MINIMUM DATA SET (MDS)

DRAFT VERSION 3.0
Proposed for validation

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

April 2, 2003

SECTION A. IDENTIFICATION INFORMATION							
Source							
MDS-PAC	**A1.**	**LEGAL NAME OF RESIDENT**	a. (First) b. (Middle Initial) c. (Last) d. (suffix)				
MDS-PAC	**A2.**	**SOCIAL SECURITY & MEDICARE NUMBERS**	a. Social Security Number __ __ __ - __ __ - __ __ __ __				
			b. Medicare number (or comparable railroad insurance number) __ __ __ __ __ __ __ __ __ __ __ __ __				
MDS-PAC	**A3.**	**GENDER** Complete only upon admission or if a change occurs	1. Male 2. Female				
MDS-PAC	**A4.**	**BIRTHDATE** Complete only upon admission or if a change occurs	__ __ - __ __ - __ __ __ __ month day year				
MDS-PAC	**A5.**	**RACE/ ETHNICITY** Complete only upon admission or if a change occurs	(Check all that apply)				
			American Indian/Alaskan Native	a.	Hispanic or Latino	d.	
			Asian	b.	Native Hawaiian or other Pacific Islander	e.	
			Black or African-American	c.	White	f.	
MDS 2.0 SectionAB	**A6.**	**MARITAL STATUS** Complete only upon admission or if a change occurs	1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated				
MDS-PAC	**A7.**	**FACILITY PROVIDER NUMBERS** Complete only upon admission or if a change occurs	a. Federal Number __ __ __ __ __ __ __ __ __ __ __ __				
			b. State Number __ __ __ __ __ __ __ __ __ __ __ __ __ __				
MDS-PAC	**A8.**	**MEDICAID NUMBER** Complete only upon admission or if a change occurs	["+" if pending, "N" if not a Medicaid recipient] __ __ __ __ __ __ __ __ __ __ __ __ __				
MDS-PAC	**A9.**	**MEDICAL RECORD NUMBER** Complete only upon admission or if a change occurs	__ __ __ __ __ __ __ __ __ __ __ __				
MDS tracking form	**A10.**	**DATE OF MOST RECENT ADMISSION**	__ __ - __ __ - __ __ __ __ month day year				
Swing bed And Added Pediatric Assessment	**A11.**	**REASON(s) FOR ASSESSMENT**	**a. Type of Facility** **1. Nursing Home** **2. Hospital Swing Bed Unit**				
			b. Special Pediatric Assessment (under 21 years) **0. No 1. Yes**				

SECTION A. IDENTIFICATION INFORMATION				
Source				
			c. Primary Reason for Assessment **OBRA REQUIRED ASSESSMENTS (nursing home)** 01. Admission assessment (required by day 14) 02. Quarterly review assessment 03. Annual assessment 04. Significant change in status assessment 05. Significant correction to prior full assessment 06. Significant correction of prior quarterly assessment **DISCHARGE/ REENTRY TRACKING (nursing home or swing bed)** 10. Discharge transaction- return not anticipated 11. Discharge transaction- return anticipated 12. Discharge prior to completing initial assessment- no return anticipated 13. Discharge prior to completing initial assessment- return anticipated 20. Reentry transaction **NONE OF ABOVE** **90. Other type of assessment/transaction**	
			d. PPS Scheduled Assessments (nursing home or swing bed) **01. 5-day assessment** **02. 14-day assessment** **03. 30-day assessment** **04. 60-day assessment** **05. 90-day assessment** **06. Readmission/return assessment** **07. Swing bed clinical change** **90. Not PPS scheduled assessment**	
			bed) **0. No 1. Yes**	
NEW	**A12.**	**SUBMISSION REQUIREMENT**	**a. Federal or State Required Assessment/Transaction** **0. No 1. Yes**	
			b. State Required Assessment/ Transaction **0. No 1. Yes**	
			c. Assessment/ Transaction Needed for Other Reasons (e.g. HMO, other insurance, etc.) **0. No 1. Yes**	
NEW	**A13.**	**MEDICARE STAY** Code Only if A11d = 01 or 06	**Start date of most recent Medicare stay** __ __ - __ __ - __ __ __ __ **month day year**	
MDS 2.0 moved from Section A	**A14.**	**ASSESSMENT REFERENCE DATE**	**a.** Observation end date __ __ - __ __ - __ __ __ __ Day Month Year **b.** Original (00) or corrected copy of form (enter number of correction)	

SECTION A. IDENTIFICATION INFORMATION

Source				
Swing bed	**A15.**	**ADMISSION/ DISCHARGE STATUS CODE**	**01. Private Home/apt with no home health care** **02. Private Home/apt with home health care** **03. Board and Care/ assisted living/ Group home** **04. Another nursing home** **05. Acute unit at own hospital** **06. Acute unit at another hospital** **07. Psychiatric hospital** **08. Rehabilitation hospital** **09. MR/DD facility** **10. Hospice** **11. Deceased** **12. Other**	
			a. Admitted from--complete if item A11c=01,12,13 OR A11d= 01, 06	
			b. Discharge status--complete if item **A11c** = 10,11,12,13	
Swing bed	**A16.**	**DISCHARGE DATE** Complete if item A11c= 10,11	__ __ - __ __ - __ __ __ __ **month day year**	
Swing bed	**A17.**	**REENTRY DATE** Complete if item A11c= 20	__ __ - __ __ - __ __ __ __ **month day year**	
MDS 2.0 Required for ICF/MR	A18.	**MENTAL HEALTH HISTORY** Complete only upon admission	Does resident's record indicate any history of mental retardation, mental illness or developmental disability problem? 0. No 1. Yes	
MDS 2.0 Required for ICF/MR	A19.	**CONDITIONS RELATED TO MR/DD STATUS** Complete only upon admission	(Check all conditions that are related to MR/DD status that were manifested before age 22 and are likely to continue indefinitely)	
			a. Not applicable- no MR/DD	a.
			b. Down's syndrome	b.
			c. Autism	c.
			d. Epilepsy	d.
			e. Other organic condition related to MR/DD	e.
			f. MR/DD with no organic condition	f.
MDS 2.0 and NEW	**A20.**	**CASE MIX GROUP**	**Medicare ___ ___ ___ ___ ___ (calculated automatically by software)** **State ___ ___ ___ ___ ___ (calculated automatically by software)** **HIPPS Code ___ ___ ___ ___ ___ (must be filled in by NH)**	
MDS 2.0	**A21.**	**SIGNATURE OF PERSONS COMPLETING THE ASSESSMENT**:		
		I certify that the accompanying information accurately reflects resident assessment 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.	
		a.Signature of RN Assessment Coordinator		
		b. Date RN Assessment Coordinator (sign on above line) signed as complete	__ __ - __ __ - __ __ __ __ month day year	

SECTION A. IDENTIFICATION INFORMATION					
Source					
		Other Signatures	Title	Sections	Date
		c.			
		d.			
		e.			
		f.			
		g.			
		h.			
		i.			
		j.			
		k.			
		l.			
		m.			

SECTION B. COGNITIVE/BEHAVIORAL PATTERNS				
Source				
MDS PAC	**B1.**	**COMATOSE**	**(Persistent vegetative state/no discernible consciousness)** **0. No 1.Yes (If yes, Skip to Section G)**	
MDS PAC	**B2.**	**MEMORY/ RECALL ABILITY (Over last 7days)**	**1. (CODE for recall of what was learned or known)** **0. Memory OK 1. Memory problem**	
			a. Short-term memory OK—Seems/appears to recall after 5 minutes	
			b. Long-term memory OK- seems/appears to recall long past	
MDS PAC	**B3.**	**COGNITIVE SKILLS FOR DAILY DECISION MAKING** (Over last 7 days)	**Making decisions regarding tasks of daily life** **0. INDEPENDENT—Decisions are consistent, reasonable, safe** **1. MODIFIED INDEPENDENCE—Some difficulty in new situations only** **2. MINIMALLY IMPAIRED—In specific situations, decisions become poor or unsafe and cues/supervision necessary at those times** **3. MODERATELY IMPAIRED—Decisions consistently poor or unsafe, cues/supervision required at all times** **4. SEVERELY IMPAIRED—Never/rarely made decisions**	
MDS Mood & Behavior Panel	**B4.**	**INDICATORS OF CONFUSION, DISORDERED THINKING, OR POSSIBLE DELIRIUM** (Over last 7 days)	**0. No 1.Yes**	
			a. Is there evidence of an acute change in mental status from the patient's baseline?	
			b. Did the (abnormal) thinking fluctuate during the day, that is tend to come and go or increase and decrease in severity?	
			c. Did the patient have difficulty focusing attention, for example being easily distractible, or having difficulty keeping track of what was being said?	
			If yes to 2 or more, trigger RAP	
MDS 2.0 Moved from Section I	**B5.**	**HALLU-CINATIONS / DELUSIONS**	Check if problem present in last 7 days	
			a. Hallucinations	a.
			b. Delusions	b.

SECTION B. COGNITIVE/BEHAVIORAL PATTERNS					
Source					
MDS 2.0 *Moved from Section E*	**B6.**	**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)**
			a. WANDERING- moved with no rational purpose, seemingly oblivious to needs or safety		
			b. VERBALLY AGGRESSIVE BEHAVIORAL SYMPTOMS- cursing or verbal aggression, screaming at others, threatening others		
			c. PHYSICALLY AGGRESSIVE BEHAVIORAL SYMPTOMS—hitting, kicking, pushing, scratching, tearing things, grabbing, sexually abusing others		
			d. NON-AGGRESSIVE BEHAVIORAL SYMPTOMS- disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior, disrobing in public, smearing or throwing of food or feces, hoarding, rummaging through other's belongings		
			e. RESISTS THE WAY CARE IS GIVEN- including taking medications/ injections, ADL assistance, bathing, eating		

SECTION C. COMMUNICATION/VISION PATTERNS (Over last 7 days)				
Source				
MDS PAC	**C1.**	**HEARING**	**Ability to hear with appliance normally used** **0. HEARS ADEQUATELY—No difficulty in normal conversation, social interaction, TV, phone** **1. MINIMAL DIFFICULTY—Requires quiet setting to hear well** **2. HEARS IN SPECIAL SITUATIONS ONLY—Speaker has to increase volume and speak distinctly** **3. HIGHLY IMPAIRED—Absence of useful hearing**	
MDS 2.0 Payment item	**C2.**	**ABILITY TO EXPRESS IDEAS** **(Expression)**	(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	
MDS PAC	**C3.**	**ABILITY TO UNDERSTAND OTHERS** **(Comprehension)**	**Understanding verbal information content (however able) with hearing appliance, if used** **0. UNDERSTANDS—Clear comprehension** **1. USUALLY UNDERSTANDS—Misses some part/intent of message BUT comprehends most conversation with little or no prompting** **2. OFTEN UNDERSTANDS—Misses some part/intent of message, with prompting can often comprehend conversation** **3. SOMETIMES UNDERSTANDS—Responds adequately to simple, direct communication only** **4. RARELY/NEVER UNDERSTANDS**	

SECTION C. COMMUNICATION/VISION PATTERNS (Over last 7 days)				
Source				
MDS PAC	**C4.**	**VISION**	**Ability to see in adequate light with glasses or other visual appliances, if normally used** **0. ADEQUATE—Sees fine detail, including regular print, in newspaper/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** **9. UNABLE TO ASSESS**	
MD 2.0	**C5.**	**SIDE VISION PROBLEMS**	Decreased peripheral vision (e.g. leaves food on one side of tray, difficulty traveling, bumps into people and objects) 0. No 1. Yes	

SECTION E. MOOD						
Source						
SwingBed Revised look back period Items o & p relocated to section N	**E1A.**	**INDICATORS OF POSSIBLE DEPRESSION, SAD MOOD** Do this if B2a=1 OR B2b = 1	(Code for indicators observed in last **14** days, irrespective of the assumed cause) 0. Indicator not exhibited in last **14** 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)			
			a. Negative statements		h. Repetitive health complaints	
			b. Repetitive questions		i. Repetitive anxious complaints/concerns	
			c. Repetitive verbalizations		j. Unpleasant mood in morning	
			d. Persistent anger with self or others		k. Insomnia/change in usual sleep pattern	
			e. Self-deprecation		l. Sad, pained, worried facial expressions	
			f. Expressions of unrealistic fears		m. Crying, tearfulness	
			g. Recurrent statements that something terrible is about to happen		n. Repetitive physical movements	
Self-Report using 5-item GDS instrument	**E1B.**	**INDICATORS OF POSSIBLE DEPRESSION, SAD MOOD –SELF-REPORT** **Complete if B1=0, B2a =0, and C2 < 3**	**(Interview resident to assess these responses)** **0. No 1. Yes**			
			1. Are you basically satisfied with your life?		**4. Do you prefer to stay in your room rather than going out and doing new things?**	
			2. Do you often get bored?		**5. Do you feel pretty worthless the way you are now?**	
			3. Do you often feel helpless?		If 2 or more are yes, complete RAP.	

SECTION F. QUALITY OF LIFE				
Source				
New from QOL report	**F1.**	**SELF-REPORT QUALITY OF LIFE** **Code only if B2a & B2b = 0**	**CODE: 0. No 1. Yes**	
			a. Can you find a place to be alone when you wish?	
			b. Can you make a private phone call?	
			c. When you have a visitor, can you find a place to visit in private?	
			d. Can you be together in private with another resident (other than your roommate)?	
			e. Do you participate in religious activities here?	
			f. Do the religious observances here have personal meaning for you?	
			g. Do you enjoy the organized activities here at the nursing home?	
			h. Outside of religious activities, do you have enjoyable things to do at the nursing home during the weekends?	
			i. Do you like the food here?	
			j. Do you enjoy mealtimes here?	
			k. Can you get your favorite foods here?	
			l. Do you feel that your possessions are safe at this nursing home?	
			m. Do your clothes get lost or damaged in the laundry?	
			n. Do you feel safe and secure?	
MDS2.0 from ATRA	**F2.**	**RELATIONSHIPS**	a. Covert/open conflict with or repeated criticism of staff	a.
			b. Unhappy with roommate	b.
			c. Unhappy with residents other than roommate	c.
			d. Openly expresses conflict/anger with family/friends	d.
			e. Absence of personal contact with family/friends	e.
			f. Recent loss of close family member/friend	f.
			g. Regular visits or correspondence with family or friends	g.
MDS 2.0	**F3.**	**PREFFERED ROUTINE (check all that apply)** **(In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home.** **Complete only if admission assessment**	Cycle of daily events	
			a. Stays up late at night (e.g. after 9 PM)	a.
			b. Naps regularly during day (at least 1 hour)	b.
			c. Goes out 1+ days a week	c.
			d. Stays busy with hobbies, reading, or fixed daily routine	d.
			e. Spends most of time alone or watching TV	e.
			f. Moves independently indoors (with appliances, if used)	f.
			g. Use of tobacco products at least daily	g.
			h. NONE OF ABOVE	h.

			Eating Patterns	
			i. Distinct food preferences	i.
			j. Eats between meals all or most days	j.
			k. Use of alcoholic beverage(s) at least weekly	k.
			l. NONE OF ABOVE	l.
			ADL Patterns	
			m. In bedclothes much of day	m.
			n. Wakens to toilet all or most nights	n.
			o. Has irregular bowel movement pattern	o.
			p. Showers for bathing	p.
			q. Bathing in PM	q.
			r. NONE OF ABOVE	r.
			Involvement Patterns	
			s. Daily contact with relatives/close friends	s.
			t. Usually attends church, temple, synagogue, etc.	t.
			u. Finds strength in faith	u.
			v. Daily animal companionship	v.
			w. Involved in group activities	w.
			x. NONE OF ABOVE	x.
			y. UNKNOWN	y.

SECTION G. FUNCTIONAL STATUS			
Source			
MDS PAC	**G1**.	**7-DAY ADL SELF-PERFORMANCE** – (Code for Performance Over All Shifts, for All Episodes, OVER LAST 7 DAYS)- [NOTE- for bathing and tub transfer, code for most dependent single episode in this period] 0. INDEPENDENT—No physical or cognitive help, setup, or supervision **1. SETUP HELP ONLY—Article or device provided or placed within reach of resident 3 or more times** 2. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during period—OR—Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during period 3. MINIMAL ASSISTANCE (LIMITED ASSISTANCE)—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times—OR—Combination of non-weight bearing help with more help provided only 1 or 2 times during period **4. MODERATE ASSISTANCE (EXTENSIVE ASSISTANCE) WITH *LESS THAN TWO* PERSON ASSIST—Resident performed part of activity AND help of following type(s) provided 3 or more times:** **a. Weight-bearing support (e.g. holding weight of limb, trunk)** **b. Full staff performance during part (but not all) of period** **5. MODERATE ASSISTANCE (EXTENSIVE ASSISTANCE WITH *TWO OR MORE* PERSON ASSIST)—Resident performed part of activity AND help of following type(s) provided 3 or more times:** **a. Weight-bearing support (e.g. holding weight of limb, trunk)** **b. Full staff performance during part (but not all) of period** **6. TOTAL ASSISTANCE (TOTAL DEPENDENCE)- WITH *LESS THAN TWO* PERSON ASSIST—Full staff performance of activity during entire period** **7. TOTAL ASSISTANCE (TOTAL DEPENDENCE) WITH *TWO OR MORE* PERSON ASSIST—Full staff performance of activity during entire period** 8. ACTIVITY DID NOT OCCUR during entire period	
MDS PAC	**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 or from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	
	c. LOCOMOTION	**How resident in facility. If in wheelchair, how moves in wheelchair**	
	d. WALK IN FACILITY	**How resident walks in room, corridor, or other place in facility**	
	e. DRESSING UPPER BODY	**How resident dresses and undresses above the waist, includes prostheses, orthotics, fasteners, pullovers, etc**	
	f. DRESSING LOWER BODY	**How resident dresses and undresses from the waist down, includes prostheses, orthotics, belts, pants, skirts, shoes, and fasteners**	
	g. EATING	How resident eats and drinks (regardless of skill), includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	
	h. TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes (EXCLUDE transfer toilet)	
	i. TRANSFER TOILET	**How resident moves on and off toilet or commode**	
	j. GROOMING/ PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (EXCLUDE baths and showers)	
	k. BATHING	**How resident takes full-body bath/shower or sponge bath (EXCLUDE washing of back and hair and TRANSFER). Includes how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area.** Code for most dependent episode	
	l. TRANSFER TUB/SHOWER	**How resident transfers in/out of tub/shower.** Code for most dependent episode	

SECTION G. FUNCTIONAL STATUS						
Source						
MDS PAC	**G2.**	**BALANCE RELATED TO TRANSITIONS- code for most dependent in last 24 hours** **0. Smooth transition, stabilizes without assistance** **1. Transition not smooth, but able to stabilize without assistance** **2. Transition not smooth, unable to stabilize without assistance** **3. ACTIVITY DID NOT OCCUR**				
		a. Balance while sitting- position, trunk control	**a.**			
		b. Moved from seated to standing position	**b.**			
		c. Turned around and faced the opposite direction	**c.**			
MDS PAC	**G3.**	**NEUROMUSCULOSKELETAL IMPAIRMENT** **A. RANGE OF MOTION** **1. No impairment** **2. Impairment on one side** **3. Impairment on both sides** **B. MOTOR FUNCTION** **0. No Loss** **1. Partial loss on 1 side** **2. Partial loss-both sides** **3. Full loss on 1 side** **4. Full loss on both sides** **C. TOUCH/SENSATION** **0. No loss** **1. Partial loss on 1 side** **2. Partial loss on both sides** **3. Full loss on 1 side** **4. Full loss on both sides**				
			A	B	C	
		a. Leg (hip, knee, ankle foot)				
		b. Arm (shoulder, elbow, wrist, hand)				
		c. Trunk and neck				
MDS PAC	**G4.**	**DEVICES & AIDS (Check all that apply)**	**a. Cane/ Crutch**	**a.**	**d. Wheelchair/scooter**	**d.**
			b. Walker	**b.**	**If d is checked:** **e. Wheeled self?**	**e.**
			c. Mechanical lift	**c.**		
MDS 2.0	**G5.**	**BEDFAST**	**Bedfast all or most of the time?** **0. No 1. Yes**			
MDS 2.0 A & b only	**G6.**	**ADL FUNCTIONAL REHABILITA-TION POTENTIAL**	**0. No 1. Yes**			
			a. Resident believes he/she is capable of increased independence in at least some ADLs			
			b. Direct care staff believe resident is capable of increased independence in at least some ADLs			

SECTION H. CONTINENCE IN LAST 7 DAYS

Source							
MDS 2.0	**H1.**	**CONTINENCE SELF CONTROL CATEGORIES** 0. CONTINENT —Complete control; DOES NOT USE any type of catheter or other urinary collection device **1. CONTINENT WITH CATHETER OR OSTOMY—Complete control with use of catheter, urinary collection device, or ostomy** 2. USUALLY CONTINENT—BLADDER: Incontinent episodes once a week or less; BOWEL: less than weekly 3. OCCASIONALLY INCONTINENT—BLADDER: 2 or more times a week but not daily; BOWEL: once a week 4. FREQUENTLY INCONTINENT—BLADDER: tended to be incontinent daily but some control present (e.g. on day shift); BOWEL: 2-3 times a week 5. INCONTINENT—Inadequate control BLADDER: multiple episodes daily; BOWEL: all or almost all of the time.					
		a. Bladder Continence					
		b. Bowel Continence					
MDS PAC	**H2.**	**APPLIANCES AND PROGRAMS (14 days)**	**CODE: 0. No 1. Yes**				
			a. Any scheduled toileting plan	a.	**e. Intermittent catheter**	e.	
			b. Indwelling catheter	b.	**f. External catheter**	f.	
			c. Bladder retraining program	c.	**g. Ostomy**	g.	
			d. Pads, briefs	d.			
MDS 2.0	**H3.**	**BOWEL ELIMINATION PATTERN (check all that apply)**	a. Constipation	a.	c. Diarrhea	c.	
			b. Fecal Impaction	b.			

NOTE: CMS thanks AHIMA to for its recommendations for Section I to improve accuracy of coding and ease of use. For electronic entry, there will be dropdown menus for each category listed in Appendix C with this document. For paper entry, the MDS 3.0 manual will provide the definitions in Appendix C as a reference.

SECTION I. DISEASE DIAGNOSES

1. DISEASES

MDS 3.0 proposed changes (AHIMA)

Endocrine / metabolic / nutritional ✔		Code	Neurological ✔		Code
a. ▼Diabetes mellitus	a.		v. Alzheimer's Disease	v.	
b. ▼Nutritional deficiency	b.		w. ▼Aphasia	w.	
c. ▼Thyroid disorder	c.		x. ▼Cerebral Palsy	x.	
d. ▼Other metabolic/ immunity disorders	d.		y. ▼CVA	y.	
Heart/circulation			z. ▼Hemiplegia	z.	
e. ▼Anemia	e.		aa. Huntington's Chorea	aa.	
f. ▼Arteriosclerotic heart disease (ASHD	f.		bb. MS	bb.	
g. ▼Cardiac dysrhythmias	g.		cc. Paraplegia	cc.	
h. Congestive heart failure	h.		dd. ▼Quadriplegia	dd.	
i. ▼Hypertension	i.		ee. Seizure Disorder	ee.	
j. ▼Hypotension	j.		**Psychiatric / mood / mental health**		
k. Peripheral vascular disease	k.		ff. ▼Dementia/Organic Psychotic Conditions	ff.	
l. ▼Other cardiovascular disease	l.		gg. ▼Anxiety disorder	gg.	
Infection			hh. ▼Depression	hh.	
m. ▼Pneumonia	m.		ii. ▼Manic depression	ii.	
n. Acute Respiratory Infection (excludes pneumonia & chronic bronchitis)	n.		jj. ▼Other nonorganic psychoses	jj.	
o. ▼Septicemia	o.		kk. ▼Paranoid states/ delusional disorders	kk.	
p. ▼Urinary Tract Infection	p.		ll. ▼Schizophrenia	ll.	
q. ▼Viral Hepatitis	q.		mm. Tourette's Disorders	mm.	
r. Wound infection (post-op)	r.		**Pulmonary (non-infectious)**		
Musculoskeletal			nn. ▼COPD & Pulmonary Conditions	nn.	
s. ▼Arthritis	s.		**Sensory**		
t. Osteoporosis	t.		oo. Cataracts	oo.	
u. ▼Fracture	u.		pp. Glaucoma	pp.	

2. OTHER CURRENT DIAGNOSES:

a.	_____._____.
b.	_____._____.
c.	_____._____.
d.	_____._____.
e.	_____._____.
f.	_____._____.
g.	_____._____.
h.	_____._____.
i.	_____._____.
j.	_____._____.
k.	_____._____.

RECOMMENDED CONTENT FOR MDS3.0 DISEASE & DIAGNOSIS QUESTION

Legend: Checkbox item required for RAPs, RUGs, QIs, or QMs
Code number used in RAPs, RUGs, QIs, or QMs
Checkbox/code recommended based on frequency

Section I: 1 Diseases (Categories sequenced in MDS2.0 order)

FORM	DROP DOWN WINDOW #1	DROP DOWN WINDOW #2	CODE(S)
❑ Diabetes Mellitus			
	Uncomplicated	Type II	250.00
		Type I	250.01
		Type I uncontrolled	250.03
	Stated as uncontrolled	Type II	250.02
	With renal manifestations	Type II	250.40
		Type I	250.41
		Type I uncontrolled	250.43
		Type II uncontrolled	250.42
	With ophthalmic manifestations	Type II	250.50
		Type I	250.51
		Type I uncontrolled	250.53
		Type II uncontrolled	250.52
	With neurological manifestations	Type II	250.60
		Type I	250.61
		Type I uncontrolled	250.63
		Type II uncontrolled	250.62
	With peripheral circulatory disorders	Type II	250.70
		Type I	250.71
		Type I uncontrolled	250.73
		Type II uncontrolled	250.72
	With other manifestations	Type II	250.80
		Type I	250.81
		Type I uncontrolled	250.83
		Type II uncontrolled	250.82
	Other DM & complications (code in I3)		***
❑ Nutritional Deficiency			
	Kwashiorkor		260
	Nutritional marasmus		261
	Other severe protein-calorie malnutrition		262
	Other Malnutrition	Malnutrition of moderate degree	263.0
		Malnutrition of mild degree	263.1
		Arrested development due to malnutrition	263.2
		Other protein-calorie	263.8

FORM	DROP DOWN WINDOW #1	DROP DOWN WINDOW #2	CODE(S)
		malnutrition	
		Unspecified protein-calorie malnutrition	263.9
	Vitamin B12 Deficiency		266.2
	Other Nutritional Deficiencies (code in I3)		***
❑ Thyroid Disorder			
	Hyperthyroidism, NOS		242.90
	Hypothyroidism, Unspecified		244.9
	Other Thyroid Disorders (code in I3)		***
❑ Other Metabolic/Immunity Disorders			
	Hypercholesterolemia		272.0
	Hyperlipidemia		272.4
	Gout		274.9
	Hyponatremia		276.1
	Dehydration		276.5
	Hypokalemia		276.8
	Obesity		278.00
	Obesity, Morbid		278.01
	Other Metabolic/Immunity Disorders (code in I3)		***
❑ Anemia			
	Iron deficiency	2nd to blood loss	280.9
		Unspecified	
	Pernicious		281.0
	Unspecified		285.9
	Other Anemia (code in I3)		***
❑ Arteriosclerotic Heart Disease			
	Of unspecified type of vessel (native or graft)		414.00
	Of native coronary artery		414.01
	Of unspecified type of bypass graft		414.05
	Other arteriosclerotic heart disease (code in I3)		***
❑ Cardiac Dysrhythmias			
	Atrial Fibrillation		427.31
	Sinus bradycardia/Sick Sinus Syndrome		427.81
	Other specified cardiac dysrhythmia		427.89
	Unspecified cardiac dysrhythmia		427.9

FORM	DROP DOWN WINDOW #1	DROP DOWN WINDOW #2	CODE(S)
	Other cardiac dysrhythmias (code in I3)		***
❑ Congestive Heart Failure			
	Unspecified		428.0
	Other congestive heart failure (code in I3)		***
❑ Hypertension			
	Unspecified type		401.9
	Malignant		401.0
	Benign		401.1
	Other hypertension (code in I3)		***
❑ Hypotension			
	Orthostatic		458.0
	Unspecified type		458.9
	Other hypotension (code in I3)		***
❑ Peripheral Vascular Disease			
	Unspecified		443.9
	Other Peripheral Vascular Disease (code in I3)		***
❑ Other cardiovascular disease			
	Cardiovascular disease, unspecified		429.2
	Cardiomegaly		429.3
	Heart failure/ cardiac insufficiency following cardiac surgery		429.4
	Heart disease, unspecified		429.9
	Other cardiovascular disease (code in I3)		***
❑ Arthritis			
	Rheumatoid Arthritis		714.0
	Osteoarthrosis, generalized, site unspecified		715.00
	Osteoarthrosis, generalized, multiple sites		715.09
	Osteoarthrosis, site unspecified		715.90
	Arthritis		716.90
	Other arthritis (code in I3)		***
❑ Osteoporosis			
	Unspecified		733.00
	Other Osteoporosis (code in I3)		***

FORM	DROP DOWN WINDOW #1	DROP DOWN WINDOW #2	CODE(S)
❑ Fracture			
	Traumatic bone fracture	Upper arm	V54.11
		Hip	V54.13
		Vertebrae	V54.17
		Other bone (code in I3)	***
	Pathologic bone fracture	Upper arm	V54.21
		Hip	V54.23
		Vertebrae	V54.27
		Other bone (code in I3)	***
	Other fracture (code in I3)		***
❑ Alzheimer's Disease			331.0
❑ Aphasia			784.3
	Aphasia		784.3
	CVA w/ Aphasia		438.11
	Other aphasia (code in I3)		***
❑ Cerebral Palsy			
	Unspecified type		343.9
	With quadriplegia		343.2
	Other cerebral palsy (code in I3)		***
❑ CVA			
	With cognitive deficits		438.0
	With speech & language deficits:	Unspecified	438.10
		Aphasia	438.11
		Dysphasia	438.12
		Other speech & language deficits	438.19
	With hemiplegia:	Unspecified side	438.20
		Dominant side	438.21
		Non-dominant side	438.22
	With dysphagia		438.82
	With other late effects		438.89
	With unspecified late effects		438.9
	Other CVA (code in I3)		***
❑ Hemiplegia			
	Unspecified	Unspecified side	342.90
		Dominant side	342.91
		Non-dominant side	342.92
	Flaccid	Unspecified side	342.00
		Dominant side	342.01
		Non-dominant side	342.02
	With CVA:	Unspecified side	438.20
		Dominant side	438.21
		Non-dominant side	438.22
	Other hemiplegia (code in I3)		***

FORM	DROP DOWN WINDOW #1	DROP DOWN WINDOW #2	CODE(S)
❑ Huntington's Chorea			333.4
❑ MS			340
❑ Paraplegia			
	Paraplegia		344.1
	Other types of paraplegia (code in I3)		***
❑ Quadriplegia			
	Unspecified		344.00
	C1 – C4 complete		344.01
	C1 – C4 incomplete		344.02
	C5 – C7 complete		344.03
	C5 – C7 incomplete		344.04
	Other vertebrae		344.09
	Other type quadriplegia (code in I3)		***
❑ Seizure Disorder			
	Unspecified		780.39
	Epileptic		345.9
	Other seizures (code in I3)		
❑ Dementia and Organic Psychotic Conditions			
	Senile dementia	Uncomplicated	290.0
		With delusional features	290.20
		With depressive features	290.21
		With delirium	290.3
	Presenile dementia	Uncomplicated	290.10
		With delirium	290.11
		With delusional features	290.12
		With depressive features	290.13
	Arteriosclerotic (vascular, multi-infarct) dementia	Uncomplicated	290.40
		With delirium	290.41
		With delusional features	290.42
		With depressive features	290.43
	Alcoholic dementia, NOS		291.2
	Acute delirium		293.0
	Psychosis (organic) d/t physical condition NEC	With delusions	293.81
		Depressive type	293.83
	Organic brain syndrome	With psychosis	294.9
		Non-psychotic, unspecified	310.9
	Other specified organic brain syndromes (chronic)		294.8
	Dementia associated with other conditions (i.e. Alzheimer's)	Without behavioral disturbance	294.10

FORM	DROP DOWN WINDOW #1	DROP DOWN WINDOW #2	CODE(S)
		With behavioral disturbance	294.11
	Other dementia (code in I3)		***
❑ Anxiety Disorder			
	Unspecified type		300.00
	Generalized anxiety		300.02
	Other anxiety disorders (code in I3)		***
❑ Depression			
	Depression		311
	Situational depression		309.0
	Anxiety depression		300.4
	Other depression (code in I3)		***
❑ Manic Depression			
	Manic depression, unspecified		296.80
	Bipolar disorder, unspecified		296.7
	Other manic depression (code in I3)		***
❑ Other Nonorganic Psychoses			
	Depressive type psychosis		298.0
	Exciative type psychosis		298.1
	Reactive confusion		298.2
	Acute paranoid reaction		298.3
	Psychogenic paranoid psychosis		298.4
	Other & unspecified reactive psychosis		298.8
	Confusion or Unspecified psychosis		298.9
	Other psychoses (code in I3)		***
❑ Paranoid States/ Delusional Disorders			
	Simple		297.0
	Paranoia		297.1
	Paraphrenia		297.2
	Shared paranoid disorder		297.3
	Other specified paranoid states		297.8
	Unspecified paranoid state		297.9
	Other paranoid/delusional disorders (code in I3)		***
❑ Schizophrenia	****50 possible codes****		
	Unspecified		295.90
	Paranoid type, unspecified		295.30
	Schizo-affective type, unspecified		295.70
	Other schizophrenia (code in I3)		***

FORM	DROP DOWN WINDOW #1	DROP DOWN WINDOW #2	CODE(S)
❑ Tourette's Disorder			307.23
❑ COPD & Pulmonary Conditions			
	COPD		496
	Asthma	Chronic, obstructive w/o mention status asthmaticus or acute exacerbation	493.20
S		Unspecified, w/o mention status asthmaticus or acute exacerbation	493.90
	Bronchitis,	Not specified as acute or chronic	490
		Chronic	491.20
		Chronic w/ acute exacerbation	491.21
	Emphysema		492.8
	Other pulmonary (code in I3)		***
❑ Cataracts			
	Unspecified		366.9
	Other cataracts (code in I3)		***
❑ Glaucoma			
	Unspecified		365.9
	Other glaucoma (code in I3)		***

Section I: 2 Infections

❑ Pneumonia			
	Pneumonia, organism unspecified		486
	Viral pneumonia, unspecified		480.9
	Pneumococcal pneumonia		481
	Pneumonia due to Staphylococcus, unspecified		482.41
	Bacterial pneumonia, unspecified		482.9
	Bronchopneumonia, organism unspecified		485
	Other pneumonia (code in I3)		***
❑ Acute Respiratory Infection (excludes Pneumonia & chronic bronchitis)			
	Upper Respiratory		465.9
	Other sites (code in I3)		***
❑ Septicemia			
	Unspecified septicemia		038.9
	Staphylococcus aureus		038.11

	septicemia		
	Septicemia due to E. coli		038.42
	Other specified septicemias		038.8
	Other septicemia (code in I3)		***
❑ Urinary Tract Infection			
	Urinary tract infection, site not specified		599.0
	Pyelonephritis, unspecified		590.80
	Urinary tract infection of other site (code in I3)		***
❑ Viral Hepatitis			
	Unspecified viral hepatitis		070.9
	Acute or unspecified hepatitis C		070.51
	Chronic hepatitis C		070.54
	Other viral hepatitis (code in I3)		***
❑ Wound Infection			
	Post-operative		998.59
	Other wound infection (code in I3)		***

SECTION J. HEALTH CONDITIONS								
Source								
MDS 2.0 & MDS-PAC	**J1.**	**PROBLEM CONDITION**	**Check all problems present in last 7days unless other time frame is indicated**					
			BALANCE		RESPIRATORY CONDITIONS			
			a. Dizziness/vertigo/light-headed or Fainting	a.	h. Inability to lie flat due to shortness of breath	h.		
			b. Unsteady gait	b.	i. Recurrent lung aspirations in last 90 days	i.		
			CARDIAC/PULMONARY		j. Shortness of breath with exertion (e.g. taking a bath)	j.		
			c. Chest pain	c.	k. Difficulty coughing and clearing airway	k.		
			d. Edema	d.	OTHER			
			FLUID STATUS		l. Internal bleeding	l.		
			e. Insufficient fluid: did not consume all/almost all liquids provided in last 3 days	e.	m. Fever	m.		
			f. Vomiting	f.	**n. Fractures (from any source)**	**n.**		
			g. Dehydration	g.				
NEW ITEM	**J2.**	**PAIN ASSESSMENT**	**Determine the presence of pain over the last 7 days** **a. Does the resident report pain?** **0. No 1. Yes 2. Unable to report** **If no *OR* unable to report, skip to J2e**.					
			b. Determine the intensity of pain at its worst using a standardized pain intensity scale (e.g., 0-10 Numeric Rating Scale, 6-level Faces Scale, Verbal Descriptor Scale, Pain Thermometer) **1. Mild pain** (1-3 NRS; Face #2; Mild VDS; Slight/mild PT) **2. Moderate pain** (4-5 NRS; Face #3; Moderate VDS; Moderate PT) **3. Severe pain** (6-7 on NRS; Face #4; Severe VDS; Severe PT) **4. Very severe; horrible pain** (8-10 on NRS; Face #5&#6; Very severe/Worst possible pain VDS; Extreme/Bad as Can Be PT)					
			c. Duration/frequency of pain in the last 7 days: **1. Pain is constant or persistent** **2. Pain comes and goes** **3. Breakthrough pain**					
			d. Does the resident show nonverbal signs of pain? **0. No 1. Yes** ***If no, skip to J3***					
			e. If resident exhibits pain behaviors, check all that apply:					
			1. Non-verbal sounds (crying, whining, moaning, groaning)					a.
			2. Facial expressions – grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth and jaw, rapid blinking					b.
			3. Bracing, guarding, rubbing, massaging a body part/area					c.
			4. Restlessness, agitation, combativeness, fidgeting, pacing, withdrawn					d.
			5. Mental status changes – confusion, distress					e.
			6. Change in interpersonal interactions					f.

SECTION J. HEALTH CONDITIONS				
Source				
NEW ITEM	**J3.**	**PAIN MANAGEMENT (Last 7 days)**	**Is resident on a pain management regimen?** **0. No 1. Yes 2. Resident has no pain**	
NEW from Falls panel	**J4.**	**NUMBER & CLASSIFICATION OF FALLS**	**Since the last assessment or since admission, record the number of falls that resulted in:**	
			a. No visible evidence of physical injury (includes falls where staff intervened before resident was injured)	
			b. Minor injury. A small scrape, abrasion or bruise that heals without treatment in a few days.	
			c. Moderate injury. A suspected bone injury requiring an X-ray with no evidence of fractures. Includes sprains, strains, and lacerations that require suturing and medical treatment. Also includes an IV infiltrate after a fall that requires treatment.	
			d. Major injury. A confirmed fracture of any bone. Head injury or major soft tissue damage that requires treatment. Include if resident had loss of consciousness as a result of striking their head due to falling.	
MDS 2.0	**J5.**	**STABILITY OF CONDITIONS** (check all that are applicable)	a. Conditions/diseases make resident's cognitive/ADL, mood, or behavior patterns unstable	a.
			b. Resident experiencing an acute episode or flare up of a recurrent or chronic condition	b.
			c. End-stage disease (6 months or fewer to live)	c.

SECTION K. ORAL/NUTRITIONAL STATUS				
Source				
ASHA	**K1.**	**SWALLOWING/ NUTRITIONAL STATUS**	**No Helper** **1. <u>Complete independence</u>. Regular diet swallowed safely without supervision or modified diet** **2. <u>Modified independence</u>. Subject requires minimal cuing or additional time to swallow safely. Regular diet; may need to avoid specific foods (e.g. popcorn, nuts) due to dysphagia** **Helper** **3. <u>Minimal Diet/Supervision</u>. Subject requires minimal diet restriction, i.e. thickened liquids OR change of diet texture. Subject requies less than 10% supervision or assistance for swallowing.** **4. <u>Modified Diet/Supervision</u>. Subject requies 10-25% assistance or supervision for swallowing; AND requires dietary restriction of liquid and solid textures.** **5. <u>Moderate Assistance</u>. Subject requires assistance or supervision fo 25- 49% of swallowing. May also require alternate feeding method** **6. <u>Maximal Assistance</u>. Subject requires assistance for 50-75% of swallowing and uses alternate feeding method** **7. <u>Total Assistance</u>. Subject performs less than 25% of swallowing. Relies on tube/parenteral feeding as a means of sustenance.**	
MDS PAC	**K2.**	**HEIGHT AND WEIGHT**	**Record (a) height in inches and (b) weight in pounds. Base weight on most recent measure in last 3 days; measure weight consistently in accordance with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in night clothes** **a. Height (inches)** (only collect at admission) ☐☐ **b. Weight (Pounds)** ☐☐☐	
MDS PAC Payment item not changed. K3b--Weight gain not in MDS PAC	**K3.**	**WEIGHT LOSS**	**Weight loss—5% or more in last 30 days (or since last assessment) or 10% or more in last 180 days** **0. No or unknown 1. Yes, planned loss 2. Yes, unplanned loss**	
MDS 2.0	**K4.**	**NUTRITIONAL APPROACHES** (Check all that apply in the last 7 days)	**a.** Parenteral/IV ☐ a. / **d.** Therapeutic diet ☐ d. **b.** Feeding tube ☐ b. / **e.** Dietary supplement between meals ☐ e. **c.** Mechanically altered diet ☐ c. / **f.** On a planned weight change program ☐ f.	
MDS 2.0 K5b shortened	**K5.**	**PARENTERAL OR ENTERAL INTAKE** (Skip if neither K4a nor 4b is checked)	a. The proportion of **total calories** the resident received through parenteral or tube feedings in the **last 7 days** 0. None 1. 1% to 25% of total calories through device 2. 26% to 50% of total calories through device 3. 51% or more of more of total calories through device	
			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 or more cc/day	

SECTION L. ORAL/DENTAL STATUS				
Item Source				
ADA	**L1.**	**ORAL STATUS AND DISEASE PREVENTION**	**Check all that apply during last 7 days**	
			a. Resident has mouth or facial pain/discomfort	a.
			b. Resident has chewing problems	b.
			c. Resident has abnormal mouth tissue (ulcers, masses, oral lesions)	c.
			d. Resident has dry mouth	d.
			e. Resident has a problem with or may need a denture or partial denture	e.
			f. Oral hygiene provided daily	f.
			g. Resident has natural teeth or tooth fragments (if not checked, skip to Section M)	g.
			h. Resident has an obvious cavity(s) or a broken natural tooth (teeth)	h.
			i. Resident has inflamed or bleeding gums next to natural teeth or tooth fragments	i.
			j. Resident has mobile (loose) natural teeth	j.

SECTION M. SKIN CONDITION					
Source					
Recommended By NPUAP	**M1.**	**STAGING PRESSURE ULCERS**	Record the number of pressure ulcers at each ulcer stage. If none present at a stage, record "0" (zero). Code all that apply during the last 7 days. Code 9=9 or more.)	**# at stage**	**# present at admission** (Complete only at admission & return admission)
			a. No pressure ulcer (if no, skip to M2)		
			b. An observable pressure related alteration of intact skin (Stage 1)		
			c. Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater. (Stage 2)		
			d. Full thickness skin loss involving damage to, or necrosis of subcutaneous tissue that may extend down to, but not through underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. (Stage 3)		
			e. Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). (Stage 4)		
			f. Not stageable. (Eschar that is intact and fully adherent to the wound base and edges or deep tissue injury with intact skin, and no prior staging available).		
NEW	**M2.**	**OTHER ULCERS**	**Record number of "other" ulcers** **a. Venous Stasis Ulcers** **b. Arterial Ulcers** **c. Other Ulcers (non-pressure)**		
NPUAP Recommended	**M3.**	**OTHER SKIN PROBLEMS OR LESIONS PRESENT (other than feet)**	**Check all that apply during last 7 days**		
			a. Bruises	a.	
			b. Burns (second or third degree)	b.	
			c. Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)	c.	
			d. Skin tears or cuts (other than surgery**)**	d.	
			e. Surgical wounds	e.	
			f. Rashes, abrasions	f.	

SECTION M. SKIN CONDITION				
Source				
MDS 2.0 And NPUAP	**M4.**	**SKIN TREATMENTS**	**Check all that apply during last 7 days**	
			a. Pressure **reducing** device(s) for chair	a.
			b. Pressure **reducing** device(s) for bed	b.
			c. Turning/repositioning program	c.
			d. Nutrition or hydration intervention to manage skin problems	d.
			e. Ulcer care	e.
			f. Surgical wound care	f.
			g. Application of dressings (with or without topical medications) other than to feet	g.
			h. Application of ointments/medications (other than to feet)	h.
			i. Other preventative or protective skin care (other than to feet)	i.
MDS 2.0 And NPUAP	**M5.**	**FOOT PROBLEMS AND CARE**	**Check all that apply during last 7 days**	
			a. Resident has one or more foot problems--e.g., corns, pain, callouses, bunions, hammer toes, overlapping toes, structural problems	a.
			b. Infection of the foot--e.g., cellulitis, purulent drainage	b.
			c. Diabetic foot ulcers	c.
			d. Open lesions of the foot	d.
			e. Nails/calluses trimmed during last 90 days	e.
			f. Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)	f.
			g. Application of dressings (with or without topical medications)	g.

SECTION N. ACTIVITY PURSUIT PATTERNS						
Item Source						
MDS 2.0	**N1.**	**TIME AWAKE**	**(Check appropriate time periods over last 3 days)** Resident awake all or most of time (i.e. naps no more than one hour per time period) in the:			
			a. Morning	a.	c. Evening	c.
			b. Afternoon	b		
(If resident is comatose, skip to Section O)						
From Section F MDS2.0 per Activity Panel	**N2.**	**SENSE OF INITIATIVE/ INVOLVEMENT**	**(Check all that apply)** a. At ease interacting with others b. At ease doing planned or structured activities c. At ease doing self-initiated activities d. Accepts invitations for group activities or individual activity interventions			a. b. c. d.
Section E MDS 2.0 Per Activity Panel	**N3.**	**LOSS OF INTEREST** **(Code for last 14 days)**	**a.** Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends 0. Not exhibited in last 14 days 1. Exhibited up to 5 days a week 2. Exhibited daily or almost daily (6, 7 days a week) **b.** Reduced social interaction 1. Not exhibited in last 14 days 2. Exhibited up to 5 days a week 3. Exhibited daily or almost daily (6, 7 days a week)			
From SectionF MDS 2.0 Per Activity panel	**N4.**	**PAST ROLES**	**(Check all that apply)** a. Strong identification with past roles and life status b. Expresses sadness/anger/empty feeling over lost roles/status c. Resident perceives that daily routine (customary routine, activities is very different from prior pattern in the community			a. b. c.
NEW per Activity panel	**N5.**	**PURSUIT/ ENGAGEMENT IN ACTIVITIES**	**1. Independent** **2. Limited Assistance** **3. Extensive Assistance** **4. Total Dependence**			
			a. Level to which resident pursues activities			
			b. Level to which resident engages self in activities			

SECTION O. MEDICATIONS

Item Source							
MDS 2.0	**O1.**	**INJECTIONS**	Record the number of DAYS injections of any type received during the last 7 days; enter 0 if none used				
Revised from MDS 2.0	**O2.**	**RECEIVED THE FOLLOWING MEDICATION**	Check all medications the resident received during the last 7 days				
			a. Antipsychotic	a.	**d.** Hypnotic	d.	
			b. Antianxiety	b.	**e.** Diuretic	e.	
			c. Antidepressant	c.	**f. Antibiotics**	**f.**	

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

Source						
MDS 2.0	**P1.**	**Special Treatments, Procedures, and Programs**	**a. SPECIAL CARE-- Check treatments or programs received in last 14 days**			
			TREATMENTS		k. Transfusions	k.
			a. Chemotherapy	a.	l. Ventilator or Respirator	l.
			b. Dialysis	b.	**PROGRAMS**	
			c. IV meds	c.	m. Alcohol/ drug treatment program	m.
			d. Intake/output	d.	n. Alzheimer's/dementia special care unit	n.
			e. Monitoring acute medical condition	e.	o. Hospice care	o.
			f. Ostomy care	f.	p. Pediatric unit	p.
			g. Oxygen therapy	g.	q. Respite care	q.
			h. Radiation	h.	r. Training in skills required to return to community	r.
				i.		
			j. Tracheostomy Care	j.		
MDS 2.0 Recreation therapy moved from Section T	**P2.**	**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]**			
					Days (A)	Min (B)
			a. Speech- language pathology & audiology services			
			b. Occupational therapy			
			c. Physical therapy			
			d. Respiratory therapy			
			e. Psychological therapy (by any licensed mental health professional)			

SECTION P. SPECIAL TREATMENTS AND PROCEDURES							
Source							
			f. Recreational therapy				
MDS 2.0	**P3.**	**Nursing Rehabilitation/ Restorative Care**	Record the NUMBER OF DAYS each of the following rehabilitative 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		
MDS 2.0	**P4.**	**Physical Restraints** Physical restraints are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body.	Code devices that meet the definition of physical restraint and have been used in the last 7 days 0. Not used 1. Used less than daily 2. Used daily				
			a. Full bed rails on all open sides of the bed				
			b. Other types of side rails used (e.g. half rail, one side)				
			c. Trunk restraint				
			d. Limb restraint				
			e. Chair prevents rising				
			f. Other				
MDS 2.0	**P5.**	**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?				
MDS 2.0	**P6.**	**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*				
NEW	**P7.**	**Expected Length of Stay** **Complete only if A11d=01 or 06**	**Enter expected length of Medicare stay (in days) anticipated by physician**				

SECTION Q. DISCHARGE POTENTIAL

Item Source				
MDS 2.0	**Q1.**	**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	

SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

Item Source				
MDS 2.0	**T1.**	**ORDERED THERAPIES**	**Skip unless this is a Medicare 5-day or Medicare readmission/return assessment** **a.** Has physician ordered any of the following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service? 0. No 1. Yes **If no, skip to next section** **b.** Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to be delivered. **c.** Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can expected to be delivered.	

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

MDS 2.0	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: o Nature of the condition (may include presence or lack of objective data and subjective complaints). o Complications and risk factors that affect your decision to proceed to care planning. o Factors that must be considered in developing individualized care plan interventions. o 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			
2. COGNITIVE LOSS			
3. VISUAL FUNCTION			
4. COMMUNICATION			
5. ADL FUNCTIONAL/ REHABILITATION POTENTIAL			
6. URINARY INCONTINENCE AND INDWELLING CATHETER			
7. PSYCHOSOCIAL WELL-BEING			
8. MOOD STATE & BEHAVIOR			
9. ACTIVITIES			
10. FALLS			
11. NUTRITION/ DEHYDRATION/ TUBE FEEDING			
12. DENTAL CARE & ORAL HYGIENE			
13. PRESSURE ULCERS-TREATMENT			
14. PRESSURE ULCER-PREVENTION			
15. PSYCHOTROPIC DRUG USE			
16. PHYSICAL RESTRAINTS			
17. QUALITY OF LIFE			
18. RESTORATIVE CARE			
19. DISCHARGE PLANNING			
20. PAIN			
21. INFECTION CONTROL & PREVENTION			

B._____

1. Signature of RN Coordinator for RAP Assessment Process

2. __ __ - __ __ - __ __ __ __
   month day year

_____

3. Signature of Person Completing Care Planning Process

4. __ __ - __ __ - __ __ __ __
   month day year

SECTION X. PREVENTIVE HEALTH (NEW)				
Item Source				
CDC	**X1.**	**INFLUENZA VACCINE** (To be asked only during January through March and October through December of each calendar year)	**If eligible, has the resident received a dose of influenza vaccine since October 1 of the current influenza season?** **0. No 1. Yes 2. Unknown** if no or unknown, go to infection control RAP	
CDC	**X2.**	**PNEUMOCOCCAL VACCINE**	**If eligible, has the resident received a dose of pneumococcal polysaccharide vaccine (PPV) in less than or equal to 5 years?** **0. No 1. Yes 2. Unknown** if no or unknown, go to infection control RAP	
CDC	**X3.**	**TETANUS VACCINE**	**If eligible, has the resident received a tetanus-containing vaccine in less than or equal to 10 years?** **0. No 1. Yes 2. Unknown** if no or unknown, go to infection control RAP	