

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

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME[Ⓞ]																																												
		a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)																																								
2.	GENDER[Ⓞ]	1. Male 2. Female																																											
3.	BIRTHDATE[Ⓞ]	<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; text-align: center;">—</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; text-align: center;">—</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: small;">Month</td> <td></td> <td></td> <td style="text-align: center; font-size: small;">Day</td> <td></td> <td></td> <td style="text-align: center; font-size: small;">Year</td> <td></td> <td></td> <td></td> </tr> </table>						—			—					Month			Day			Year																							
		—			—																																								
Month			Day			Year																																							
4.	RACE/[Ⓞ] ETHNICITY	<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																																													
5.	SOCIAL SECURITY[Ⓞ] AND MEDICARE NUMBERS[Ⓞ] [C in 1 st 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																																													
b. Medicare number (or comparable railroad insurance number)																																													
6.	FACILITY PROVIDER NO.[Ⓞ]	<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.																																													
b. Federal No.																																													
7.	MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient][Ⓞ]	<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>																																											
8.	REASONS FOR ASSESSMENT	<p>[Note—Other codes do not apply to this form]</p> <p>a. Primary reason for assessment</p> <ol style="list-style-type: none"> 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. NONE OF ABOVE <p>b. Codes for assessments required for Medicare PPS or the State</p> <ol style="list-style-type: none"> 1. Medicare 5 day assessment 2. Medicare 30 day assessment 3. Medicare 60 day assessment 4. Medicare 90 day assessment 5. Medicare readmission/return assessment 6. Other state required assessment 7. Medicare 14 day assessment 8. Other Medicare required assessment 																																											

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

GENERAL INSTRUCTIONS

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

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

SECTION AC. CUSTOMARY ROUTINE

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

SECTION AD. FACE SHEET SIGNATURES

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

SECTION D. VISION PATTERNS

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

SECTION E. MOOD AND BEHAVIOR PATTERNS

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

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

SECTION F. PSYCHOSOCIAL WELL-BEING

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

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

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

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

SECTION H. CONTINENCE IN LAST 14 DAYS

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

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

SECTION J. HEALTH CONDITIONS

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

SECTION M. SKIN CONDITION

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

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

SECTION K. ORAL/NUTRITIONAL STATUS

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

SECTION L. ORAL/DENTAL STATUS

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

SECTION N. ACTIVITY PURSUIT PATTERNS

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

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

SECTION O. MEDICATIONS

1. NUMBER OF MEDICATIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used)		
2. NEW MEDICATIONS	(Resident currently receiving medications that were initiated during the last 90 days) 0. No 1. Yes		
3. INJECTIONS	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)		
4. DAYS RECEIVED THE FOLLOWING MEDICATION	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) [Note—count only post admission therapies]				
(A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in last 7 days				
			DAYS MIN (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:) 0. Not used 1. Used less than daily 2. Used daily	
	Bed rails	
	a. — Full bed rails on all open sides of bed	
	b. — Other types of side rails used (e.g., half rail, one side)	
	c. Trunk restraint	
	d. Limb restraint	
	e. Chair prevents rising	
5. HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no hospital admissions)	
6. EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no ER visits)	
7. PHYSICIAN VISITS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter 0 if none)	
8. PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter 0 if none)	
9. ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission)? 0. No 1. Yes	

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1. DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0. No 1. Yes	
	b. Resident has a support person who is positive towards discharge 0. No 1. Yes	
	c. Stay projected to be of a short duration— discharge projected within 90 days (do not include expected discharge due to death) 0. No 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) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support	

SECTION R. ASSESSMENT INFORMATION

1. PARTICIPATION IN ASSESSMENT	a. Resident:	0. No	1. Yes
	b. Family:	0. No	1. Yes 2. No family
	c. Significant other:	0. No	1. Yes 2. None
2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:			
a. Signature of RN Assessment Coordinator (sign on above line)			
b. Date RN Assessment Coordinator signed as complete			
		Month	Day Year

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 (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? 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"> Resident received physical therapy involving gait training (P.1.b.c) Physical therapy was ordered for the resident involving gait training (T.1.b) Resident received nursing rehabilitation for walking (P.3.f) Physical therapy involving walking has been discontinued within the past 180 days <p><i>Skip to item 3 if resident did not walk in last 7 days</i></p> <p>(FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)</p> <p>a. Furthest distance walked without sitting down during this episode.</p> <table border="0"> <tr> <td>0. 150+ feet</td> <td>3. 10-25 feet</td> </tr> <tr> <td>1. 51-149 feet</td> <td>4. Less than 10 feet</td> </tr> <tr> <td>2. 26-50 feet</td> <td></td> </tr> </table> <p>b. Time walked without sitting down during this episode.</p> <table border="0"> <tr> <td>0. 1-2 minutes</td> <td>3. 11-15 minutes</td> </tr> <tr> <td>1. 3-4 minutes</td> <td>4. 16-30 minutes</td> </tr> <tr> <td>2. 5-10 minutes</td> <td>5. 31+ minutes</td> </tr> </table> <p>c. Self-Performance in walking during this episode.</p> <p>0. INDEPENDENT—No help or oversight 1. SUPERVISION—Oversight, encouragement or cueing provided 2. LIMITED ASSISTANCE—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3. EXTENSIVE ASSISTANCE—Resident received weight bearing assistance while walking</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 1. Setup help only 2. One person physical assist 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>												

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/ REHABILITATION POTENTIAL	<input type="checkbox"/>		<input type="checkbox"/>
6. URINARY INCONTINENCE AND 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	ADL-Maintenance Trigger A @	Urinary Incontinence Trigger B @	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	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

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

E1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (cont.)	VERBAL EXPRESSIONS OF DISTRESS f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues	SLEEP-CYCLE ISSUES j. Unpleasant mood in morning k. Insomnia/change in usual sleep pattern SAD, APATHETIC, ANXIOUS APPEARANCE l. Sad, pained, worried facial expressions—e.g., furrowed brows m. Crying, tearfulness n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking LOSS OF INTEREST o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends p. Reduced social interaction
E2.	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood indicators present, indicators easily altered 1. Indicators present, not easily altered	
E4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequency in last 7 days 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) Behavioral symptom alterability in last 7 days 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered	(A) (B)
G1.	(A) ADL SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)	0. INDEPENDENT—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days 1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days 2. LIMITED ASSISTANCE—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days 3. EXTENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: —Weight-bearing support — Full staff performance during part (but not all) of last 7 days 4. TOTAL DEPENDENCE—Full staff performance of activity during entire 7 days 8. ACTIVITY DID NOT OCCUR during entire 7 days	(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.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		
G2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) Code for most dependent in self-performance. (A) BATHING SELF PERFORMANCE codes appear below 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	(A)	
G4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION	(Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury) (A) RANGE OF MOTION 0. No limitation 1. Limitation on one side 2. Limitation on both sides (B) VOLUNTARY MOVEMENT 0. No loss 1. Partial loss 2. Full loss	(A) (B)	
G6.	MODES OF TRANSFER	(Check all that apply during last 7 days) Bedfast all or most of time Bed rails used for bed mobility or transfer	a. NONE OF ABOVE b.	f.
H1.	CONTINENCE SELF-CONTROL CATEGORIES (Code for resident's PERFORMANCE OVER ALL SHIFTS) 0. CONTINENT—Complete control [includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool] 1. USUALLY CONTINENT—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. OCCASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not daily; BOWEL, once a week 3. FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week 4. INCONTINENT—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time			
a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed		
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed		
H2.	BOWEL ELIMINATION PATTERN	Fecal impaction	d. NONE OF ABOVE	e.
H3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan Bladder retraining program External (condom) catheter	a. Indwelling catheter b. Ostomy present c. NONE OF ABOVE	d. i. j.
I2.	INFECTIONS	Urinary tract infection in last 30 days	j. NONE OF ABOVE	m.
I3.	OTHER CURRENT DIAGNOSES AND ICD-9 CODES	(Include only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death) a. _____ b. _____		
J1.	PROBLEM CONDITIONS	(Check all problems present in last 7 days) Dehydrated; output exceeds input Hallucinations	c. NONE OF ABOVE	i. p.
J2.	PAIN SYMPTOMS	(Code the highest level of pain present in the last 7 days) a. FREQUENCY with which resident complains or shows evidence of pain 0. No pain (skip to J4) 1. Pain less than daily 2. Pain daily b. INTENSITY of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating		
J4.	ACCIDENTS	(Check all that apply) Fell in past 30 days Fell in past 31-180 days	a. Hip fracture in last 180 days b. Other fracture in last 180 days c. NONE OF ABOVE	c. d. e.

J5.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating) Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem End-stage disease, 6 or fewer months to live NONE OF ABOVE	a. b. c. d.
K3.	WEIGHT CHANGE	a. Weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes	
K5.	NUTRITIONAL APPROACHES	Feeding tube On a planned weight change program NONE OF ABOVE	b. h. i.
M1.	ULCERS (Due to any cause)	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.] a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue. d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	Number at Stage
M2.	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4) a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
N1.	TIME AWAKE	(Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning a. Evening c. Afternoon b. NONE OF ABOVE d.	
(If resident is comatose, skip to Section O)			
N2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None	
O1.	NUMBER OF MEDICATIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used)	
O4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly) a. Antipsychotic b. Antianxiety c. Antidepressant d. Hypnotic e. Diuretic	
P4.	DEVICES AND RESTRAINTS	Use the following codes for last 7 days: 0. Not used 1. Used less than daily 2. Used daily Bed rails a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side) c. Trunk restraint d. Limb restraint e. Chair prevents rising	
Q2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support	
R2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:			
a. Signature of RN Assessment Coordinator (sign on above line)			
b. Date RN Assessment Coordinator signed as complete _____ Month Day Year			

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

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

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

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

K5.	NUTRITIONAL APPROACHES	(Check all that apply in last 7 days) Parenteral/IV Feeding tube	a. <input type="checkbox"/> On a planned weight change program b. <input type="checkbox"/> NONE OF ABOVE	h. <input type="checkbox"/> i. <input type="checkbox"/>
K6.	PARENTERAL OR ENTERAL INTAKE	(Skip to Section M if neither 5a nor 5b is checked) a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days 0. None 1. 1% to 25% 2. 26% to 50% 3. 51% to 75% 4. 76% to 100% b. Code the average fluid intake per day by IV or tube in last 7 days 0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day		
M1.	ULCERS (Due to any cause)	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.] a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue. d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	Number at Stage	
M2.	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4) a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities		
M4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT (Check all that apply during last 7 days)	Abrasions, bruises Burns (second or third degree) Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster Skin desensitized to pain or pressure Skin tears or cuts (other than surgery) Surgical wounds NONE OF ABOVE	a. <input type="checkbox"/> b. <input type="checkbox"/> c. <input type="checkbox"/> d. <input type="checkbox"/> e. <input type="checkbox"/> f. <input type="checkbox"/> g. <input type="checkbox"/> h. <input type="checkbox"/>	
M5.	SKIN TREATMENTS (Check all that apply during last 7 days)	Pressure relieving device(s) for chair Pressure relieving device(s) for bed Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE	a. <input type="checkbox"/> b. <input type="checkbox"/> c. <input type="checkbox"/> d. <input type="checkbox"/> e. <input type="checkbox"/> f. <input type="checkbox"/> g. <input type="checkbox"/> h. <input type="checkbox"/> i. <input type="checkbox"/> j. <input type="checkbox"/>	
M6.	FOOT PROBLEMS AND CARE (Check all that apply during last 7 days)	Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE	a. <input type="checkbox"/> b. <input type="checkbox"/> c. <input type="checkbox"/> d. <input type="checkbox"/> e. <input type="checkbox"/> f. <input type="checkbox"/> g. <input type="checkbox"/>	
N1.	TIME AWAKE	(Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning Evening Afternoon NONE OF ABOVE	a. <input type="checkbox"/> b. <input type="checkbox"/>	c. <input type="checkbox"/> d. <input type="checkbox"/>
(If resident is comatose, skip to Section O)				
N2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 3. None		
O1.	NUMBER OF MEDICATIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used)		
O3.	INJECTIONS	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)		
O4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly) a. Antipsychotic b. Antianxiety c. Antidepressant d. Hypnotic e. Diuretic		

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

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

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME [Ⓞ]																																												
		a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)																																								
2.	GENDER [Ⓞ]	1. Male 2. Female																																											
3.	BIRTHDATE [Ⓞ]	<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; text-align: center;">—</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; text-align: center;">—</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																																										
4.	RACE/ETHNICITY [Ⓞ]	<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																																													
5.	SOCIAL SECURITY AND MEDICARE NUMBERS [Ⓞ] [C in 1 st 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																																													
b. Medicare number (or comparable railroad insurance number)																																													
6.	FACILITY PROVIDER NO. [Ⓞ]	<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.																																													
b. Federal No.																																													
7.	MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] [Ⓞ]	<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>																																											
8.	REASONS FOR ASSESSMENT	<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																																													
9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form																																													
<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)

1.	DATE OF ENTRY	<p><i>Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date</i></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; text-align: center;">—</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; text-align: center;">—</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																						
2.	ADMITTED FROM (AT ENTRY)	<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

6.	MEDICAL RECORD NO.	<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>																		

SECTION R. ASSESSMENT/DISCHARGE INFORMATION

3.	DISCHARGE STATUS	<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																									
4.	DISCHARGE DATE	<p><i>Date of death or discharge</i></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; text-align: center;">—</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; text-align: center;">—</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

REENTRY TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

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

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

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

Correction Request Form

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

TO MODIFY A RECORD IN THE STATE DATABASE:

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

TO INACTIVATE A RECORD IN THE STATE DATABASE:

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

PRIOR RECORD SECTION.

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

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

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

RN COORDINATOR ATTESTATION OF COMPLETION

AT5.	ATTESTING INDIVIDUAL NAME															
		a. (First)	b. (Last)	c. (Title)												
	SIGNATURE															
AT6.	ATTESTATION DATE	<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> </tr> <tr> <td style="text-align: center;">Month</td> <td style="text-align: center;">Day</td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table>									Month	Day	Year			
Month	Day	Year														
AT7.	ATTESTATION OF ACCURACY AND SIGNATURES OF PERSONS WHO CORRECT A PORTION OF ASSESSMENT OR TRACKING INFORMATION															
	<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.	ATTESTATION SEQUENCE NUMBER	(Enter total number of attestations for this record, including the present one)	
AT2.	ACTION REQUESTED	<ol style="list-style-type: none"> 1. MODIFY record in error. (Attach and submit a COMPLETE assessment or tracking form. Do NOT submit the corrected items ONLY. Proceed to item AT3 below.) 2. INACTIVE record in error. (Do NOT submit an assessment or tracking form. Submit the correction request only. Skip to item AT4.) 	

