



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. SEVERELY IMPAIRED — no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	1, 2, 3
2	VISUAL LIMITATIONS/DIFFICULTIES	Side vision problems — decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes NONE OF ABOVE	a. ✓ b. c.
3	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

**SECTION E. 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/week)	
	VERBAL EXPRESSIONS OF DISTRESS	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	1, 2 1, 2
	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"		1, 2
	b. Repetitive questions -- e.g., "Where do I go; What do I do?"		1, 2
	c. Repetitive verbalizations — e.g., calling out for help, ("God help me").	SLEEP CYCLE ISSUES— j. Unpleasant mood in morning	1, 2 1, 2
	d. Persistent anger with self or others — e.g., easily annoyed, anger at placement in nursing home; anger at care received	k. Insomnia / change in usual sleep pattern	1, 2
	e. Self deprecation — e.g., "I am nothing; I am of no use to anyone"	SAD, APATHETIC ANXIOUS APPEARANCE	1, 2
	f. Expressions of what appear to be unrealistic fears — e.g., fear of being abandoned, left alone, being with others	l. Sad, pained, worried facial expressions — e.g., furrowed brows m. Crying, tearfulness	1, 2 1, 2
	g. Recurrent statements that something terrible is about to happen — e.g., believes he or she is about to die, have a heart attack	n. Repetitive physical movements, e.g., pacing, hand wringing, restlessness fidgeting, picking	1, 2
		LOSS OF INTEREST	1, 2
		o. Withdrawal from activities of interest — e.g., no interest in long standing activities or being with family / friends p. Reduced social interaction	1, 2 1, 2
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 1. Indicators present, easily altered 2. Indicators present, not easily altered	1, 2
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	2
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) (B)
	A. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)		1, 2, 3
	B. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)		1, 2, 3
	C. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		1, 2, 3
	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)		1, 2, 3
	E. RESISTS CARE (resisted taking medications / injections, ADL assistance, or eating)		1, 2, 3

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

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

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

1	(A) ADL SELF-PERFORMANCE - (Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days — Not including setup) 0. INDEPENDENT — No help or oversight — OR — Help/oversight provided only 1 or 2 times during last 7 days 1. SUPERVISION — Oversight, encouragement or cueing provided 3 or more times during last 7 days—OR—Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days 2. LIMITED ASSISTANCE — Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times — OR — More help provided only 1 or 2 times during last 7 days 3. EXTENSIVE ASSISTANCE — While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: —Weight-bearing support —Full staff performance during part (but not all) of last 7 days 4. TOTAL DEPENDENCE — Full staff performance of activity during entire 7 days 8. ACTIVITY DID NOT OCCUR during entire 7 days		
	(B) ADL SUPPORT PROVIDED — (Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)		(A) (B)
	0. No setup or physical help from staff 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	SELF-PERF SUPPORT
a	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed	1, 2, 3, 4, 8
b	TRANSFER	How resident moves between surfaces—to / from: bed, chair, wheelchair, standing position (EXCLUDE to / from bath / toilet)	1, 2, 3, 4
c	WALK IN ROOM	How residents walks between locations in his / her room	1, 2, 3, 4
d	WALK IN CORRIDOR	How resident walks in corridor on unit	1, 2, 3, 4
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	1, 2, 3, 4
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.	1, 2, 3, 4
g	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning / removing prosthesis	1, 2, 3, 4
h	EATING	How resident eats and drinks (regardless of skill.) Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	1, 2, 3, 4
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	1, 2, 3, 4
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)	1, 2, 3, 4

2	BATHING	How resident takes full-body bath / shower, sponge bath, and transfers in / out of tub / shower (EXCLUDE washing of back and hair). <b>Code for most dependent in self-performance and support.</b> (A) BATHING SELF-PERFORMANCE codes appear below 0. Independent — no help provided 1. Supervision — Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur during entire 7 days (Bathing support codes are as defined in Item 1, code B above)	(A)	(B)
			1,2,3,4	

3	TESTING 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	1, 2, 3
			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)	(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	

5	MODES OF LOCOMOTION	(Check all that apply during last 7 days) Cane / walker / crutch Wheeled self Other person wheeled	a.	Wheelchair primary mode of locomotion	d.
			b.	NONE OF ABOVE	e.

6	MODES OF TRANSFER	(Check all that apply during last 7 days) Bedfast all or most of time Bed rails used for bed Or transfer Lifted manually	a.	Lifted mechanically Transfer aid (e.g., slide board, trapeze, cane, walker, brace)	d.
			b.	NONE OF ABOVE	e.

7	TASK SEGMENTATION	Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them 1. No 2. Yes	
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8	ADL FUNCTIONAL REHABILITATION POTENTIAL	Resident believes he / she is capable of increased independence in at least some ADLs Direct care staff believe resident is capable of increased independence in at least some ADLs Resident able to perform tasks / activity but is very slow Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings NONE OF ABOVE	a.	✓
			b.	✓

9	CHANGE IN ADL FUNCTION	Resident's ADL self-performance status has changed as compared to status of 90 days ago (or since assessment if less than 90 days) 0, No change 1. Improved 2. Deteriorated	
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**SECTION H. CONTINENCE IN LAST 14 DAYS**

1	CONTINENCE SELF-CONTROL CATEGORIES (Code for resident 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	
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a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	1, 2, 3, 4	
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume is insufficient to soak through underpants,) with appliances (e.g., foley) or continence programs, if employed	1, 2, 3	
2.	BOWEL ELIMINATION PATTERN	a.	Diarrhea	c.
		b.	Fecal impaction	d.
		Constipation	NONE OF ABOVE	e.

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. ✓
		External (condom) catheter	c. ✓	Enemas / irrigation	h.
		Indwelling catheter	d. ✓	Ostomy present	i.
		Intermittent catheter	e. ✓	NONE OF ABOVE	j.

4	CHANGE IN URINARY CONTINENCE	Resident's urinary continence has changed as compared to status of 90 days ago (or since assessment if less than 90 days) 0, No change 1. Improved 2. Deteriorated	
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**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.	Multiple sclerosis	v.
		Hyperthyroidism	b.	Paraplegia	w.
		Hypothyroidism	c.	Parkinson's disease	x.
		HEART / CIRCULATION		Quadruplegia	y.
		Arteriosclerotic heart disease (ASHD)	d.	Seizure disorder	aa.
		Cardiac dysrhythmias	e.	Transient ischemic attack (TIA)	bb.
		Congestive heart failure	f.	Traumatic brain injury	cc.
		Deep vein thrombosis	g.	PSYCHIATRIC / MOOD	
		Hypertension	h.	Anxiety disorder	dd.
		Hypotension	i. ✓	Depression	ee. ✓
		Peripheral vascular disease	j.	Manic depression (bipolar disorder)	ff.
		Other cardiovascular disease	k.	Schizophrenia	gg.
		MUSCULOSKELETAL		PULMONARY	
		Arthritis	l.	Asthma	hh.
		Hip fracture	m.	Emphysema / COPD	ii.
		Missing limb (e.g. amputation)	n.	SENSORY	
		Osteoporosis	o.	Cataracts	jj. ✓
		Pathological bone fracture	p.	Diabetic retinopathy	kk.
		NEUROLOGICAL		Glaucoma	ll. ✓
		Alzheimer's disease	q.	Macular degeneration	mm.
		Aphasia	r.	OTHER	
		Cerebral palsy	s.	Allergies	nn.
		Cerebrovascular accident (stroke)	t.	Anemia	oo.
		Dementia other than Alzheimer's disease	u.	Cancer	pp.
				Renal failure	qq.
				NONE OF ABOVE	rr.

2	INFECTIONS	(If none apply, CHECK the NONE OF ABOVE box)			
			Antibiotic resistant infection (e.g., Methicillin resistant staph)	a.	Septicemia
		Clostridium difficile	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	A. Dehydration	2	7	6	1	5
		B.					
		C.					
		D.					
		E.					

**SECTION J. HEALTH CONDITIONS**

1	PROBLEM CONDITION	(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	a. ✓	Dizziness / Vertigo	f. ✓
		Inability to lie flat due to shortness of breath	b.	Edema	g.
		Dehydrated; output exceeds input	c. ✓	Fever	h. ✓
		Insufficient fluid; did NOT consume all / almost all liquids provided during last 3 days	d. ✓	Hallucinations	i. ✓
		OTHER		Internal bleeding	j. ✓
		Delusions	e.	Recurrent lung aspirations in last 90 days	k. ✓
				Shortness of breath	l.
				Syncope (fainting)	m. ✓
				Unsteady gait	n. ✓
				Vomiting	o.
				NONE OF ABOVE	p.

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

**SECTION K. ORAL / NUTRITIONAL STATUS**

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

1	<b>ORAL STATUS AND DISEASE PREVENTION</b>	Debris (soft, easily movable substances) present in mouth prior to going to bed at night Has dentures or removable bridge Some / all natural teeth lost — does not have or does not use dentures (or partial plates) Broke, loose, or carious teeth Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes Daily cleaning of teeth / dentures or daily mouth care — by resident or staff <b>NONE OF ABOVE</b>		a. ✓ b. c. ✓ d. ✓ e. ✓ f. no ✓ g.
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**SECTION M. SKIN CONDITION**

1	<b>ULCERS (Due to any cause)</b>	Record the number of ulcers at each ulcer stage — regardless of cause. If none present at a stage, record "0" (zero... Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.] a. <b>Stage 1</b> A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. b. <b>Stage 2</b> A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow layers that crater. c. <b>Stage 3</b> A full thickness of skin is lost, exposing the subcutaneous tissues — presents as a deep crater with or without undermining adjacent tissue. d. <b>Stage 4</b> A full thickness of skin and subcutaneous tissue is lost, exposing muscle and / or bone.	Number at Stage
2	<b>TYPE OF ULCER</b>	(For each type of ulcer, code for the <b>highest stage</b> 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	1, 2, 3, 4
3	<b>HISTORY OF RESOLVED ULCERS</b>	Resident had an ulcer that was resolved or cured in <b>LAST 90 DAYS</b> 0. No 1. Yes	1
4	<b>OTHER SKIN PROBLEMS OR LESIONS PRESENT</b>	(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., incontinence, eczema, drug rash, heat rash, herpes zoster Skin desensitized to pain or pressure Skin tears or cuts (other than surgery) Surgical wounds <b>NONE OF ABOVE</b>	a. b. c. d. e. ✓ f. g. h.
5	<b>SKIN TREATMENTS</b>	(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 preventive or protective skin care (other than to feet) <b>NONE OF ABOVE</b>	a. b. c. d. e. f. g. h. i. j.
6	<b>FOOT PROBLEMS AND CARE</b>	(Check all that apply during last 7 days) Resident has one or more foot problems — e.g., corns, calluses, 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 <b>last 90 days</b> Received preventive or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) <b>NONE OF ABOVE</b>	a. b. c. d. e. f. g.

**SECTION N. ACTIVITY PURSUIT PATTERNS**

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

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

**SECTION O. MEDICATIONS**

1	NUMBER OF MEDICATIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used)	
2	NEW MEDICATIONS	(Resident currently receiving medications that were initiated during the last 90 days) 0. No    1. Yes	
3	INJECTIONS	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)	
4	DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the number of DAYS during last 7 days; enter "0" if not used. Note — enter "1" for long-acting meds used less than weekly)	
		a. Antipsychotic b. Antianxiety c. Hypnotic d. Diuretic	1 or more 1 or more 1 or more

**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																																															
		<table border="0"> <tr> <td>TREATMENTS</td> <td></td> <td>Ventilator or respirator</td> <td>l.</td> </tr> <tr> <td>Chemotherapy</td> <td>a.</td> <td>PROGRAMS</td> <td>m.</td> </tr> <tr> <td>Dialysis</td> <td>b.</td> <td>Alcohol / drug treatment program</td> <td>n.</td> </tr> <tr> <td>IV medication</td> <td>c.</td> <td>Alzheimer's / dementia special care unit</td> <td>o.</td> </tr> <tr> <td>Intake / output</td> <td>d.</td> <td>Hospice care</td> <td>p.</td> </tr> <tr> <td>Monitoring acute medical condition</td> <td>e.</td> <td>Pediatric unit</td> <td>q.</td> </tr> <tr> <td>Ostomy care</td> <td>f.</td> <td>Respite care</td> <td>r.</td> </tr> <tr> <td>Oxygen therapy</td> <td>g.</td> <td>Training in skills required to return to the community (e.g., taking medications, housework, shopping, transportation, ADLs)</td> <td>s.</td> </tr> <tr> <td>Radiation</td> <td>h.</td> <td></td> <td></td> </tr> <tr> <td>Suctioning</td> <td>i.</td> <td></td> <td></td> </tr> <tr> <td>Tracheostomy care</td> <td>j.</td> <td></td> <td></td> </tr> <tr> <td>Transfusions</td> <td>k.</td> <td></td> <td></td> </tr> </table> <p>NONE OF ABOVE</p>	TREATMENTS		Ventilator or respirator	l.	Chemotherapy	a.	PROGRAMS	m.	Dialysis	b.	Alcohol / drug treatment program	n.	IV medication	c.	Alzheimer's / dementia special care unit	o.	Intake / output	d.	Hospice care	p.	Monitoring acute medical condition	e.	Pediatric unit	q.	Ostomy care	f.	Respite care	r.	Oxygen therapy	g.	Training in skills required to return to the community (e.g., taking medications, housework, shopping, transportation, ADLs)	s.	Radiation	h.			Suctioning	i.			Tracheostomy care	j.			Transfusions	k.	
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		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																																															
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		b. Occupational therapy																																															
		c. Physical therapy																																															
		d. Respiratory therapy																																															
		e. Psychological therapy (by any licensed mental health professional)																																															

2	INTERVENTION PROGRAMS FOR MOOD BEHAVIOR, COGNITIVE LOSS	(Check all interventions or strategies used in last 7 days — no matter where received)	
		Special behavior symptom evaluation program Evaluation by a licensed mental health specialist in last 90 days Group therapy Resident-specific deliberate changes in the environment to address mood/ behavior patterns — e.g., providing bureau in which to rummage Reorientation — e.g., cueing NONE OF ABOVE	a. b. c. d. e. 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.)																							
		<table border="0"> <tr> <td>a. Range of motion (passive)</td> <td></td> <td>f. Walking</td> <td></td> </tr> <tr> <td>b. Range of motion (active)</td> <td></td> <td>g. Dressing or grooming</td> <td></td> </tr> <tr> <td>c. Splint or brace assistance</td> <td></td> <td>h. Eating or swallowing</td> <td></td> </tr> <tr> <td>TRAINING AND SKILL PRACTICE IN:</td> <td></td> <td>i. Amputation / prosthesis care</td> <td></td> </tr> <tr> <td>d. Bed mobility</td> <td></td> <td>j. Communication</td> <td></td> </tr> <tr> <td>e. Transfer</td> <td></td> <td>k. Other</td> <td></td> </tr> </table>	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
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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	1, 2 1, 2 1, 2

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)	
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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)	
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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)	
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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)	
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9	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission)? 0. No    1. Yes	
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**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 persons who is positive toward discharge 0. No    1. Yes c. Stay projected to be of a short duration — discharge projected within 90 days (do not include expected discharge due to death) 0. No    2. Within 31—90 days 1. Within 30 days    3. Discharge status uncertain	

2	OVERALL CHANGE IN CARE NEEDS	Resident's overall self-sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved — receives fewer supports, needs less restrictive level of care 2. Deteriorated — receives more support	
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**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	
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**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

<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	

MDS QUARTERLY REVIEW

QUARTERS

1 2 3

A2	RESIDENT NAME	_____		
		(First)	(Middle initial)	(Last)
A3	SOCIAL SECURITY	□□□□	- □□□	- □□□□□□

QUARTERS

1 2 3

B2	MEMORY	(Recall or 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	□	□	□
C4	MAKING SELF UNDERSTOOD TO OTHERS	(Express 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	□	□	□
C5	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	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+ times during last 7 days — OR — Supervision 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+ 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	□	□	□
b.	TRANSFER	How resident moves between surfaces — to / from bed, chair, wheelchair, standing position, (EXCLUDE to / from bath / toilet)	□	□	□
c.	LOCOMOTION	How resident moves between locations in his / her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	□	□	□
d.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning / removing prosthesis	□	□	□
e.	EATING	How resident eats and drinks (regardless of skill)	□	□	□
f.	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	□	□	□
E3	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. 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	□	□	□

F1.	CONTINENCE SELF-CONTROL CATEGORIES (Code for resident performance over all shifts) 0. CONTINENT — Complete control 1. USUALLY CONTINENT — BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. OCCASIONALLY INCONTINENT — BLADDER, 2+ 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 appliance (e.g., Foley) or continence programs, if employed	□	□	□
H2	MOOD PERSISTENCE	Sad or anxious mood intrudes on daily life over last 7 days — not easily altered, doesn't "cheer up" 0. No 1. Yes	□	□	□
H3	PROBLEM BEHAVIOR	(Code for behavior in last 7 days) 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred less than daily 2. Behavior of this type occurred daily or more frequently  WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety) VERBALLY ABUSIVE (others were threatened, screamed at, cursed at) PHYSICALLY ABUSIVE (others were hit, shoved, scratched, sexually abused) SOCIALY INAPPROPRIATE / DISRUPTIVE BEHAVIOR (made disrupting sounds, noisy, screams, self-abusive acts, sexual behavior or disrobing in public, smeared / threw food / feces, hoarding, rummaged through others' belongings)	□	□	□
J2.	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, behavior status, medical treatments, or risk of death)  FIRST QUARTER a. _____ b. _____  SECOND QUARTER c. _____ d. _____  THIRD QUARTER e. _____ f. _____	□	□	□
L2.	WEIGHT LOSS	(i.e., 5% + in last 30 days; or 10% in last 180 days) 0. No 1. Yes	□	□	□
04.	DAYS RECEIVED THE FOLLOWING MEDICATION	(Record the number of days during the last 7 days; enter "0" if not used; enter "1" if long-acting meds. used less than weekly)  Antipsychotics  Antianxiety / hypnotics  Antidepressants	□	□	□
P3	DEVICES AND RESTRAINTS	(Use the following codes for last 7 days) 0. Not used 1. Used less than daily 2. Used daily  b. Trunk restraint  d. Chair prevents rising	□	□	□

**MDS QUARTERLY REVIEW — Signatures and Dates**

**FIRST QUARTER**

Signature of RN Assessment Coordinator

Review indicates change necessary to plan of care?

\_\_\_\_\_

Yes  No

Signatures of Others Who Completed Part of the Assessment

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Assessment:

Month Day Year

**SECOND QUARTER**

Signature of RN Assessment Coordinator

Review indicates change necessary to plan of care?

\_\_\_\_\_

Yes  No

Signatures of Others Who Completed Part of the Assessment

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Assessment:

Month Day Year

**THIRD QUARTER**

Signature of RN Assessment Coordinator

Review indicates change necessary to plan of care?

\_\_\_\_\_

Yes  No

Signatures of Others Who Completed Part of the Assessment

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Assessment:

Month Day Year