |                     | K5a       |
| K5b       | Feeding tube                    |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       | ●                  |               |                               |             |                 |                       |                     | K5b       |
| K5c       | Mechanically altered            |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       | ●                  |               |                               |             |                 |                       |                     | K5c       |
| K5d       | Spring feeding                  |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       | ●                  |               |                               |             |                 |                       |                     | K5d       |
| K5e       | Therapeutic diet                |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       | ●                  |               |                               |             |                 |                       |                     | K5e       |
| L1a,c,d,e | Dental                          |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     | L1a,c,d,e |
| L1f       | Daily cleaning teeth            |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     | L1f       |
| M2a       | Pressure ulcer                  |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       | ●                  |               |                               |             |                 |                       |                     | M2a       |
| M2a       | Pressure ulcer                  |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     | M2a       |
| M3        | Previous pressure ulcer         |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     | M3        |
| M4e       | Impaired tactile sense          |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     | M4e       |
| N1a       | Awake morning                   |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      | ②     |                    |               |                               |             |                 |                       |                     | N1a       |
| N2        | Involved in activities          |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      | ②     |                    |               |                               |             |                 |                       |                     | N2        |
| N2        | Involved in activities          |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      | ●     |                    |               |                               |             |                 |                       |                     | N2        |
| N5a,b     | Prefers change in daily routine |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     | N5a,b     |
| O4a       | Antipsychotics                  |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       | *                   | O4a       |
| O4b       | Anti-anxiety                    |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       | *                   | O4b       |
| O4c       | Antidepressants                 |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       | *                   | O4c       |
| O4e       | Diuretic                        |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     | O4e       |
| P4c       | Trunk restraint                 |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     | P4c       |
| P4c       | Trunk restraint                 |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     | P4c       |
| P4d       | Limb restraint                  |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     | P4d       |
| P4e       | Chair prevents rising           |          |                         |                 |               |                                |                             |                                  |                         |            |                     |                      |                      |       |                    |               |                               |             |                 |                       |                     | P4e       |

# MDS QUARTERLY ASSESSMENT FORM

Numeric Identifier \_\_\_\_\_

|     |                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|-----|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| A1. | RESIDENT NAME                                                 | a. (First)      b. (Middle Initial)      c. (Last)      d. (Jr/Sr)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| A2. | ROOM NUMBER                                                   | <input type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| A3. | ASSESSMENT REFERENCE DATE                                     | a. Last day of MDS observation period<br><input type="text"/> — <input type="text"/> — <input type="text"/><br>Month      Day      Year<br>b. Original (0) or corrected copy of form (enter number of correction)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| A4a | DATE OF REENTRY                                               | Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)<br><input type="text"/> — <input type="text"/> — <input type="text"/><br>Month      Day      Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| A6. | MEDICAL RECORD NO.                                            | <input type="text"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| B1. | COMATOSE                                                      | (Persistent vegetative state/no discernible consciousness)<br>0. No      1. Yes (Skip to Section G)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| B2. | MEMORY                                                        | (Recall of what was learned or known)<br>a. Short-term memory OK—seems/appears to recall after 5 minutes<br>0. Memory OK      1. Memory problem<br>b. Long-term memory OK—seems/appears to recall long past<br>0. Memory OK      1. Memory problem                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| B4. | COGNITIVE SKILLS FOR DAILY DECISION-MAKING                    | (Made decisions regarding tasks of daily life)<br>0. INDEPENDENT—decisions consistent/reasonable<br>1. MODIFIED INDEPENDENCE—some difficulty in new situations only<br>2. MODERATELY IMPAIRED—decisions poor; cues/supervision required<br>3. SEVERELY IMPAIRED—never/rarely made decisions                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| B5. | INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/AWARENESS | (Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time].<br>0. Behavior not present<br>1. Behavior present, not of recent onset<br>2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)<br>a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)<br>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)<br>c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)<br>d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)<br>e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)<br>f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not) |
| C4. | MAKING SELF UNDERSTOOD                                        | (Expressing information content—however able)<br>0. UNDERSTOOD<br>1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts<br>2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests<br>3. RARELY/NEVER UNDERSTOOD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| C6. | ABILITY TO UNDERSTAND OTHERS                                  | (Understanding verbal information content—however able)<br>0. UNDERSTANDS<br>1. USUALLY UNDERSTANDS—may miss some part/intent of message<br>2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication<br>3. RARELY/NEVER UNDERSTANDS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| E1. | INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD                   | (Code for indicators observed in last 30 days, irrespective of the assumed cause)<br>0. Indicator not exhibited in last 30 days<br>1. Indicator of this type exhibited up to five days a week<br>2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)<br>VERBAL EXPRESSIONS OF DISTRESS<br>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"<br>b. Repetitive questions—e.g., "Where do I go; What do I do?"<br>c. Repetitive verbalizations—e.g., calling out for help, ("God help me")<br>d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received<br>e. Self deprecation—e.g., "I am nothing; I am of no use to anyone"                                                                                                                                                                                                                                                                                                                                                                                                                              |

|     |                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|-----|-------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| E1. | INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (cont.)                                                               | VERBAL EXPRESSIONS OF DISTRESS<br>f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others<br>g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack<br>h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions<br>i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues                                                                                                                                                                                                                                                                                                                                          | SLEEP-CYCLE ISSUES<br>j. Unpleasant mood in morning<br>k. Insomnia/change in usual sleep pattern<br>SAD, APATHETIC, ANXIOUS APPEARANCE<br>l. Sad, pained, worried facial expressions—e.g., furrowed brows<br>m. Crying, tearfulness<br>n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking<br>LOSS OF INTEREST<br>o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends<br>p. Reduced social interaction |
| E2. | MOOD PERSISTENCE                                                                                                  | One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days<br>0. No mood indicators present, indicators easily altered      1. Indicators present, not easily altered      2. Indicators present, not easily altered                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| E4. | BEHAVIORAL SYMPTOMS                                                                                               | (A) Behavioral symptom frequency in last 7 days<br>0. Behavior not exhibited in last 7 days<br>1. Behavior of this type occurred 1 to 3 days in last 7 days<br>2. Behavior of this type occurred 4 to 6 days, but less than daily<br>3. Behavior of this type occurred daily<br>(B) Behavioral symptom alterability in last 7 days<br>0. Behavior not present OR behavior was easily altered<br>1. Behavior was not easily altered                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (A) (B)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| G1. | (A) ADL SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup) | 0. INDEPENDENT—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days<br>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<br>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<br>3. EXTENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:<br>—Weight-bearing support<br>— Full staff performance during part (but not all) of last 7 days<br>4. TOTAL DEPENDENCE—Full staff performance of activity during entire 7 days<br>8. ACTIVITY DID NOT OCCUR during entire 7 days | (A)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| a.  | BED MOBILITY                                                                                                      | How resident moves to and from lying position, turns side to side, and positions body while in bed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| b.  | TRANSFER                                                                                                          | How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| c.  | WALK IN ROOM                                                                                                      | How resident walks between locations in his/her room.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| d.  | WALK IN CORRIDOR                                                                                                  | How resident walks in corridor on unit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| e.  | LOCOMOTION ON UNIT                                                                                                | How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| f.  | LOCOMOTION OFF UNIT                                                                                               | How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| g.  | DRESSING                                                                                                          | How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| h.  | EATING                                                                                                            | How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |

|     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                            |          |
|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|----------|
| i.  | <b>TOILET USE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes                                                                                                                                                                                                                                                                                                                                           |                                                                                            |          |
| j.  | <b>PERSONAL HYGIENE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)                                                                                                                                                                                                                                                                                                                      |                                                                                            |          |
| G2. | <b>BATHING</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.)<br><b>Code for most dependent in self-performance.</b><br><b>(A) BATHING SELF PERFORMANCE</b> codes appear below<br>0. Independent—No help provided<br>1. Supervision—Oversight help only<br>2. Physical help limited to transfer only<br>3. Physical help in part of bathing activity<br>4. Total dependence<br>8. Activity itself did not occur during entire 7 days | (A)                                                                                        |          |
| G4. | <b>FUNCTIONAL LIMITATION IN RANGE OF MOTION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury)<br><b>(A) RANGE OF MOTION</b><br>0. No limitation<br>1. Limitation on one side<br>2. Limitation on both sides<br><b>(B) VOLUNTARY MOVEMENT</b><br>0. No loss<br>1. Partial loss<br>2. Full loss                                                                                                                                                                                 | (A) (B)                                                                                    |          |
| G6. | <b>MODES OF TRANSFER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (Check all that apply during last 7 days)<br>Bedfast all or most of time<br>Bed rails used for bed mobility or transfer                                                                                                                                                                                                                                                                                                                                                                              | a. NONE OF ABOVE<br>b.                                                                     | f.       |
| H1. | <b>CONTINENCE SELF-CONTROL CATEGORIES (Code for resident's PERFORMANCE OVER ALL SHIFTS)</b><br>0. CONTINENT—Complete control [includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]<br>1. USUALLY CONTINENT—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly<br>2. OCCASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not daily; BOWEL, once a week<br>3. FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week<br>4. INCONTINENT—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                            |          |
| a.  | <b>BOWEL CONTINENCE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Control of bowel movement, with appliance or bowel continence programs, if employed                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                            |          |
| b.  | <b>BLADDER CONTINENCE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed                                                                                                                                                                                                                                                                                                                                 |                                                                                            |          |
| H2. | <b>BOWEL ELIMINATION PATTERN</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Fecal impaction                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | d. NONE OF ABOVE                                                                           | e.       |
| H3. | <b>APPLIANCES AND PROGRAMS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Any scheduled toileting plan<br>Bladder retraining program<br>External (condom) catheter                                                                                                                                                                                                                                                                                                                                                                                                             | a. Indwelling catheter<br>b. Ostomy present<br>c. NONE OF ABOVE                            | d. i. j. |
| I2. | <b>INFECTIONS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Urinary tract infection in last 30 days                                                                                                                                                                                                                                                                                                                                                                                                                                                              | j. NONE OF ABOVE                                                                           | m.       |
| I3. | <b>OTHER CURRENT DIAGNOSES AND ICD-9 CODES</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (Include only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death)<br>a. _____<br>b. _____                                                                                                                                                                                                                                                              |                                                                                            |          |
| J1. | <b>PROBLEM CONDITIONS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (Check all problems present in last 7 days)<br>Dehydrated; output exceeds input<br>Hallucinations                                                                                                                                                                                                                                                                                                                                                                                                    | c. NONE OF ABOVE                                                                           | i. p.    |
| J2. | <b>PAIN SYMPTOMS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (Code the highest level of pain present in the last 7 days)<br>a. FREQUENCY with which resident complains or shows evidence of pain<br>0. No pain (skip to J4)<br>1. Pain less than daily<br>2. Pain daily<br>b. INTENSITY of pain<br>1. Mild pain<br>2. Moderate pain<br>3. Times when pain is horrible or excruciating                                                                                                                                                                             |                                                                                            |          |
| J4. | <b>ACCIDENTS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (Check all that apply)<br>Fell in past 30 days<br>Fell in past 31-180 days                                                                                                                                                                                                                                                                                                                                                                                                                           | a. Hip fracture in last 180 days<br>b. Other fracture in last 180 days<br>c. NONE OF ABOVE | c. d. e. |

|                                                                              |                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                 |
|------------------------------------------------------------------------------|-----------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|
| J5.                                                                          | <b>STABILITY OF CONDITIONS</b>                | Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating)<br>Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem<br>End-stage disease, 6 or fewer months to live<br>NONE OF ABOVE                                                                                                                                                                                                                                                                                                                                                                                                                                              | a. b. c. d.     |
| K3.                                                                          | <b>WEIGHT CHANGE</b>                          | a. Weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days<br>0. No 1. Yes<br>b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days<br>0. No 1. Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                 |
| K5.                                                                          | <b>NUTRITIONAL APPROACHES</b>                 | Feeding tube<br>On a planned weight change program<br>NONE OF ABOVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | b. h. i.        |
| M1.                                                                          | <b>ULCERS (Due to any cause)</b>              | (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.]<br>a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.<br>b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.<br>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.<br>d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. | Number at Stage |
| M2.                                                                          | <b>TYPE OF ULCER</b>                          | (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)<br>a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue<br>b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities                                                                                                                                                                                                                                                                                                                                                                                                                            |                 |
| N1.                                                                          | <b>TIME AWAKE</b>                             | (Check appropriate time periods over last 7 days)<br>Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:<br>Morning a. Evening c.<br>Afternoon b. NONE OF ABOVE d.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                 |
| <b>(If resident is comatose, skip to Section O)</b>                          |                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                 |
| N2.                                                                          | <b>AVERAGE TIME INVOLVED IN ACTIVITIES</b>    | (When awake and not receiving treatments or ADL care)<br>0. Most—more than 2/3 of time 2. Little—less than 1/3 of time<br>1. Some—from 1/3 to 2/3 of time 3. None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                 |
| O1.                                                                          | <b>NUMBER OF MEDICATIONS</b>                  | (Record the number of different medications used in the last 7 days; enter "0" if none used)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                 |
| O4.                                                                          | <b>DAYS RECEIVED THE FOLLOWING MEDICATION</b> | (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)<br>a. Antipsychotic<br>b. Antianxiety<br>c. Antidepressant<br>d. Hypnotic<br>e. Diuretic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                 |
| P4.                                                                          | <b>DEVICES AND RESTRAINTS</b>                 | Use the following codes for last 7 days:<br>0. Not used<br>1. Used less than daily<br>2. Used daily<br>Bed rails<br>a. — Full bed rails on all open sides of bed<br>b. — Other types of side rails used (e.g., half rail, one side)<br>c. Trunk restraint<br>d. Limb restraint<br>e. Chair prevents rising                                                                                                                                                                                                                                                                                                                                                                                                                               |                 |
| Q2.                                                                          | <b>OVERALL CHANGE IN CARE NEEDS</b>           | Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days)<br>0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support                                                                                                                                                                                                                                                                                                                                                                                                                                              |                 |
| <b>R2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:</b>                  |                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                 |
| a. Signature of RN Assessment Coordinator (sign on above line)               |                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                 |
| b. Date RN Assessment Coordinator signed as complete _____<br>Month Day Year |                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                 |

## MINIMUM DATA SET (MDS) - VERSION 2.0

### FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

#### SECTION W. SUPPLEMENTAL MDS ITEMS

|           |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
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| <b>1.</b> | <b>National<br/>Provider<br/>ID</b>   | Enter for all assessments and tracking forms, if available.<br><br><div style="display: flex; justify-content: center; gap: 5px;"> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> </div> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|           |                                       | 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.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>2.</b> | <b>Influenza<br/>Vaccine</b>          | a . Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)?<br><br>0. No (If No, go to item W2b)<br>1. Yes (If Yes, go to item W3)<br><br>b. If Influenza vaccine not received, state reason:<br>1. Not in facility during this year's flu season<br>2. Received outside of this facility<br>3. Not eligible<br>4. Offered and declined<br>5. Not offered<br>6. Inability to obtain vaccine                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <div style="background-color: black; width: 20px; height: 20px; margin-bottom: 5px;"></div> <div style="background-color: black; width: 20px; height: 20px; margin-bottom: 5px;"></div> <div style="background-color: black; width: 20px; height: 20px; margin-bottom: 5px;"></div> <div style="background-color: black; width: 20px; height: 20px; margin-bottom: 5px;"></div> <div style="background-color: black; width: 20px; height: 20px; margin-bottom: 5px;"></div> <div style="background-color: black; width: 20px; height: 20px; margin-bottom: 5px;"></div> |
| <b>3.</b> | <b>Pneumo-<br/>coccal<br/>Vaccine</b> | a. Is the resident's PPV status up to date?<br>0. No (If No, go to item W3b)<br>1. Yes (If Yes, skip item W3b)<br><br>b. If PPV not received, state reason:<br>1. Not eligible<br>2. Offered and declined<br>3. Not offered                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <div style="background-color: black; width: 20px; height: 20px; margin-bottom: 5px;"></div> <div style="background-color: black; width: 20px; height: 20px; margin-bottom: 5px;"></div> <div style="background-color: black; width: 20px; height: 20px; margin-bottom: 5px;"></div> <div style="background-color: black; width: 20px; height: 20px; margin-bottom: 5px;"></div>                                                                                                                                                                                         |



|                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |         |         |
|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|---------|
| <b>G1.</b>                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (A) (B) |         |
| <b>c. WALK IN ROOM</b>                                                                                    | How resident walks between locations in his/her room                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |         |         |
| <b>d. WALK IN CORRIDOR</b>                                                                                | How resident walks in corridor on unit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |         |         |
| <b>e. LOCOMOTION ON UNIT</b>                                                                              | How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |         |
| <b>f. LOCOMOTION OFF UNIT</b>                                                                             | 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                                                                                                                                                                                                                                                                                                                                                                      |         |         |
| <b>g. DRESSING</b>                                                                                        | How resident puts on, fastens, and takes off all items of <b>street clothing</b> , including donning/removing prosthesis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |         |         |
| <b>h. EATING</b>                                                                                          | How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |         |
| <b>i. TOILET USE</b>                                                                                      | How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |         |
| <b>j. PERSONAL HYGIENE</b>                                                                                | How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)                                                                                                                                                                                                                                                                                                                                                                                                                                                           |         |         |
| <b>G2. BATHING</b>                                                                                        | How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.)<br><b>Code for most dependent in self-performance.</b><br><b>(A) BATHING SELF PERFORMANCE</b> codes appear below                                                                                                                                                                                                                                                                                                                                                                                            |         | (A)     |
|                                                                                                           | 0. Independent—No help provided                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |         |         |
|                                                                                                           | 1. Supervision—Oversight help only                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |         |
|                                                                                                           | 2. Physical help limited to transfer only                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |         |
|                                                                                                           | 3. Physical help in part of bathing activity                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |         |         |
|                                                                                                           | 4. Total dependence                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |         |         |
|                                                                                                           | 8. Activity itself did not occur during entire 7 days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |         |
| <b>G3. TEST FOR BALANCE</b><br><small>(see training manual)</small>                                       | <i>(Code for ability during test in the last 7 days)</i><br>0. Maintained position as required in test<br>1. Unsteady, but able to rebalance self without physical support<br>2. Partial physical support during test; or stands (sits) but does not follow directions for test<br>3. Not able to attempt test without physical help                                                                                                                                                                                                                                                                                                      |         |         |
|                                                                                                           | a. Balance while standing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |         |
|                                                                                                           | b. Balance while sitting—position, trunk control                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |         |
| <b>G4. FUNCTIONAL LIMITATION IN RANGE OF MOTION</b>                                                       | <i>(Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury)</i><br><b>(A) RANGE OF MOTION</b> <b>(B) VOLUNTARY MOVEMENT</b><br>0. No limitation                                      0. No loss<br>1. Limitation on one side                              1. Partial loss<br>2. Limitation on both sides                              2. Full loss                                                                                                                                                                                                                            |         | (A) (B) |
|                                                                                                           | a. Neck                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |         |
|                                                                                                           | b. Arm—Including shoulder or elbow                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |         |
|                                                                                                           | c. Hand—Including wrist or fingers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |         |
|                                                                                                           | d. Leg—Including hip or knee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |         |         |
|                                                                                                           | e. Foot—Including ankle or toes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |         |         |
|                                                                                                           | f. Other limitation or loss                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |         |
| <b>G6. MODES OF TRANSFER</b>                                                                              | <i>(Check all that apply during last 7 days)</i><br>Bedfast all or most of time                      a. <b>NONE OF ABOVE</b><br>Bed rails used for bed mobility or transfer                      b.                                                                                                                                                                                                                                                                                                                                                                                                                                       |         | f.      |
| <b>G7. TASK SEGMENTATION</b>                                                                              | Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them<br>0. No                                      1. Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |         |         |
| <b>H1. CONTINENCE SELF-CONTROL CATEGORIES</b><br><i>(Code for resident's PERFORMANCE OVER ALL SHIFTS)</i> | 0. <b>CONTINENT</b> —Complete control [includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]<br>1. <b>USUALLY CONTINENT</b> —BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly<br>2. <b>OCCASIONALLY INCONTINENT</b> —BLADDER, 2 or more times a week but not daily; BOWEL, once a week<br>3. <b>FREQUENTLY INCONTINENT</b> —BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week<br>4. <b>INCONTINENT</b> —Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time |         |         |
| <b>a. BOWEL CONTINENCE</b>                                                                                | Control of bowel movement, with appliance or bowel continence programs, if employed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |         |         |
| <b>b. BLADDER CONTINENCE</b>                                                                              | Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |         |         |
| <b>H2. BOWEL ELIMINATION PATTERN</b>                                                                      | Diarrhea                                      c. <b>NONE OF ABOVE</b><br>Fecal impaction                                      d.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |         | e.      |

|                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                 |                                  |                                                                                                                                                                                                              |                                                          |
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| <b>H3. APPLIANCES AND PROGRAMS</b>                                                                                                                                                                                      | Any scheduled toileting plan<br>Bladder retraining program<br>External (condom) catheter                                                                                                                                                                                                                                                                                        | a.<br>b.<br>c.                   | Indwelling catheter<br>Ostomy present<br><b>NONE OF ABOVE</b>                                                                                                                                                | d.<br>i.<br>j.                                           |
| <b>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)</b> |                                                                                                                                                                                                                                                                                                                                                                                 |                                  |                                                                                                                                                                                                              |                                                          |
| <b>I1. DISEASES</b>                                                                                                                                                                                                     | <i>(If none apply, CHECK the NONE OF ABOVE box)</i><br><b>MUSCULOSKELETAL</b><br>Hip fracture<br><b>NEUROLOGICAL</b><br>Aphasia<br>Cerebral palsy<br>Cerebrovascular accident (stroke)<br>Hemiplegia/Hemiparesis                                                                                                                                                                | m.<br>r.<br>s.<br>t.<br>v.       | Multiple sclerosis<br>Quadriplegia<br><b>PSYCHIATRIC/MOOD</b><br>Depression<br>Manic depressive (bipolar disease)<br><b>OTHER</b><br><b>NONE OF ABOVE</b>                                                    | w.<br>z.<br>ee.<br>ff.<br>rr.                            |
| <b>I2. INFECTIONS</b>                                                                                                                                                                                                   | <i>(If none apply, CHECK the NONE OF ABOVE box)</i><br>Antibiotic resistant infection (e.g., Meticillin resistant staph)<br>Clostridium difficile (c. diff.)<br>Conjunctivitis<br>HIV infection<br>Pneumonia<br>Respiratory infection                                                                                                                                           | a.<br>b.<br>c.<br>d.<br>e.<br>f. | Septicemia<br>Sexually transmitted diseases<br>Tuberculosis<br>Urinary tract infection in last 30 days<br>Viral hepatitis<br>Wound infection<br><b>NONE OF ABOVE</b>                                         | g.<br>h.<br>i.<br>j.<br>k.<br>l.<br>m.                   |
| <b>I3. OTHER CURRENT DIAGNOSES AND ICD-9 CODES</b>                                                                                                                                                                      | <i>(Include only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death)</i><br>a. _____<br>b. _____                                                                                                                                  |                                  |                                                                                                                                                                                                              |                                                          |
| <b>J1. PROBLEM CONDITIONS</b>                                                                                                                                                                                           | <i>(Check all problems present in last 7 days unless other time frame is indicated)</i><br><b>INDICATORS OF FLUID STATUS</b><br>Weight gain or loss of 3 or more pounds within a 7 day period<br>Inability to lie flat due to shortness of breath<br>Dehydrated; output exceeds input<br>Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days |                                  | <b>OTHER</b><br>Delusions<br>Edema<br>Fever<br>Hallucinations<br>Internal bleeding<br>Recurrent lung aspirations in last 90 days<br>Shortness of breath<br>Unsteady gait<br>Vomiting<br><b>NONE OF ABOVE</b> | e.<br>g.<br>h.<br>i.<br>j.<br>k.<br>l.<br>n.<br>o.<br>p. |
| <b>J2. PAIN SYMPTOMS</b>                                                                                                                                                                                                | <i>(Code the highest level of pain present in the last 7 days)</i><br><b>a. FREQUENCY</b> with which resident complains or shows evidence of pain<br>0. No pain ( <i>skip to J4</i> )<br>1. Pain less than daily<br>2. Pain daily                                                                                                                                               |                                  | <b>b. INTENSITY</b> of pain<br>1. Mild pain<br>2. Moderate pain<br>3. Times when pain is horrible or excruciating                                                                                            |                                                          |
| <b>J4. ACCIDENTS</b>                                                                                                                                                                                                    | <i>(Check all that apply)</i><br>Fell in past 30 days<br>Fell in past 31-180 days                                                                                                                                                                                                                                                                                               | a.<br>b.                         | Hip fracture in last 180 days<br>Other fracture in last 180 days<br><b>NONE OF ABOVE</b>                                                                                                                     | c.<br>d.<br>e.                                           |
| <b>J5. STABILITY OF CONDITIONS</b>                                                                                                                                                                                      | Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating)<br>Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem<br>End-stage disease, 6 or fewer months to live<br><b>NONE OF ABOVE</b>                                                                              |                                  |                                                                                                                                                                                                              | a.<br>b.<br>c.<br>d.                                     |
| <b>K1. ORAL PROBLEMS</b>                                                                                                                                                                                                | Chewing problem<br>Swallowing problem<br><b>NONE OF ABOVE</b>                                                                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                                                                              | a.<br>b.<br>d.                                           |
| <b>K2. HEIGHT AND WEIGHT</b>                                                                                                                                                                                            | <i>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</i><br>a. HT (in.) _____ b. WT (lb.) _____                                                                   |                                  |                                                                                                                                                                                                              |                                                          |
| <b>K3. WEIGHT CHANGE</b>                                                                                                                                                                                                | <b>a. Weight loss</b> —5% or more in last 30 days; or 10% or more in last 180 days<br>0. No                                      1. Yes<br><b>b. Weight gain</b> —5% or more in last 30 days; or 10% or more in last 180 days<br>0. No                                      1. Yes                                                                                              |                                  |                                                                                                                                                                                                              |                                                          |



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

**SECTION W. SUPPLEMENTAL MDS ITEMS**

|           |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
|-----------|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>1.</b> | <b>National Provider ID</b> | Enter for all assessments and tracking forms, if available.<br><div style="border: 1px solid black; display: inline-block; width: 100px; height: 15px; margin-top: 5px;"></div>                                                                                                                                                                                                                                                                                    |  |
|           |                             | 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.                                                                                                                                                                                                                                                                                                                                |  |
| <b>2.</b> | <b>Influenza Vaccine</b>    | a . Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)?<br><br>0. No (If No, go to item W2b)<br>1. Yes (If Yes, go to item W3)<br><br>b. If Influenza vaccine not received, state reason:<br>1. Not in facility during this year's flu season<br>2. Received outside of this facility<br>3. Not eligible<br>4. Offered and declined<br>5. Not offered<br>6. Inability to obtain vaccine |  |
| <b>3.</b> | <b>Pneumococcal Vaccine</b> | a. Is the resident's PPV status up to date?<br>0. No (If No, go to item W3b)<br>1. Yes (If Yes, skip item W3b)<br><br>b. If PPV not received, state reason:<br>1. Not eligible<br>2. Offered and declined<br>3. Not offered                                                                                                                                                                                                                                        |  |



|                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |         |         |
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| <b>G1.</b>                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (A) (B) |         |
| <b>c. WALK IN ROOM</b>                                                                                    | How resident walks between locations in his/her room                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |         |         |
| <b>d. WALK IN CORRIDOR</b>                                                                                | How resident walks in corridor on unit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |         |         |
| <b>e. LOCOMOTION ON UNIT</b>                                                                              | How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |         |
| <b>f. LOCOMOTION OFF UNIT</b>                                                                             | 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                                                                                                                                                                                                                                                                                                                                                                      |         |         |
| <b>g. DRESSING</b>                                                                                        | How resident puts on, fastens, and takes off all items of <b>street clothing</b> , including donning/removing prosthesis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |         |         |
| <b>h. EATING</b>                                                                                          | How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |         |
| <b>i. TOILET USE</b>                                                                                      | How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |         |         |
| <b>j. PERSONAL HYGIENE</b>                                                                                | How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)                                                                                                                                                                                                                                                                                                                                                                                                                                                           |         |         |
| <b>G2. BATHING</b>                                                                                        | How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.)<br><b>Code for most dependent in self-performance.</b><br><b>(A) BATHING SELF PERFORMANCE</b> codes appear below                                                                                                                                                                                                                                                                                                                                                                                            | (A)     |         |
|                                                                                                           | 0. Independent—No help provided                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |         |         |
|                                                                                                           | 1. Supervision—Oversight help only                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |         |
|                                                                                                           | 2. Physical help limited to transfer only                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |         |
|                                                                                                           | 3. Physical help in part of bathing activity                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |         |         |
|                                                                                                           | 4. Total dependence                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |         |         |
|                                                                                                           | 8. Activity itself did not occur during entire 7 days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |         |         |
| <b>G3. TEST FOR BALANCE</b><br><small>(see training manual)</small>                                       | <i>(Code for ability during test in the last 7 days)</i><br>0. Maintained position as required in test<br>1. Unsteady, but able to rebalance self without physical support<br>2. Partial physical support during test; or stands (sits) but does not follow directions for test<br>3. Not able to attempt test without physical help                                                                                                                                                                                                                                                                                                      |         |         |
|                                                                                                           | a. Balance while standing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |         |         |
|                                                                                                           | b. Balance while sitting—position, trunk control                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |         |         |
| <b>G4. FUNCTIONAL LIMITATION IN RANGE OF MOTION</b>                                                       | <i>(Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury)</i><br><b>(A) RANGE OF MOTION</b> <b>(B) VOLUNTARY MOVEMENT</b><br>0. No limitation                                      0. No loss<br>1. Limitation on one side                              1. Partial loss<br>2. Limitation on both sides                              2. Full loss                                                                                                                                                                                                                            |         | (A) (B) |
|                                                                                                           | a. Neck                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |         |         |
|                                                                                                           | b. Arm—Including shoulder or elbow                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |         |
|                                                                                                           | c. Hand—Including wrist or fingers                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |         |         |
|                                                                                                           | d. Leg—Including hip or knee                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |         |         |
|                                                                                                           | e. Foot—Including ankle or toes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |         |         |
|                                                                                                           | f. Other limitation or loss                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |         |         |
| <b>G6. MODES OF TRANSFER</b>                                                                              | <i>(Check all that apply during last 7 days)</i><br>Bedfast all or most of time                      a. <b>NONE OF ABOVE</b><br>Bed rails used for bed mobility or transfer                      b.                                                                                                                                                                                                                                                                                                                                                                                                                                       |         | f.      |
| <b>G7. TASK SEGMENTATION</b>                                                                              | Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them<br>0. No                                      1. Yes                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |         |         |
| <b>H1. CONTINENCE SELF-CONTROL CATEGORIES</b><br><i>(Code for resident's PERFORMANCE OVER ALL SHIFTS)</i> | 0. <b>CONTINENT</b> —Complete control [includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]<br>1. <b>USUALLY CONTINENT</b> —BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly<br>2. <b>OCCASIONALLY INCONTINENT</b> —BLADDER, 2 or more times a week but not daily; BOWEL, once a week<br>3. <b>FREQUENTLY INCONTINENT</b> —BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week<br>4. <b>INCONTINENT</b> —Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time |         |         |
| <b>a. BOWEL CONTINENCE</b>                                                                                | Control of bowel movement, with appliance or bowel continence programs, if employed                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |         |         |
| <b>b. BLADDER CONTINENCE</b>                                                                              | Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |         |         |
| <b>H2. BOWEL ELIMINATION PATTERN</b>                                                                      | Diarrhea                                      c. <b>NONE OF ABOVE</b><br>Fecal impaction                                      d.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |         | e.      |

|                                                                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                 |                                  |                                                                                                                                                                                                              |                                                          |
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| <b>H3. APPLIANCES AND PROGRAMS</b>                                                                                                                                                                                      | Any scheduled toileting plan<br>Bladder retraining program<br>External (condom) catheter                                                                                                                                                                                                                                                                                        | a.<br>b.<br>c.                   | Indwelling catheter<br>Ostomy present<br><b>NONE OF ABOVE</b>                                                                                                                                                | d.<br>i.<br>j.                                           |
| <b>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)</b> |                                                                                                                                                                                                                                                                                                                                                                                 |                                  |                                                                                                                                                                                                              |                                                          |
| <b>I1. DISEASES</b>                                                                                                                                                                                                     | <i>(If none apply, CHECK the NONE OF ABOVE box)</i><br><b>ENDOCRINE/METABOLIC/NUTRITIONAL</b><br>Diabetes mellitus<br><b>MUSCULOSKELETAL</b><br>Hip fracture<br><b>NEUROLOGICAL</b><br>Aphasia<br>Cerebral palsy<br>Cerebrovascular accident (stroke)                                                                                                                           | a.<br>m.<br>r.<br>s.<br>t.       | Hemiplegia/Hemiparesis<br>Multiple sclerosis<br>Quadriplegia<br><b>PSYCHIATRIC/MOOD</b><br>Depression<br>Manic depressive (bipolar disease)<br><b>OTHER</b><br><b>NONE OF ABOVE</b>                          | v.<br>w.<br>z.<br>ee.<br>ff.<br>rr.                      |
| <b>I2. INFECTIONS</b>                                                                                                                                                                                                   | <i>(If none apply, CHECK the NONE OF ABOVE box)</i><br>Antibiotic resistant infection (e.g., Methicillin resistant staph)<br>Clostridium difficile (c. diff.)<br>Conjunctivitis<br>HIV infection<br>Pneumonia<br>Respiratory infection                                                                                                                                          | a.<br>b.<br>c.<br>d.<br>e.<br>f. | Septicemia<br>Sexually transmitted diseases<br>Tuberculosis<br>Urinary tract infection in last 30 days<br>Viral hepatitis<br>Wound infection<br><b>NONE OF ABOVE</b>                                         | g.<br>h.<br>i.<br>j.<br>k.<br>l.<br>m.                   |
| <b>I3. OTHER CURRENT DIAGNOSES AND ICD-9 CODES</b>                                                                                                                                                                      | <i>(Include only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death)</i><br>a. _____<br>b. _____                                                                                                                                  |                                  |                                                                                                                                                                                                              |                                                          |
| <b>J1. PROBLEM CONDITIONS</b>                                                                                                                                                                                           | <i>(Check all problems present in last 7 days unless other time frame is indicated)</i><br><b>INDICATORS OF FLUID STATUS</b><br>Weight gain or loss of 3 or more pounds within a 7 day period<br>Inability to lie flat due to shortness of breath<br>Dehydrated; output exceeds input<br>Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days | a.<br>b.<br>c.<br>d.             | <b>OTHER</b><br>Delusions<br>Edema<br>Fever<br>Hallucinations<br>Internal bleeding<br>Recurrent lung aspirations in last 90 days<br>Shortness of breath<br>Unsteady gait<br>Vomiting<br><b>NONE OF ABOVE</b> | e.<br>g.<br>h.<br>i.<br>j.<br>k.<br>l.<br>n.<br>o.<br>p. |
| <b>J2. PAIN SYMPTOMS</b>                                                                                                                                                                                                | <i>(Code the highest level of pain present in the last 7 days)</i><br>a. <b>FREQUENCY</b> with which resident complains or shows evidence of pain<br>0. No pain ( <i>skip to J4</i> )<br>1. Pain less than daily<br>2. Pain daily                                                                                                                                               |                                  | b. <b>INTENSITY</b> of pain<br>1. Mild pain<br>2. Moderate pain<br>3. Times when pain is horrible or excruciating                                                                                            |                                                          |
| <b>J4. ACCIDENTS</b>                                                                                                                                                                                                    | <i>(Check all that apply)</i><br>Fell in past 30 days<br>Fell in past 31-180 days                                                                                                                                                                                                                                                                                               | a.<br>b.                         | Hip fracture in last 180 days<br>Other fracture in last 180 days<br><b>NONE OF ABOVE</b>                                                                                                                     | c.<br>d.<br>e.                                           |
| <b>J5. STABILITY OF CONDITIONS</b>                                                                                                                                                                                      | Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating)<br>Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem<br>End-stage disease, 6 or fewer months to live<br><b>NONE OF ABOVE</b>                                                                              |                                  |                                                                                                                                                                                                              | a.<br>b.<br>c.<br>d.                                     |
| <b>K1. ORAL PROBLEMS</b>                                                                                                                                                                                                | Chewing problem<br>Swallowing problem<br><b>NONE OF ABOVE</b>                                                                                                                                                                                                                                                                                                                   |                                  |                                                                                                                                                                                                              | a.<br>b.<br>d.                                           |
| <b>K2. HEIGHT AND WEIGHT</b>                                                                                                                                                                                            | 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.)                                                                                                                                                                                 |                                                          |
| <b>K3. WEIGHT CHANGE</b>                                                                                                                                                                                                | a. <b>Weight loss</b> —5% or more in last 30 days; or 10% or more in last 180 days<br>0. No                                      1. Yes<br>b. <b>Weight gain</b> —5% or more in last 30 days; or 10% or more in last 180 days<br>0. No                                      1. Yes                                                                                              |                                  |                                                                                                                                                                                                              |                                                          |

|                                              |                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                    |                                                            |
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| K5.                                          | <b>NUTRITIONAL APPROACHES</b>                                                              | (Check all that apply in last 7 days)<br>Parenteral/IV<br>Feeding tube                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | a. <input type="checkbox"/> On a planned weight change program<br>b. <input type="checkbox"/> NONE OF ABOVE                                                                                                                                                                                                        | h. <input type="checkbox"/><br>i. <input type="checkbox"/> |
| K6.                                          | <b>PARENTERAL OR ENTERAL INTAKE</b>                                                        | (Skip to Section M if neither 5a nor 5b is checked)<br>a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days<br>0. None<br>1. 1% to 25%<br>2. 26% to 50%<br>3. 51% to 75%<br>4. 76% to 100%<br>b. Code the average fluid intake per day by IV or tube in last 7 days<br>0. None<br>1. 1 to 500 cc/day<br>2. 501 to 1000 cc/day<br>3. 1001 to 1500 cc/day<br>4. 1501 to 2000 cc/day<br>5. 2001 or more cc/day                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                    |                                                            |
| M1.                                          | <b>ULCERS (Due to any cause)</b>                                                           | (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.]<br>a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.<br>b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.<br>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.<br>d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. | Number at Stage                                                                                                                                                                                                                                                                                                    |                                                            |
| M2.                                          | <b>TYPE OF ULCER</b>                                                                       | (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)<br>a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue<br>b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                    |                                                            |
| M4.                                          | <b>OTHER SKIN PROBLEMS OR LESIONS PRESENT</b><br>(Check all that apply during last 7 days) | Abrasions, bruises<br>Burns (second or third degree)<br>Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)<br>Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster<br>Skin desensitized to pain or pressure<br>Skin tears or cuts (other than surgery)<br>Surgical wounds<br>NONE OF ABOVE                                                                                                                                                                                                                                                                                                                                                                                                              | a. <input type="checkbox"/><br>b. <input type="checkbox"/><br>c. <input type="checkbox"/><br>d. <input type="checkbox"/><br>e. <input type="checkbox"/><br>f. <input type="checkbox"/><br>g. <input type="checkbox"/><br>h. <input type="checkbox"/>                                                               |                                                            |
| M5.                                          | <b>SKIN TREATMENTS</b><br>(Check all that apply during last 7 days)                        | Pressure relieving device(s) for chair<br>Pressure relieving device(s) for bed<br>Turning/repositioning program<br>Nutrition or hydration intervention to manage skin problems<br>Ulcer care<br>Surgical wound care<br>Application of dressings (with or without topical medications) other than to feet<br>Application of ointments/medications (other than to feet)<br>Other preventative or protective skin care (other than to feet)<br>NONE OF ABOVE                                                                                                                                                                                                                                                                                | a. <input type="checkbox"/><br>b. <input type="checkbox"/><br>c. <input type="checkbox"/><br>d. <input type="checkbox"/><br>e. <input type="checkbox"/><br>f. <input type="checkbox"/><br>g. <input type="checkbox"/><br>h. <input type="checkbox"/><br>i. <input type="checkbox"/><br>j. <input type="checkbox"/> |                                                            |
| M6.                                          | <b>FOOT PROBLEMS AND CARE</b><br>(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<br>Infection of the foot—e.g., cellulitis, purulent drainage<br>Open lesions on the foot<br>Nails/calluses trimmed during last 90 days<br>Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)<br>Application of dressings (with or without topical medications)<br>NONE OF ABOVE                                                                                                                                                                                                                                                                    | a. <input type="checkbox"/><br>b. <input type="checkbox"/><br>c. <input type="checkbox"/><br>d. <input type="checkbox"/><br>e. <input type="checkbox"/><br>f. <input type="checkbox"/><br>g. <input type="checkbox"/>                                                                                              |                                                            |
| N1.                                          | <b>TIME AWAKE</b>                                                                          | (Check appropriate time periods over last 7 days)<br>Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:<br>Morning<br>Evening<br>Afternoon<br>NONE OF ABOVE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | a. <input type="checkbox"/><br>b. <input type="checkbox"/>                                                                                                                                                                                                                                                         | c. <input type="checkbox"/><br>d. <input type="checkbox"/> |
| (If resident is comatose, skip to Section O) |                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                    |                                                            |
| N2.                                          | <b>AVERAGE TIME INVOLVED IN ACTIVITIES</b>                                                 | (When awake and not receiving treatments or ADL care)<br>0. Most—more than 2/3 of time<br>1. Some—from 1/3 to 2/3 of time<br>2. Little—less than 1/3 of time<br>3. None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                    |                                                            |
| O1.                                          | <b>NUMBER OF MEDICATIONS</b>                                                               | (Record the number of different medications used in the last 7 days; enter "0" if none used)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                    |                                                            |
| O3.                                          | <b>INJECTIONS</b>                                                                          | (Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                    |                                                            |
| O4.                                          | <b>DAYS RECEIVED THE FOLLOWING MEDICATION</b>                                              | (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)<br>a. Antipsychotic<br>b. Antianxiety<br>c. Antidepressant<br>d. Hypnotic<br>e. Diuretic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                    |                                                            |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                      |   |   |   |   |   |   |   |   |       |  |     |  |      |  |  |  |
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| P1.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS</b> | a. SPECIAL CARE—Check treatments or programs received during the last 14 days<br><b>TREATMENTS</b><br>Chemotherapy<br>Dialysis<br>IV medication<br>Intake/output<br>Monitoring acute medical condition<br>Ostomy care<br>Oxygen therapy<br>Radiation<br>Suctioning<br>Tracheostomy care<br>Transfusions<br><b>PROGRAMS</b><br>Ventilator or respirator<br>Alcohol/drug treatment program<br>Alzheimer's/dementia special care unit<br>Hospice care<br>Pediatric unit<br>Respite care<br>Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)<br>NONE OF ABOVE | a. <input type="checkbox"/><br>b. <input type="checkbox"/><br>c. <input type="checkbox"/><br>d. <input type="checkbox"/><br>e. <input type="checkbox"/><br>f. <input type="checkbox"/><br>g. <input type="checkbox"/><br>h. <input type="checkbox"/><br>i. <input type="checkbox"/><br>j. <input type="checkbox"/><br>k. <input type="checkbox"/> | l. <input type="checkbox"/><br>m. <input type="checkbox"/><br>n. <input type="checkbox"/><br>o. <input type="checkbox"/><br>p. <input type="checkbox"/><br>q. <input type="checkbox"/><br>r. <input type="checkbox"/><br>s. <input type="checkbox"/> |   |   |   |   |   |   |   |   |       |  |     |  |      |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                     | 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]<br>(A) = # of days administered for 15 minutes or more<br>(B) = total # of minutes provided in last 7 days                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                      |   |   |   |   |   |   |   |   |       |  |     |  |      |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                     | a. Speech - language pathology and audiology services<br>b. Occupational therapy<br>c. Physical therapy<br>d. Respiratory therapy<br>e. Psychological therapy (by any licensed mental health professional)                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                      |   |   |   |   |   |   |   |   |       |  |     |  |      |  |  |  |
| P3.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>NURSING REHABILITATION/RESTORATIVE CARE</b>      | 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)<br>a. Range of motion (passive)<br>b. Range of motion (active)<br>c. Splint or brace assistance<br>d. Bed mobility<br>e. Transfer<br>f. Walking<br>g. Dressing or grooming<br>h. Eating or swallowing<br>i. Amputation/prosthesis care<br>j. Communication<br>k. Other                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                      |   |   |   |   |   |   |   |   |       |  |     |  |      |  |  |  |
| P4.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>DEVICES AND RESTRAINTS</b>                       | Use the following codes for last 7 days:<br>0. Not used<br>1. Used less than daily<br>2. Used daily<br>Bed rails<br>a. — Full bed rails on all open sides of bed<br>b. — Other types of side rails used (e.g., half rail, one side)<br>c. Trunk restraint<br>d. Limb restraint<br>e. Chair prevents rising                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                      |   |   |   |   |   |   |   |   |       |  |     |  |      |  |  |  |
| P7.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>PHYSICIAN VISITS</b>                             | In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter 0 if none)                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                      |   |   |   |   |   |   |   |   |       |  |     |  |      |  |  |  |
| P8.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>PHYSICIAN ORDERS</b>                             | In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter 0 if none)                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                      |   |   |   |   |   |   |   |   |       |  |     |  |      |  |  |  |
| Q2.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | <b>OVERALL CHANGE IN CARE NEEDS</b>                 | Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days)<br>0. No change<br>1. Improved—receives fewer supports, needs less restrictive level of care<br>2. Deteriorated—receives more support                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                      |   |   |   |   |   |   |   |   |       |  |     |  |      |  |  |  |
| <b>R2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                      |   |   |   |   |   |   |   |   |       |  |     |  |      |  |  |  |
| a. Signature of RN Assessment Coordinator (sign on above line)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                      |   |   |   |   |   |   |   |   |       |  |     |  |      |  |  |  |
| b. Date RN Assessment Coordinator signed as complete                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                      |   |   |   |   |   |   |   |   |       |  |     |  |      |  |  |  |
| <table style="width: 100%; border: none;"> <tr> <td style="border: none; width: 20%;"></td> <td style="border: none; width: 10%; text-align: center;">—</td> <td style="border: none; width: 20%; text-align: center;">—</td> <td style="border: none; width: 10%; text-align: center;">—</td> <td style="border: none; width: 10%; text-align: center;">—</td> <td style="border: none; width: 10%; text-align: center;">—</td> <td style="border: none; width: 10%; text-align: center;">—</td> <td style="border: none; width: 10%; text-align: center;">—</td> </tr> <tr> <td style="border: none; text-align: center;">Month</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">Day</td> <td style="border: none;"></td> <td style="border: none; text-align: center;">Year</td> <td style="border: none;"></td> <td style="border: none;"></td> <td style="border: none;"></td> </tr> </table> |                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                      |   | — | — | — | — | — | — | — | Month |  | Day |  | Year |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | —                                                   | —                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | —                                                                                                                                                                                                                                                                                                                                                 | —                                                                                                                                                                                                                                                    | — | — | — |   |   |   |   |   |       |  |     |  |      |  |  |  |
| Month                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                     | Day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                   | Year                                                                                                                                                                                                                                                 |   |   |   |   |   |   |   |   |       |  |     |  |      |  |  |  |

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

**SECTION W. SUPPLEMENTAL MDS ITEMS**

|                                                                                                                                     |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| <b>1.</b>                                                                                                                           | <b>National<br/>Provider<br/>ID</b>   | Enter for all assessments and tracking forms, if available.<br><br><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>                                                                                                                                                                          |  |
| 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. |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
| <b>2.</b>                                                                                                                           | <b>Influenza<br/>Vaccine</b>          | <p>a. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)?</p> <p>0. No (If No, go to item W2b)<br/>1. Yes (If Yes, go to item W3)</p> <p>b. If Influenza vaccine not received, state reason:</p> <p>1. Not in facility during this year's flu season<br/>2. Received outside of this facility<br/>3. Not eligible<br/>4. Offered and declined<br/>5. Not offered<br/>6. Inability to obtain vaccine</p> |  |
| <b>3.</b>                                                                                                                           | <b>Pneumo-<br/>coccal<br/>Vaccine</b> | <p>a. Is the resident's PPV status up to date?</p> <p>0. No (If No, go to item W3b)<br/>1. Yes (If Yes, skip item W3b)</p> <p>b. If PPV not received, state reason:</p> <p>1. Not eligible<br/>2. Offered and declined<br/>3. Not offered</p>                                                                                                                                                                                                                                      |  |

## 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

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| <b>1.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>RESIDENT NAME</b> <sup>Ⓞ</sup>                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                        | a. (First)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | b. (Middle Initial) | c. (Last) | d. (Jr/Sr) |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>2.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>GENDER</b> <sup>Ⓞ</sup>                                                                             | 1. Male                      2. Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>3.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>BIRTHDATE</b> <sup>Ⓞ</sup>                                                                          | <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">—</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">—</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">Month</td> <td style="text-align: center; font-size: 8px;">Day</td> <td></td> <td style="text-align: center; font-size: 8px;">Year</td> <td colspan="6"></td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                     |           |            |                                   |             | —                                    |                                  |                                  | — |                                                      |  |  |  | Month | Day |  | Year |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Month                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Day                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Year                |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>4.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>RACE/ETHNICITY</b> <sup>Ⓞ</sup>                                                                     | <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1. American Indian/Alaskan Native</td> <td style="width: 50%;">4. Hispanic</td> </tr> <tr> <td>2. Asian/Pacific Islander</td> <td>5. White, not of Hispanic origin</td> </tr> <tr> <td>3. Black, not of Hispanic origin</td> <td></td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |           |            | 1. American Indian/Alaskan Native | 4. Hispanic | 2. Asian/Pacific Islander            | 5. White, not of Hispanic origin | 3. Black, not of Hispanic origin |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 1. American Indian/Alaskan Native                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 4. Hispanic                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 2. Asian/Pacific Islander                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 5. White, not of Hispanic origin                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 3. Black, not of Hispanic origin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>5.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>SOCIAL SECURITY AND MEDICARE NUMBERS</b> <sup>Ⓞ</sup><br>[C in 1 <sup>st</sup> box if non med. no.] | <table style="width: 100%; border: none;"> <tr> <td colspan="10">a. Social Security Number</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="10">b. Medicare number (or comparable railroad insurance number)</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> |                     |           |            | a. Social Security Number         |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  | b. Medicare number (or comparable railroad insurance number) |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| a. Social Security Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| b. Medicare number (or comparable railroad insurance number)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| <b>6.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>FACILITY PROVIDER NO.</b> <sup>Ⓞ</sup>                                                              | <table style="width: 100%; border: none;"> <tr> <td colspan="10">a. State No.</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="10">b. Federal No.</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>                                                            |                     |           |            | a. State No.                      |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  | b. Federal No.                                               |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| a. State No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| b. Federal No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| <b>7.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>MEDICAID NO.</b> ["+" if pending, "N" if not a Medicaid recipient] <sup>Ⓞ</sup>                     | <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| <b>8.</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>REASONS FOR ASSESSMENT</b>                                                                          | <p>[Note—Other codes do not apply to this form]</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">a. Primary reason for assessment</td> <td style="width: 50%;"></td> </tr> <tr> <td>6. Discharged—return not anticipated</td> <td></td> </tr> <tr> <td>7. Discharged—return anticipated</td> <td></td> </tr> <tr> <td>8. Discharged prior to completing initial assessment</td> <td></td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                     |           |            | a. Primary reason for assessment  |             | 6. Discharged—return not anticipated |                                  | 7. Discharged—return anticipated |   | 8. Discharged prior to completing initial assessment |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| a. Primary reason for assessment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 6. Discharged—return not anticipated                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 7. Discharged—return anticipated                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 8. Discharged prior to completing initial assessment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <b>9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| <p>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.</p> |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature and Title                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                        | Sections                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                     | Date      |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| a.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| b.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| c.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                     |           |            |                                   |             |                                      |                                  |                                  |   |                                                      |  |  |  |       |     |  |      |  |  |  |  |  |  |                                                              |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

#### SECTION AB. DEMOGRAPHIC INFORMATION

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

|                                                   |                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |      |  |   |                                                   |  |                                                |  |                                              |   |                 |  |                        |  |                                         |     |                            |      |          |  |  |  |  |  |
|---------------------------------------------------|---------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--|---|---------------------------------------------------|--|------------------------------------------------|--|----------------------------------------------|---|-----------------|--|------------------------|--|-----------------------------------------|-----|----------------------------|------|----------|--|--|--|--|--|
| <b>1.</b>                                         | <b>DATE OF ENTRY</b>            | <p>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</p> <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">—</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">—</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">Month</td> <td style="text-align: center; font-size: 8px;">Day</td> <td></td> <td style="text-align: center; font-size: 8px;">Year</td> <td colspan="6"></td> </tr> </table> |      |  |   |                                                   |  | —                                              |  |                                              | — |                 |  |                        |  | Month                                   | Day |                            | Year |          |  |  |  |  |  |
|                                                   |                                 | —                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |      |  | — |                                                   |  |                                                |  |                                              |   |                 |  |                        |  |                                         |     |                            |      |          |  |  |  |  |  |
| Month                                             | Day                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Year |  |   |                                                   |  |                                                |  |                                              |   |                 |  |                        |  |                                         |     |                            |      |          |  |  |  |  |  |
| <b>2.</b>                                         | <b>ADMITTED FROM (AT ENTRY)</b> | <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1. Private home/apt. with no home health services</td> <td style="width: 50%;"></td> </tr> <tr> <td>2. Private home/apt. with home health services</td> <td></td> </tr> <tr> <td>3. Board and care/assisted living/group home</td> <td></td> </tr> <tr> <td>4. Nursing home</td> <td></td> </tr> <tr> <td>5. Acute care hospital</td> <td></td> </tr> <tr> <td>6. Psychiatric hospital, MR/DD facility</td> <td></td> </tr> <tr> <td>7. Rehabilitation hospital</td> <td></td> </tr> <tr> <td>8. Other</td> <td></td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |      |  |   | 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 |  |  |  |  |  |
| 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

|           |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|-----------|---------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| <b>6.</b> | <b>MEDICAL RECORD NO.</b> | <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table> |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|           |                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

#### SECTION R. ASSESSMENT/DISCHARGE INFORMATION

|                                                        |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |      |  |   |                                                        |  |                                                     |  |                                   |   |                             |  |                        |  |                                         |     |                            |      |             |  |          |  |  |  |
|--------------------------------------------------------|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------|--|---|--------------------------------------------------------|--|-----------------------------------------------------|--|-----------------------------------|---|-----------------------------|--|------------------------|--|-----------------------------------------|-----|----------------------------|------|-------------|--|----------|--|--|--|
| <b>3.</b>                                              | <b>DISCHARGE STATUS</b> | <p>a. Code for resident disposition upon discharge</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1. Private home/apartment with no home health services</td> <td style="width: 50%;"></td> </tr> <tr> <td>2. Private home/apartment with home health services</td> <td></td> </tr> <tr> <td>3. Board and care/assisted living</td> <td></td> </tr> <tr> <td>4. Another nursing facility</td> <td></td> </tr> <tr> <td>5. Acute care hospital</td> <td></td> </tr> <tr> <td>6. Psychiatric hospital, MR/DD facility</td> <td></td> </tr> <tr> <td>7. Rehabilitation hospital</td> <td></td> </tr> <tr> <td>8. Deceased</td> <td></td> </tr> <tr> <td>9. Other</td> <td></td> </tr> </table> <p>b. Optional State Code</p>                                                                                                                                                                                                                                                      |      |  |   | 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 |  |  |  |
| 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                                               |                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |      |  |   |                                                        |  |                                                     |  |                                   |   |                             |  |                        |  |                                         |     |                            |      |             |  |          |  |  |  |
| <b>4.</b>                                              | <b>DISCHARGE DATE</b>   | <p>Date of death or discharge</p> <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">—</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; padding: 0 5px;">—</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 8px;">Month</td> <td style="text-align: center; font-size: 8px;">Day</td> <td></td> <td style="text-align: center; font-size: 8px;">Year</td> <td colspan="6"></td> </tr> </table> |      |  |   |                                                        |  | —                                                   |  |                                   | — |                             |  |                        |  | Month                                   | Day |                            | Year |             |  |          |  |  |  |
|                                                        |                         | —                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |      |  | — |                                                        |  |                                                     |  |                                   |   |                             |  |                        |  |                                         |     |                            |      |             |  |          |  |  |  |
| Month                                                  | Day                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Year |  |   |                                                        |  |                                                     |  |                                   |   |                             |  |                        |  |                                         |     |                            |      |             |  |          |  |  |  |

Ⓞ = Key items for computerized resident tracking

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

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

**SECTION W. SUPPLEMENTAL MDS ITEMS**

|                                                                                                                                     |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |
|-------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1.                                                                                                                                  | <b>National<br/>Provider<br/>ID</b>   | Enter for all assessments and tracking forms, if available.<br><br><div style="border: 1px solid black; width: 100px; height: 15px; margin: 0 auto;"></div>                                                                                                                                                                                                                                                                                                                                                                              |  |
| 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.                                                                                                                                  | <b>Influenza<br/>Vaccine</b>          | <p>a. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)?</p> <p style="margin-left: 20px;">0. No (If No, go to item W2b)<br/>1. Yes (If Yes, go to item W3)</p> <p>b. If Influenza vaccine not received, state reason:</p> <p style="margin-left: 20px;">1. Not in facility during this year's flu season<br/>2. Received outside of this facility<br/>3. Not eligible<br/>4. Offered and declined<br/>5. Not offered<br/>6. Inability to obtain vaccine</p> |  |
| 3.                                                                                                                                  | <b>Pneumo-<br/>coccal<br/>Vaccine</b> | <p>a. Is the resident's PPV status up to date?</p> <p style="margin-left: 20px;">0. No (If No, go to item W3b)<br/>1. Yes (If Yes, skip item W3b)</p> <p>b. If PPV not received, state reason:</p> <p style="margin-left: 20px;">1. Not eligible<br/>2. Offered and declined<br/>3. Not offered</p>                                                                                                                                                                                                                                      |  |

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

### REENTRY TRACKING FORM

#### SECTION AA. IDENTIFICATION INFORMATION

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     |           |            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------|------------|
| 1.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>RESIDENT NAME</b> <sup>Ⓞ</sup>                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     |           |            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        | a. (First)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | b. (Middle Initial) | c. (Last) | d. (Jr/Sr) |
| 2.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>GENDER</b> <sup>Ⓞ</sup>                                                                             | 1. Male                      2. Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |           |            |
| 3.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>BIRTHDATE</b> <sup>Ⓞ</sup>                                                                          | <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/><br>Month                      Day                      Year                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                     |           |            |
| 4.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>RACE/ETHNICITY</b> <sup>Ⓞ</sup>                                                                     | 1. American Indian/Alaskan Native                      4. Hispanic<br>2. Asian/Pacific Islander                                      5. White, not of Hispanic origin<br>3. Black, not of Hispanic origin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                     |           |            |
| 5.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>SOCIAL SECURITY AND MEDICARE NUMBERS</b> <sup>Ⓞ</sup><br>[C in 1 <sup>st</sup> box if non med. no.] | a. Social Security Number<br><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> — <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/><br>b. Medicare number (or comparable railroad insurance number)<br><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> |                     |           |            |
| 6.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>FACILITY PROVIDER NO.</b> <sup>Ⓞ</sup>                                                              | a. State No.<br><input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>                                                                                                                                                                                                                                                                                                                            |                     |           |            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        | b. Federal No. <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>                                                                                                                                                                                                                                                                                                                             |                     |           |            |
| 7.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>MEDICAID NO.</b> ["+" if pending, "N" if not a Medicaid recipient] <sup>Ⓞ</sup>                     | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>                                                                                                                                                                                                                                                                                                                                            |                     |           |            |
| 8.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <b>REASONS FOR ASSESSMENT</b>                                                                          | [Note—Other codes do not apply to this form]<br>a. Primary reason for assessment<br><br>9. Reentry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                     |           |            |
| <b>9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     |           |            |
| I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf. |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     |           |            |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                        | Signature and Title                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Sections            | Date      |            |
| a.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     |           |            |
| b.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     |           |            |
| c.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                     |           |            |

#### SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

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

Ⓞ = Key items for computerized resident tracking

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

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

**SECTION W. SUPPLEMENTAL MDS ITEMS**

|    |                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
|----|---------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| 1. | <b>National<br/>Provider<br/>ID</b>   | Enter for all assessments and tracking forms, if available.<br><div style="border: 1px solid black; display: inline-block; width: 100px; height: 15px; margin-top: 5px;"></div>                                                                                                                                                                                                                                                                                    |  |
|    |                                       | 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. | <b>Influenza<br/>Vaccine</b>          | a . Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)?<br><br>0. No (If No, go to item W2b)<br>1. Yes (If Yes, go to item W3)<br><br>b. If Influenza vaccine not received, state reason:<br>1. Not in facility during this year's flu season<br>2. Received outside of this facility<br>3. Not eligible<br>4. Offered and declined<br>5. Not offered<br>6. Inability to obtain vaccine |  |
| 3. | <b>Pneumo-<br/>coccal<br/>Vaccine</b> | a. Is the resident's PPV status up to date?<br>0. No (If No, go to item W3b)<br>1. Yes (If Yes, skip item W3b)<br><br>b. If PPV not received, state reason:<br>1. Not eligible<br>2. Offered and declined<br>3. Not offered                                                                                                                                                                                                                                        |  |

# MINIMUM DATA SET (MDS) — VERSION 2.0

## FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

### Correction Request Form

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

**TO MODIFY A RECORD IN THE STATE DATABASE:**

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

**TO INACTIVATE A RECORD IN THE STATE DATABASE:**

1. Complete this correction request form;
2. Create an electronic record of the Correction Request Form; and
3. Electronically submit this Correction Request record to the MDS database at the State.

**PRIOR RECORD SECTION.**

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

|               |                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |           |            |      |  |  |  |  |  |  |  |       |     |  |  |  |  |      |
|---------------|----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------|------------|------|--|--|--|--|--|--|--|-------|-----|--|--|--|--|------|
| Prior<br>AA1. | <b>RESIDENT NAME</b>             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |           |            |      |  |  |  |  |  |  |  |       |     |  |  |  |  |      |
|               |                                  | a. (First)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | b. (Middle Initial) | c. (Last) | d. (Jr/Sr) |      |  |  |  |  |  |  |  |       |     |  |  |  |  |      |
| Prior<br>AA2. | <b>GENDER</b>                    | 1. Male                      2. Female                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                     |           |            |      |  |  |  |  |  |  |  |       |     |  |  |  |  |      |
| Prior<br>AA3. | <b>BIRTHDATE</b>                 | <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td colspan="4"></td> <td style="text-align: center;">Year</td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                     |           |            |      |  |  |  |  |  |  |  | Month | Day |  |  |  |  | Year |
|               |                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |           |            |      |  |  |  |  |  |  |  |       |     |  |  |  |  |      |
| Month         | Day                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |           |            | Year |  |  |  |  |  |  |  |       |     |  |  |  |  |      |
| Prior<br>AA5. | <b>SOCIAL SECURITY</b>           | a. Social Security Number                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                     |           |            |      |  |  |  |  |  |  |  |       |     |  |  |  |  |      |
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|               |                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |           |            |      |  |  |  |  |  |  |  |       |     |  |  |  |  |      |
| Prior<br>AA8. | <b>REASONS FOR ASSESSMENT</b>    | <p>a. Primary reason for assessment ASSESSMENT (Complete Prior Date item Prior A3a ONLY)</p> <ol style="list-style-type: none"> <li>1. Admission assessment (required by day 14)</li> <li>2. Annual assessment</li> <li>3. Significant change in status assessment</li> <li>4. Significant correction of prior full assessment</li> <li>5. Quarterly review assessment</li> <li>10. Significant correction of prior quarterly assessment</li> <li>0. NONE OF ABOVE</li> </ol> <p>DISCHARGE TRACKING (Complete Prior Date item Prior R4 ONLY)</p> <ol style="list-style-type: none"> <li>6. Discharged—return not anticipated</li> <li>7. Discharged—return anticipated</li> <li>8. Discharged prior to completing initial assessment</li> </ol> <p>REENTRY TRACKING (Complete Prior Date item Prior A4a ONLY)</p> <ol style="list-style-type: none"> <li>9. Reentry</li> </ol> <p>b. Codes for assessments required for Medicare PPS or the State</p> <ol style="list-style-type: none"> <li>1. Medicare 5 day assessment</li> <li>2. Medicare 30 day assessment</li> <li>3. Medicare 60 day assessment</li> <li>4. Medicare 90 day assessment</li> <li>5. Medicare readmission/return assessment</li> <li>6. Other state required assessment</li> <li>7. Medicare 14 day assessment</li> <li>8. Other Medicare required assessment</li> </ol> |                     |           |            |      |  |  |  |  |  |  |  |       |     |  |  |  |  |      |
|               | <b>PRIOR DATE</b>                | (Complete one only)<br>Complete Prior A3a if Primary Reason (Prior AA8a) equals 1, 2, 3, 4, 5, 10, or 0.<br>Complete Prior R4 if Primary Reason (Prior AA8a) equals 6, 7, or 8.<br>Complete Prior A4a if Primary Reason (Prior AA8a) equals 9.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                     |           |            |      |  |  |  |  |  |  |  |       |     |  |  |  |  |      |
| Prior<br>A3.  | <b>ASSESSMENT REFERENCE DATE</b> | a. Last day of MDS observation period                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                     |           |            |      |  |  |  |  |  |  |  |       |     |  |  |  |  |      |
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|               |                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |           |            |      |  |  |  |  |  |  |  |       |     |  |  |  |  |      |
| Month         | Day                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |           |            | Year |  |  |  |  |  |  |  |       |     |  |  |  |  |      |
| Prior<br>R4.  | <b>DISCHARGE DATE</b>            | Date of discharge                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                     |           |            |      |  |  |  |  |  |  |  |       |     |  |  |  |  |      |
|               |                                  | <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td colspan="4"></td> <td style="text-align: center;">Year</td> </tr> </table>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                     |           |            |      |  |  |  |  |  |  |  | Month | Day |  |  |  |  | Year |
|               |                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |           |            |      |  |  |  |  |  |  |  |       |     |  |  |  |  |      |
| Month         | Day                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |           |            | Year |  |  |  |  |  |  |  |       |     |  |  |  |  |      |
| Prior<br>A4a. | <b>DATE OF REENTRY</b>           | Date of reentry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |           |            |      |  |  |  |  |  |  |  |       |     |  |  |  |  |      |
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|               |                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |           |            |      |  |  |  |  |  |  |  |       |     |  |  |  |  |      |
| Month         | Day                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                     |           |            | Year |  |  |  |  |  |  |  |       |     |  |  |  |  |      |

|      |                                 |                                                                                                                                                                                                                                                                                                                                                                               |  |
|------|---------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| AT3. | <b>REASONS FOR MODIFICATION</b> | <p>(If AT2=1, check at least one of the following reasons; check all that apply, then skip to AT5)</p> <ol style="list-style-type: none"> <li>a. Transcription error</li> <li>b. Data entry error</li> <li>c. Software product error</li> <li>d. Item coding error</li> <li>e. Other error<br/>If "Other" checked, please specify: _____</li> </ol>                           |  |
| AT4. | <b>REASONS FOR INACTIVATION</b> | <p>(If AT2=2, check at least one of the following reasons; check all that apply)</p> <ol style="list-style-type: none"> <li>a. Test record submitted as production record</li> <li>b. Event did not occur</li> <li>c. Inadvertent submission of inappropriate record</li> <li>d. Other reason requiring inactivation<br/>If "Other" checked, please specify: _____</li> </ol> |  |

**RN COORDINATOR ATTESTATION OF COMPLETION**

|       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |            |  |      |  |  |  |  |  |  |       |     |  |  |  |  |      |
|-------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|------------|--|------|--|--|--|--|--|--|-------|-----|--|--|--|--|------|
| AT5.  | <b>ATTESTING INDIVIDUAL NAME</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |            |  |      |  |  |  |  |  |  |       |     |  |  |  |  |      |
|       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | a. (First)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | b. (Last)        | c. (Title) |  |      |  |  |  |  |  |  |       |     |  |  |  |  |      |
|       | <b>SIGNATURE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |            |  |      |  |  |  |  |  |  |       |     |  |  |  |  |      |
| AT6.  | <b>ATTESTATION DATE</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | <table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td colspan="4"></td> <td style="text-align: center;">Year</td> </tr> </table> |                  |            |  |      |  |  |  |  |  |  | Month | Day |  |  |  |  | Year |
|       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |            |  |      |  |  |  |  |  |  |       |     |  |  |  |  |      |
| Month | Day                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |            |  | Year |  |  |  |  |  |  |       |     |  |  |  |  |      |
| AT7.  | <b>ATTESTATION OF ACCURACY AND SIGNATURES OF PERSONS WHO CORRECT A PORTION OF ASSESSMENT OR TRACKING INFORMATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |            |  |      |  |  |  |  |  |  |       |     |  |  |  |  |      |
|       | <p>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.</p> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |            |  |      |  |  |  |  |  |  |       |     |  |  |  |  |      |
|       | Signature and Title                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Attestation Date |            |  |      |  |  |  |  |  |  |       |     |  |  |  |  |      |
|       | a.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |            |  |      |  |  |  |  |  |  |       |     |  |  |  |  |      |
|       | b.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |            |  |      |  |  |  |  |  |  |       |     |  |  |  |  |      |
|       | c.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |            |  |      |  |  |  |  |  |  |       |     |  |  |  |  |      |
|       | d.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |            |  |      |  |  |  |  |  |  |       |     |  |  |  |  |      |
|       | e.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |            |  |      |  |  |  |  |  |  |       |     |  |  |  |  |      |
|       | f.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                  |            |  |      |  |  |  |  |  |  |       |     |  |  |  |  |      |

**CORRECTION ATTESTATION SECTION.**

COMPLETE THIS SECTION TO EXPLAIN AND ATTEST TO THE CORRECT REQUEST

|      |                                    |                                                                                                                                                                                                                                                                                                                                                         |  |
|------|------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|
| AT1. | <b>ATTESTATION SEQUENCE NUMBER</b> | (Enter total number of attestations for this record, including the present one)                                                                                                                                                                                                                                                                         |  |
| AT2. | <b>ACTION REQUESTED</b>            | <ol style="list-style-type: none"> <li>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.)</li> <li>2. INACTIVE record in error. (Do NOT submit an assessment or tracking form. Submit the correction request only. Skip to item AT4.)</li> </ol> |  |

