

**LONG TERM CARE FACILITY
RESIDENT ASSESSMENT INSTRUMENT (RAI)
USER'S MANUAL**

For Use With Version 2.0 of the
Health Care Financing Administration's
Minimum Data Set,
Resident Assessment Protocols, and
Utilization Guidelines

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October 1995

The Long Term Care Facility Resident Assessment Instrument User's Manual for Version 2.0 is published by the Health Care Financing Administration (HCFA) and is a public document. It may be copied freely, as our goal is to disseminate information broadly to facilitate accurate and effective resident assessment practices in long term care facilities.

This manual is intended to replace HCFA's original *RAI Training Manual and Reference Guide*, published December 1990.

Authors of this *User's Manual* include John N. Morris, Katharine Murphy, Sue Nonemaker, Gloria Smit, Allan Stegemann, Janne Swearengen, and David Zimmerman.

In addition to John N. Morris, Katharine Murphy, and Sue Nonemaker, other authors of HCFA's 1990 Training Manual are Catherine Hawes, Charles Phillips, Brant Fries, and Vincent Mor. These individuals also contributed to Chapter 3 of the *Version 2.0 Users Manual*.

HCFA ACKNOWLEDGEMENT

The RAI Version 2.0 and related training materials were developed under a HCFA contract with **the** Hebrew Rehabilitation Center for Aged (**HRCA**). John N. Morris and Katharine **Murphy**, key members of the original **RAI** design team, had primary responsibility for **developing** 2.0 and participated in the development of training materials.. They 'were assisted on tasks related to 2.0 by Steven Littlehale, Jon Wolf, **Yvonne** Anderson, **Romanna Michajliw**, Wee Lock Ooi, David Levine, and other members of HRCA research and **clinical** staff. Staff at the Health Insights Research Group (**HIRG**), **including Allan Stegemann**, Gloria **Smit**, **Janne** Swearengen, and David Zimmerman, **also** participated in the development of **materials** for **this** User's **Manual** and had lead responsibility for its production. Sue Frey, **Kris** Engbring, Patti Beutel, and Mary Ann Sveum contributed to the final production of **this Manual**.

We also acknowledge the continued thoughtful input into version 2.0 by the principal investigators on the original design team, specifically Catherine Hawes, Charles Phillips, **Brant** Fries, and **Vince** Mor. Members of the international community using the **MDS** also contributed to the development of version 2.0 through their *interRAI* association.

We particularly appreciate the continued involvement and support of the countless professional associations and clinical **experts** that have been involved in the resident assessment initiative since its onset. They are too numerous to name individually, but special mention must be made of the contributions of individuals representing the key associations with which we have worked on nursing home reform issues: Marcia Richards, American Health Care Association; Ewie **Munley**, **American** Association of Homes and Services for **the** Aging; and Sarah Burger, National Citizens' Coalition for Nursing Home Reform.

State and HCFA Regional office personnel have played a key role in working with **nursing** home staff to implement the **RAI**. Specifically, we acknowledge the exceptional contributions of Marlene Black (Washington State), Ruth Jacobs-Jackson (California), Sheree Zbylot (Mississippi), Pat **Maben** (Kansas), Ellen **Mullins** (Alabama), Diane Carter (Colorado), and Pat Bendert (**HCFA** Region IV - Atlanta), all of whom have contributed their own time to serve on workgroups or develop training materials. **Betty** Cornelius, HCFA Project Officer and staff from her Nursing Home **Case-Mix** and **Quality** Demonstration States, have also contributed freely. We particularly appreciate the suggestions of Bob **Godbout** (Texas), Peter **Arbuthnot** (Mississippi), and Dave Wilcox (New York) in modifying the MDS 2.0 to make it more computer "**friendly**."

HCFA ACKNOWLEDGEMENT
(Continued)

Lastly, this work would not have been possible without the continued support of management within the Health Standards and Quality Bureau at HCFA.. Most specifically, Helene Fredeking, Director of the Division of Long Term Care Services, has played a key substantive role, as well as garnered necessary resources to support work on this initiative. Katie Phillips has worked closely with the States and Regions on **RAI** issues for the past several years, and has been deeply involved in developing both the State Operations Manual and pending final regulations on resident assessment. Finally, a major contribution to the original RAI development effort, the revisions associated with version 2.0, and the development of training materials for both versions was made by Sue Nonemaker, HCFA Project Officer for both initiatives. She also provided the HCFA **leadership** and coordination necessary to implement the **RAI** nationally.

IF YOU HAVE QUESTIONS RELATED TO RESIDENT ASSESSMENT

Questions related to the **RAI** should be referred initially to the **State** (see Appendix A for a list of contact persons, addresses, and phone numbers.) HCFA Regional office RAI coordinators are also listed in Appendix A.

Questions that cannot be resolved at the State level or suggestions for improving this **User's Manual** should be referred to:

MDS Coordinator
Center on Long Term Care
Health Standards and Quality Bureau
Health Care **Financing** Administration
7500 Security Boulevard
Baltimore, Maryland 212441850

PREFACE '

The nursing home reform law of OBRA '87 provided an opportunity to ensure good **clinical** practice by creating a regulatory framework that recognized the importance of comprehensive assessment as the foundation for planning and delivering care to this country's nursing home residents. The Resident Assessment Instrument (**RAI**) requirements can be viewed as empowering to clinicians in that they provide regulatory support for good clinical practice. The RAI is simply, a standard, new approach for doing what clinicians have always been **doing, or** should have been doing, related to assessing, planning and providing individualized care. **HCFA's** efforts in developing the **RAI** and **associated** policies, therefore, have always been centered on the premise "What is the right thing to do in terms of good clinical practice, and for all nursing home residents?"

This same philosophy has been shared by the other members of the original design team, and the countless individuals representing associations and State governments with which we have worked in partnership in implementing the RAI nationally. I believe that it is this emphasis on interweaving tenets of good clinical practice within a regulatory model, more **than** any other factor, that has contributed to our successful implementation of the RAI nationally, and more importantly, the successful use of the RAI by individual nursing homes to provide quality care to their residents.

In introducing version 2.0 of the RAI, it is important to note that we always intended that the **RAI** would be a dynamic tool. In essence, we recognized that we could not **simply publish** the MDS and **RAPs** in 1990 and expect that they could serve as a foundation for the delivery of long term care services without ongoing evaluation and refinement over time. Consequently, with the designation of the original version of the RAI, HCFA made a commitment to the providers and consumers of nursing home services that we would sponsor the continued refinement of the RAI. While change is always difficult, this work is necessary in order for the RAI to incorporate **state-of-the-art** changes in clinical practice and assessment methodologies, as well as accommodate the changing **needs** of the nursing home population.

HCFA began an open and very collaborative process to develop **version 2.0** of the **RAI** in early 1993 by requesting comments on the original version through a notice of proposed rulemaking published in the Federal Register. Working in concert with key members of the original RAI development team, John N. Morris, Ph.D., and Katharine Murphy, R.N., M.S., at Hebrew Rehabilitation Center for Aged in Boston, HCFA then began the arduous task of consulting with nursing home staff, State agencies, and national organizations representing the industry, consumers, and professional disciplines. We produced a series of draft **documents**, and continued our **refinements** based on comments from individuals and organizations with years of experience in using the original RAI. We made many substantive changes based on the comments of **nursing** home staff participating in a field test of the new MDS, which focused on ensuring the **clinical** utility and inter-rater reliability of new MDS items. We also consulted with a number of States and organizations with experience in automating the MDS, in order to make version 2.0 more computer - "friendly."

There were a number of “guiding principles” we used in developing version 2.0 that give insight into the programmatic goals and priorities that shaped the new instrument:

- In keeping with the clinical focus used to design the original MDS, we made **only** those additions or changes that nursing home staff viewed as providing useful information for care planning. Our primary rule of thumb in deciding whether to add or change an item was “Is this something that clinicians need to know in order to provide care for a nursing home resident?” We also strove to keep this a minimum data set. As we waded through an innumerable number of excellent suggestions for additional items, we would ask ourselves whether the item provided vital information or would simply be “nice to know,” and whether it was something that was necessary to know for all nursing home residents. This was truly a difficult task and will no doubt result in several unhappy individuals whose suggestions did not ‘survive such scrutiny. As such, the MDS version 2.0 remains a symbol of compromise—probably less information than we might like to have, but clearly an improvement as evidenced by the positive responses of facility staff participating in our field test and the positive comments received from States and associations.
- We also recognized the increasing purposes for which MDS data is **being** used by both nursing home staff and States. Provided that items met the primary test of supplying necessary information for clinical staff, we chose to add some items that would also support programmatic needs, such as for payment and quality improvement systems. To the extent that such programs could be supported by the clinical information obtained **from** the MDS, it was felt that this would **minimize** burden on facilities by reducing the need to report duplicative sets of information. Consequently, in response to the increasing number of States that have already implemented or expressed an interest in using **MDS data** for a Medicaid case-mix reimbursement system, we added those items necessary to calculate Resource Utilization Groups III (**RUGs-III**). **RUGs-III** is the payment classification system that was developed for the HCFA sponsored “Nursing Home **Case-Mix and Quality**” Demonstration. It has already been implemented as the basis for Medicaid payment by the four States participating in the Demonstration, with plans for six States to move to **RUGs-III** driven payment for Medicare in participating facilities. Designing version 2.0 to support case-mix reimbursement systems required the addition of **several** items **from** the tool known as the **MDS+**, which has been used in ten States for Medicaid payment. This was not in opposition to our **primary rule** of “clinical utility,” however, as many of the **MDS+** items addressed **clinical** “holes” in the original MDS (e.g., issues related to restorative nursing care, therapies, skin care, etc.). The incorporation of all “payment” items into the core MDS eliminates the need for States to implement alternate instruments to support payment systems, unless additional items are needed for **State-specific** payment systems.
- In keeping with the goal of HCFA’s Health Standards and Quality Bureau (**HSQB**) to move forward with an **MDS-driven** quality monitoring **and improvement** system, we have also added those **MDS+** items necessary to generate many of the Quality Indicators (**QI’s**), as developed by the University of Wisconsin under the auspices of the aforementioned Demonstration. This required the addition of a few items to the core MDS. More significantly, this programmatic goal underscores the importance of the quarterly review,

as more information, submitted more frequently, will be required to support our future quality monitoring systems. However, it should also be stressed that no items were added to the quarterly review requirement solely to provide **QI** data. There **was** significant agreement within the associations and States with which we consulted that the original quarterly review requirement did not provide facilities with all items necessary **to** adequately monitor residents' status. In this regard, we also had to compromise and **could** not accommodate all of the good suggestions we received for adding items to the quarterly review requirement.

You will notice a number of changes in the new MDS, which are highlighted below:

- The sections have been reordered (e.g., **ADLs** are now found in Section G). **All State RAIs** will now have one consistent ordering of sections, with any additional State specific items found in Section S. Sections T and U have been developed for use in States participating in **the** Medicare Nursing Home **Case-Mix** and Quality Demonstration, and are not a part of the core MDS.
- A number of items and sections have been constructed **to** facilitate **computerization** and data entry. There are also new forms designed for this purpose: Basic Assessment Tracking Form, Section AA - Identification Information, which has all key information needed to track residents in data systems; **and forms** for tracking residents on discharge and reentry into the facility.
- Several new scales have been added to help **clinicians** better understand a resident's status in a number of areas. For example, there are now scales that measure the alterability and frequency of behavioral symptoms and the frequency and intensity of pain.
- Several items have been added in response to the changing needs of the nursing home population. For example, the increase in subacute, hospice, and short-term stay populations led to the inclusion of **items assessing** pain, discharge potential, restorative and rehabilitation needs, and **infections**.

Version 2.0 brings an attempt to **streamline** the **RAP** triggers. Analyses of large data sets were conducted to improve the predictive power of the triggers. In more simple terms, **which** triggers contributed most **significantly** to the identification of problems warranting care plans? Which trigger items could be eliminated? Along with reducing the number of trigger items overall, we **also** eliminated the distinction between automatic and potential triggers.

There have also been a number of changes in the RAI utilization guidelines, which is a regulatory term for our instructions on how the instrument must be used. For example, we created a new definition of significant change and modified our guidance on when a significant change reassessment is required, decreased the time for retention of **RAI** records, and changed the procedures by which errors may be corrected.

We expect the changes within version 2.0 and our policies regarding its use to be **only the** beginning of our commitment to improving the instrument and facilities' ability to use it

effectively. Over the **next** few **months**, we will begin a process to review and revise the existing **RAPs**, as well as to develop new **RAPs** to address areas of significant clinical **importance**. We also expect to conduct an ongoing assessment of training needs and to intensify **our** efforts to produce educational materials for both nursing home staff and surveyors. Over the next few years, we expect to revise all of the RAPs, as well as begin work on the next version of the MDS. We welcome your suggestions on all of these areas and invite you to Consider volunteering to participate in developing or reviewing materials in your own area of clinical expertise.

Finally, we thank you for all of your hard work in implementing the **RAI** and using it to provide quality care to nursing home residents throughout the nation.

Sue Nonemaker, R.N., M.S.
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September 4, 1995

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CHAPTER 1: OVERVIEW OF THE RAI

1.1 Overview of RAI Components

Providing care to residents of long term care facilities is complex and **challenging work**. It utilizes” clinical competence, observational skills, and assessment expertise **from** all disciplines to develop individualized care plans. The Resident Assessment Instrument (**RAI**) helps facility staff to gather definitive information on a resident’s strengths and **needs** which must be addressed in an individualized care plan. It also assists staff to evaluate goal achievement and revise care plans accordingly by enabling the facility to track changes in the resident’s status. As the process of problem identification is integrated with sound clinical interventions, the care plan becomes each resident’s unique path toward achieving or maintaining his or her **highest practicable** level of well-being.

The RAI helps facility staff to look at residents holistically — as individuals for whom quality of **life** and quality of care are mutually ‘significant and necessary. Interdisciplinary use of the RAI promotes this very emphasis on quality of care and quality of **life**. Facilities have found that involving disciplines such as dietary, social work, physical therapy, occupational therapy, speech language pathology, pharmacy and activities in the **RAI** process has fostered a more holistic approach to resident care and strengthened team communication.

Persons generally enter a nursing facility due to functional status problems caused by physical deterioration, cognitive decline, or other related factors. The ability to manage independently has **been** limited to the extent that assistance or medical treatment is **needed** for residents to function or to live safely from day to day. All necessary resources and disciplines must be used to ensure that residents achieve the highest level of functioning possible (Quality of Care) and maintain their sense of individuality (Quality of Life). This is true for long stay residents, as well as the resident in a rehabilitative program anticipating return to a less restrictive environment.

Clinicians are generally taught a problem identification process as part of their professional education. For example, the nursing profession’s problem identification model is called the nursing process, which consists of assessment, planning, implementation and evaluation. The RAI simply provides a structured, **standardized** approach for applying a problem identification process in long term care facilities. **The RAI should not, nor was it ever meant to be an additional burden for nursing facility staff.**

All good problem identification models have similar steps:

a.) **Assessment** - Taking stock of all observations, information and knowledge about a resident; understanding the resident’s limitations and **strengths; finding** out who the resident is.

b.) **Decision-making** - Determining the severity, functional impact, and scope of a resident’s problems; understanding the causes and relationships between a resident’s **problems**; discovering the “what’s” and “whys” of resident problems.

c.) Care Planning - Establishing a course of action that moves a resident toward a specific goal utilizing individual resident strengths and interdisciplinary expertise; crafting the “how” of resident care.

d.) Implementation - Putting that course of action (specific interventions on **the care plan**) into motion by staff knowledgeable about the resident care goals and approaches; carrying out the “how” ‘and “when” of resident care.

e.) Evaluation - Critically reviewing care plan goals, interventions and implementation’ in terms of achieved resident outcomes and assessing the need to modify the care. plan (i.e., change interventions) to adjust to changes in the resident’s status, either improvement or decline.

This is how the problem identification process would look as a pathway. ‘This manual will feature this pathway throughout and will highlight the point in the pathway that each chapter discusses.



If you look at the **RAI** system as solution oriented and dynamic, it becomes a richly practical **means** of helping **facility** staff to gather and analyze information in order to improve a resident’s quality of care and quality of life. In an already overburdened structure, the **RAI** offers a clear path toward utilizing all members of the interdisciplinary team in a proactive process. There is absolutely no reason to insert the RAI process as an added task or view it as another “layer” of labor.

The key to **understanding** the **RAI** process, and successfully using it, is believing that its structure is designed to enhance resident care and promote the quality of a resident’s life. This occurs not only because it follows an interdisciplinary problem solving model but also because staff; across all shifts, are involved in its ‘hands on” approach. The result is a process that flows smoothly from one component to the next and allows for good communication and **uncomplicated** tracking of resident care. In short, it works!

Over the course of the **years since** the **RAI** has been implemented, facilities who have applied the **RAI** in the manner we have discussed have discovered that it works in the following ways:

Residents respond to individualized care. While we will discuss other positive responses to the **RAI** below, there is none more persuasive or powerful than good resident outcomes both in terms of a resident’s quality of care and quality of life. Facility after facility has found that when the care plan reflects careful consideration of individual problems and causes, liied with appropriate resident specific approaches to **care**, residents have experienced goal achievement and either the level of functioning has improved or’deteriorated at a slower rate. Facilities report that **as** individualized attention **increases**, resident satisfaction with quality of life is also increased.

Staff communication has become more effective. When staff are involved in a resident's ongoing assessment and have input into **the** determination and development of a resident's care plan, the commitment to and the understanding of that care plan is enhanced. All levels of staff, including nursing assistants, have a stake in the process. Knowledge gained from careful examination of possible causes and solutions of resident problems (i.e., from using **the RAPs**) challenges staff to hone the professional skills of their discipline as well as focus on the individuality of the resident and holistically consider how that individuality must be accommodated in **the** care plan.

Resident and **family** involvement in care has increased. There has been a dramatic increase in the frequency and nature of resident and family involvement in the care planning process. Input has been provided on individual resident strengths, problems, and preferences. Staff have a much better picture of the resident, and residents 'and. families have a better understanding of the goals and processes of care.

Documentation has become clearer. When the approaches to achieving a specific goal are understood and distinct, the need for voluminous documentation diminishes. Likewise, when staff are communicating effectively among themselves with respect to resident care, repetitive documentation is not necessary and contradictory notes do not occur. In addition, new staff, consultants, or others who review records **find** that information documented about a resident is clearer and tracking care and outcomes is more easily accomplished.

It is the intent of this manual to 'offer clear guidance, through instruction and example, for the effective use of the RAI, and thereby help facilities achieve the benefits listed above.

In keeping with objectives set forth in the Institute of Medicine (**IOM**) study completed in 1986 that made recommendations to improve the quality of care in nursing homes, the **RAI** provides each resident with a standardized, comprehensive and reproducible assessment. It evaluates a resident's ability to perform daily life functions and identifies significant impairments in a resident's functional capacity. In essence, with an accurate RAI completed periodically, caregivers have a genuine and consistently recorded "look" at the resident and can attend to that resident's needs with realistic goals in hand.

With the consistent application of item definitions, the **RAI** ensures standardii communication both within the facility and between facilities (e.g., other long **term care** facilities or hospitals). Basically, when everyone is speaking the same language, the opportunity for **misunderstanding** or error is diminished considerably.

The **RAI** consists of **three** basic components; the Minimum Data Set (**MDS**), Resident Assessment Protocols (**RAPs**), and Utiliition Guidelines specified in State Operations Manual (**SOM**) Transmittal #272. All components are discussed in detail in this manual.

Utilization of the three components of **the** RAI yields information about a resident's functional **status**, strengths, weaknesses and preferences, and offers guidance on further assessment once problems have been identified. Each component flows naturally into the next as follows:

- **Minimum Data Set (MDS).** A **core** set of screening; clinical **and** functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified **to** participate in Medicare or Medicaid. The items in the **MDS** standardize communication about resident problems and conditions within facilities, between **facilities**, and between facilities and outside agencies. A **copy of the MDS Version 2.0** can be **found at the end of this chapter, beginning on page 1-6 and Appendix B.**
- **Resident Assessment Protocols (RAPs).** A component of the utilization guidelines, the **RAPs** are structured, problem-oriented frameworks for organizing MDS information, and examining additional clinically relevant **information** about an individual. **RAPs** help identify social, medical and psychological problems and form the **basis** for individualized care planning.
- Utilization Guidelines. **Instructions** concerning when and **how** to use the **RAI.**

1.2 Overview of RAI Version 2.0 User's Manual

The manual layout is as follows:

Chapter 1 - Overview of the RAI

Chapter 2 - Using the RAI: Statutory and Regulatory Requirements and Suggestions for Integration in Clinical Practice

Chapter 3 - Completing the MDS: Item by Item Definitions and Instructions

Chapter 4 - Procedures for Completing the Resident Assessment Protocols (RAPs)

Chapter 5 - Liig Assessment to Individualized Care Plans

APPENDICES

Appendix A: State Agencies Responsible for Answering RAI Questions

Appendix B: MDS and Quarterly Review Forms for Version 2.0

Appendix C: Trigger Legend, RAP Summary Form-and 18 RAPs for Version 2.0

Appendix D: Interviewing Techniques

Appendix E: Commonly Prescribed Medications by Category

Appendix F: Cognitive Performance Scale (CPS) Scoring Rules

Appendix G: Statutory and Regulatory Requirements for Long Term Care Facilities - Resident Assessment and Care Planning

Appendix H: RAI Background

Index**1.3 Suggestions for the Use of This Manual**

This manual is designed to meet the needs of facility staff who are both skilled in the use of the RAI and staff who are just beginning to work with it.

For those who have had experience with the RAI, this manual will show you “what’s new” about the RAI Version 2.0 and serve as a reference. While the MDS has change& the process of completion and application has not. You will find the item by item section informative with respect to new items and items that have been refined or expanded. You will also find that the case studies and examples provide direction regarding “how to” complete the RAP review process and what kind of documentation is required.

If you are new to the RAI and its process, you will find’ this manual an invaluable companion. The following fundamental concepts associated with the RAI are interwoven as themes throughout this manual:

- A. The resident is an individual with strengths, as well as functional limitations and health problems.
- B. Possible causes for each problem area and guidance for further assessment and resolution or intervention are presented in the RAPs.
- C. An interdisciplinary approach. to resident care is vital — both in assessment and in developing the resident’s care plan.
- D. Good clinical practice requires solid, sound assessment.

In essence, this manual promotes a step-by-step system of assessing resident needs and functional status based on standardized definitions of items (the MDS). It then helps you think through possible reasons for and risk factors that contribute to a resident’s clinical status (RAPs). This informative material offers the interdisciplinary team realistic approaches to resident care that are based on specific, individual characteristics.

ERRATA SHEET FOR MINIMUM DATA SET (MDS) — VERSION 2.0

SECTION AA. IDENTIFICATION INFORMATION

ITEM AA8b. Special codes for use with supplemental **assessment types in Case Mix demonstration states or other states where required**

- Should read:
- b. Codes for assessments **required for Medicare PPS or the State**
 1. Medicare 5 day assessment
 2. Medicare 30 day assessment
 3. **Medicare 60 day assessment**
 4. Medicare 90 day assessment
 5. Medicare **readmission/return assessment**
 6. Other state **required assessment**
 7. Medicare 14 day assessment
 8. Other Medicare required assessment

**SECTION T. SUPPLEMENT — CASE MIX DEMO. : SECTING HEADING HAS BEEN CHANGED TO:
THERAPY SUPPLEMENT FOR MEDICARE PPS**

ITEM T1. *Instruction in bold italics between items a and b should read:* Skip **unless** this is a Medicare **5 day or Medicare readmission/return** assessment.

RUG-III QUARTERLY (10/18/94h) & RUG-III QUARTERLY (1997 Update)

ITEM A4a: **Date of Readmission**

Change to: **Date of Reentry and change instruction** to: Date of **reentry** from **most** recent temporary discharge to a hospital in last 90 **days** (or since last **assessment or admission** if less than 90 days).

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

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

SECTION AC. CUSTOMARY ROUTINE

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

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

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:		
1. Signature of RN Assessment Coordinator		Date
2. Signatures	Title	Sections
		Date

Resident

Numeric Identifier

2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) <i>Code for most dependent in self-performance and support.</i> (A) BATHING SELF-PERFORMANCE codes appear below	(A)	(B)
		0. Independent—No help provided		
		1. Supervision—Oversight help only		
		2. Physical help limited to transfer only		
		3. Physical help in part of bathing activity		
		4. Total dependence		
		8. Activity itself did not occur during entire 7 days (Bathing support codes are as defined in Item 1, code B above)		
3.	TEST FOR BALANCE (see training manual)	(Code for ability during test in the last 7 days) 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help		
		a. Balance while standing		
		b. Balance while sitting—position, trunk control		
4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)	(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury) (A) RANGE OF MOTION 0. No limitation 1. Limitation on one side 2. Limitation on both sides (B) VOLUNTARY MOVEMENT 0. No loss 1. Partial loss 2. Full loss	(A)	(B)
		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 mobility or transfer Lifted manually	a. Lifted mechanically b. Transfer aid (e.g., slide board, trapeze, cane, walker, brace) c. NONE OF ABOVE	f.
				g.
7.	TASK SEGMENTATION	Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them 0. No 1. Yes		
8.	ADL FUNCTIONAL REHABILITATION POTENTIAL	Resident believes he/she is capable of increased independence in at least some ADLs 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		
9.	CHANGE IN ADL FUNCTION	Resident's ADL self-performance status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated		

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

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 Hypertension Hypothyroidism HEART/CIRCULATION Arteriosclerotic heart disease (ASHD) Cardiac dysrhythmias Congestive heart failure Deep vein thrombosis Hypertension Hypotension Peripheral vascular disease Other cardiovascular disease	a. Hemiplegia/Hemiparesis b. Multiple sclerosis c. Paraplegia d. Parkinson's disease e. Quadriplegia f. Seizure disorder g. Transient Ischemic attack (TIA) h. Traumatic brain injury i. PSYCHIATRIC/MOOD j. Anxiety disorder k. Depression l. Manic depression (bipolar disease) m. Schizophrenia n. PULMONARY o. Asthma p. Emphysema/COPD q. SENSORY r. Cataracts s. Diabetic retinopathy t. Glaucoma u. Macular degeneration v. OTHER w. Allergies x. Anemia y. Cancer z. Renal failure aa. NONE OF ABOVE	w.
	MUSCULOSKELETAL	Arthritis Hip fracture Missing limb (e.g., amputation) Osteoporosis Pathological bone fracture		
	NEUROLOGICAL	Alzheimer's disease Aphasia Cerebral palsy Cerebrovascular accident (stroke) Dementia other than Alzheimer's disease		
2.	INFECTIONS	(If none apply, CHECK the NONE OF ABOVE box) Antibiotic resistant infection (e.g., Methicillin resistant staph) Clostridium difficile (c. diff) Conjunctivitis HIV infection Pneumonia Respiratory infection	a. Septicemia b. Sexually transmitted diseases c. Tuberculosis d. Urinary tract infection in last 90 days e. Viral hepatitis f. Wound infection g. NONE OF ABOVE	g.
				h.
				i.
				j.
				k.
				l.
				m.
3.	OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES			

SECTION H. CONTINENCE IN LAST 14 DAYS

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

SECTION J. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS	(Check all problems present in last 7 days unless other time frame is indicated)		
	INDICATORS OF FLUID STATUS	Weight gain or loss of 3 or more pounds within a 7 day period Inability to lie flat due to shortness of breath Dehydrated; output exceeds input Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days	a. Dizziness/Vertigo b. Edema c. Fever d. Hallucinations e. Internal bleeding f. Recurrent lung aspirations in last 90 days g. Shortness of breath h. Syncope (fainting) i. Unsteady gait j. Vomiting	k.
				l.
				m.
				n.
				o.

Resident _____

Numeric Identifier _____

SECTION M. SKIN CONDITION

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

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

SECTION K. ORAL/NUTRITIONAL STATUS

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

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	(Check appropriate time periods over last 7 days)
		Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:
		Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/>
		NONE OF ABOVE
(If resident is comatose, skip to Section O)		
2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care)
		0. Most—more than 2/3 of time 2. Little—less than 1/3 of time
		1. Some—from 1/3 to 2/3 of time 3. None
3.	PREFERRED ACTIVITY SETTINGS	(Check all settings in which activities are preferred)
		Own room <input type="checkbox"/> Outside facility <input type="checkbox"/>
		Day/activity room <input type="checkbox"/> Inside N/A unit <input type="checkbox"/>
		NONE OF ABOVE
4.	GENERAL ACTIVITY PREFERENCES (adapted to resident's)	(Check all PREFERENCES whether or not activity is currently available to resident)
		Trips/shopping <input type="checkbox"/>
		Cards/other games <input type="checkbox"/> Walking/wheeling outdoors <input type="checkbox"/>
		Crafts/arts <input type="checkbox"/> Watching TV <input type="checkbox"/>
		Exercise/sports <input type="checkbox"/>

SECTION L. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION	Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
		Has dentures or removable bridge	b.
		Some/all natural teeth lost—does not have or does not use dentures (or partial plates)	c.
		Broken, loose, or carious teeth	d.
		Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes	e.

SEC-I-ION D. VISION PATTERNS

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

SECTION E. MOOD AND BEHAVIOR PATTERNS

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

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

1. SENSE OF INITIATIVE/INVOLVEMENT	At ease interacting with others At ease doing planned or structured activities At ease doing self-initiated activities Establishes own goals Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) Accepts invitations into most group activities NONE OF ABOVE	a. b. c. d. e. f. g.
2. UNSETTLED RELATIONSHIPS	Cover/open conflict with or repeated criticism of staff Unhappy with roommate Unhappy with residents other than roommate Openly expresses conflict/anger with family/friends Absence of personal contact with family/friends Recent loss of close family member/friend Does not adjust easily to change in routines 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 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 5. ACTIVITY DID NOT OCCUR during entire 7 days		
(B) ADL SUPPORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)	0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+ persons physical assist 8. ADL activity itself did not occur during entire 7 days		(A) (B) SELF-PERF SUPPORT
a. BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b. TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bathroom)		
c. WALK IN ROOM	How resident walks between locations in his/her room		
d. WALK IN CORRIDOR	How resident walks in corridor on unit		
e. LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f. LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g. DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis		
h. EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i. TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j. PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

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

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

SECTION 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	<input type="checkbox"/>	d. Hypnotic	<input type="checkbox"/>
	b. Anti-anxiety	<input type="checkbox"/>	e. Diuretic	<input type="checkbox"/>
	c. Antidepressant	<input type="checkbox"/>		

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE—Check treatments or programs received during the last 14 days		
	TREATMENTS	<input type="checkbox"/> Ventilator or respirator <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Dialysis <input type="checkbox"/> IV medication <input type="checkbox"/> Intake/output <input type="checkbox"/> Monitoring acute medical condition <input type="checkbox"/> Ostomy care <input type="checkbox"/> Oxygen therapy <input type="checkbox"/> Radiation <input type="checkbox"/> Suctioning <input type="checkbox"/> Tracheostomy care <input type="checkbox"/> Transfusions	
	PROGRAMS	<input type="checkbox"/> Alcohol/drug treatment program <input type="checkbox"/> Alzheimer's/dementia special care unit <input type="checkbox"/> Hospice care <input type="checkbox"/> Pediatric unit <input type="checkbox"/> Respite care <input type="checkbox"/> Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) <input type="checkbox"/> NONE OF ABOVE	
	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	DAYS (A)	MIN (B)
	(B) = total # of minutes provided in last 7 days		
	a. Speech - language pathology and audiology services		
	b. Occupational therapy		
	c. Physical therapy		
	d. Respiratory therapy		
	e. Psychological therapy (by any licensed mental health professional)		
	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	<input type="checkbox"/>
		Evaluation by a licensed mental health specialist in last 90 days	<input type="checkbox"/>
		Group therapy	<input type="checkbox"/>
Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage		<input type="checkbox"/>	
Reorientation—e.g., cueing	<input type="checkbox"/>		
NONE OF ABOVE	<input type="checkbox"/>		
3. NURSING REHABILITATION/ RESTORATIVE CARE	Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily)		
	a. Range of motion (passive)	<input type="checkbox"/>	
	b. Range of motion (active)	<input type="checkbox"/>	
	c. Splint or brace assistance	<input type="checkbox"/>	
	TRAINING AND SKILL PRACTICE IN:		
	d. Bed mobility	<input type="checkbox"/>	
	e. Transfer	<input type="checkbox"/>	
	f. Walking	<input type="checkbox"/>	
	g. Dressing or grooming	<input type="checkbox"/>	
	h. Eating or swallowing	<input type="checkbox"/>	
i. Amputation/prosthesis care	<input type="checkbox"/>		
j. Communication	<input type="checkbox"/>		
k. Other	<input type="checkbox"/>		

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1. DISCHARGE POTENTIAL	a. Resident expresses/indicates preference to return to the community 0. No 1. Yes
	b. Resident has a support person who is positive towards discharge 0. No 1. Yes
	c. Stay projected to be of a short duration— discharge projected within 90 days (do not include expected discharge due to death) 0. No 1. Within 30 days 2. Within 31-90 days 3. Discharge status uncertain
2. OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support

SECTION R. ASSESSMENT INFORMATION

1. PARTICIPATION IN ASSESSMENT	a. Resident: 0. No 1. Yes														
	b. Family: 0. No 1. Yes 2. No family														
	c. Significant other: 0. No 1. Yes 2. None														
2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:															
a. Signature of RN Assessment Coordinator (sign on above line)															
b. Date RN Assessment Coordinator signed as complete															
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CHAPTER 2: USING THE RAI: STATUTORY AND REGULATORY REQUIREMENTS AND SUGGESTIONS FOR INTEGRATION IN CLINICAL PRACTICE



This chapter presents the regulatory basis for the RAI and discusses how the RAI process can be implemented procedurally in the course of clinical practice with facility residents. Some of the procedures are required by statutory law, Federal regulation or HCFA utilization guidelines, while others are recommended based on sound experience of facilities that have used the RAI process successfully.

12.1 Statutory and Regulatory Basis for the RAI

The statutory authority for the Minimum Data Set (MDS) and the Resident Assessment Instrument (RAI) is found in section 1819 (f)(6)(A-B) for Medicare and 1919 (f)(6)(A-B) for Medicaid in the Social Security Act, as amended by the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). These sections of the Social Security Act required the Secretary of the Department of Health and Human Services (the Secretary) to specify a minimum data set of core elements to use in conducting comprehensive assessments. It furthermore required the Secretary to designate one or more resident assessment instruments based on the minimum data set. The Secretary designated Version 2.0 of the RAI in the State Operations Manual Transmittal #272, issued April 1995.

Federal requirements¹ at 42 CFR 483.20 (b)(1)(i) -- (F272) require that facilities use an RAI that has been specified by the State. This assessment system provides a comprehensive, accurate, standardized, reproducible assessment of each long term care facility resident's functional capabilities and helps staff to identify health problems.

12.2 Content of the RAI

- All State RAIs include at least the Health Care Financing Administration's (HCFA's):
- MDS
 - Triggers
 - Resident Assessment Protocols (RAPS)
 - Utilization Guidelines

¹For further information regarding the statutory basis for the RAI, see Appendix G.

Some States have added items to the core MDS that must be completed for each resident when an **RAI** comprehensive assessment is **required**. **Thus, while** the basic MDS form (as included in this manual) is the standard foundation for States, you may **find** that other items have **been added** at the end of the form (i.e., Sections **S**, **T**, or **U**) in your State.

Additionally, States must **specify** a Quarterly Assessment Form for use by facilities that includes at least the items on the **HCFA-designated** form. **(See Section 2.4 and Appendix B of this manual for a list of the items.)** **Several States have also** expanded the list of MDS items that must be documented on the resident's Quarterly Assessment.

HCFA's approval of a State's RAI covers the core items included on the instrument, the working and sequence of those items, and all definitions and instructions for the RAI. HCFA's approval of the RAI does not include, characteristics related to formatting (e.g., print type, color **coding**, or changes such as printing triggers on the assessment form).

If allowed by the State, facilities may have some flexibility in form design (e.g., print type, color, shading, integrating triggers) or use a computer generated printout of the **RAI** as long as the State can ensure that the facility's RAI form 'in the resident's record accurately and completely represents the State's RAI as approved by HCFA in **accordance** with **42 CFR 483.20 (b)**. This applies to either pre-printed forms **or** computer generated printouts. States also have the prerogative of requiring facilities to use the State form. Facilities may insert additional items within automated assessment programs but must be able to "extract" and print the **MDS** in a manner that replicates the State's RAI (i.e., using the **exact** wording and sequencing of items as is found on the State **RAI**). Facility assessment systems 'must always be based on the **MDS** (i.e., both item terminology and definitions).

Additional information about State specification of the **RAI, variations** in format and HCFA approval of **alternative** State instruments can be found in Sections **4145.1 - 4145.6** of the HCFA State Operations Manual, Transmittal **#272** issued April 1995.

To fulfill Federal requirements at 42 CFR 483.20, each time a comprehensive assessment is required, long term care facilities must complete:

- The MDS, plus any additional core **items that make up the State RAI**;
- The RAP Summary form, **on** which facilities **must indicate** which **RAPs** have been triggered, the location of information gathered during the **RAP** review process, and the final care planning decision; and
- Documentation of clinical information (e.g., assessment information) from the RAP review to assist in care planning and follow-up.

The following is a schematic of the overall **RAI framework**:



The MDS consists of a core set of screening and **assessment** elements, including common definitions and coding categories, that forms the **foundation** of the comprehensive assessment.

The **triggers** are specific resident responses for one or a **combination** of **MDS** elements. The triggers identify residents who either have or are at **risk** for developing specific functional problems and require further evaluation using Resident **Assessment Protocols (RAPs)** designated within the **State specified RAI**. **MDS** item responses that define triggers are specified in each RAP and on the Trigger Legend form. Turn to the **RAPs (in Appendix C)** to review these items and the accompanying RAP Guidelines. Once you are familiar with the **RAP** triggers and guidelines, the Trigger Legend form serves as a useful **summary** of all RAP triggers. Note that the symbols on this form have been changed and the process streamlined. The Trigger Legend summarizes which **MDS** item responses trigger individual **RAPs and has been designed as a helpful tool for facilities if they choose to use it. It is a worksheet, not a required form, and does not need to be maintained in each resident's clinical record.**

The **RAPs** provide structured, problem-oriented **frameworks** for organizing **MDS** information, and additional **clinically** relevant information about an **individual's** health problems or functional **status**. What are the problems that require immediate attention? What risk factors are important? Are there issues that might cause you to proceed in an **unconventional** manner for the RAP in question? Clinical staff are responsible for answering **questions** such as these. The information from the **MDS** and **RAPs** forms the basis for **individualized** care planning.

The Utilization Guidelines are instructions concerning **when and how to use the RAI**. 'The Utilization Guidelines for Version 2.0 of the **RAI were** published by HCFA in the **State Operations Manual²** Transmittal #272, and are **discussed more** extensively in this User's Manual.

The individual resident's care plan must be evaluated **and** revised, if appropriate, each **time** an **RAI** comprehensive assessment is completed. Facilities **may** either make changes on the original care plan or develop a new care plan.

Additional information relevant to a resident's status, **but not** necessarily included on the **RAI**, may be documented in the resident's active record. This **documentation** should include progress notes or facility specific flowsheets.

²The SOM is a reference only; it is not necessary for effective use of the **RAI**. The SOM can be ordered from the National Technical Information Service (NTIS); **PB#-95-950007**; \$27; (703)487-465

2.3 Applicability of RAI to Facility Residents

The requirements for resident assessment found at 42 CFR 483.20 are **applicable** to all residents in certified long term care facilities. The requirements are applicable regardless of age, diagnosis, length of stay or payment category.

An RAI **must** be completed for any resident residing in the facility longer than 14 days, including:

- **All residents** of Medicare (Title 18) skilled nursing facilities or Medicaid (Title 19) nursing facilities. This includes **distinct** part certified **SNFs** or **NFs** and certified **SNFs** or **NFs** in hospitals, regardless of payment source.
- **Hospice Residents.** When a SNF or **NF** is the hospice patient's residence for **purposes of the** hospice benefit, the facility must comply with the requirements for participation in Medicare or Medicaid. This means the hospice resident must **be** assessed using the **RAI**, have a care plan and be provided with the services required under **the** plan of care. This can be achieved through cooperation between the hospice and long term care facility staff with the consent of the resident. In these situations, the hospice team may participate in completing the **RAI**.
- **Short term stay or respite residents.** An RAI must be completed for any individual residing more than 14 days on a unit of a facility that is certified as a long term care facility for participation in the Medicare or Medicaid programs.

Given the nature of short stay or respite admissions, staff **members** may not have **access** to all information required to complete some MDS items prior to the resident's discharge (e.g., the physician may not be available, or the family may **not** be able to provide information on the resident's Customary Routine.) In that case the **"no-information"** convention should be used. (**"NA"** or "circled" dash - See Section 2.7 for more **information.**) **For respite residents** who come in and out of the facility on a relatively frequent basis and readmission can be expected, the resident may be **discharged** to "extended" leave status. This status does **not. require:** reassessment each time the resident returns **to the facility** unless a significant change in the resident's status has occurred in the intervening period.

- **Special populations (e.g. pediatric or residents with a psychiatric diagnosis).** Certified facilities are required to complete an **RAI** for all residents who reside in the **facility**, regardless of age or diagnosis.

An RAI is **not required** for:

- **SNF residents residing in a Medicare certified "swing-bed" hospital.** The requirement for a comprehensive assessment is not incorporated in the **long** term care requirements for **"swing-bed"** hospitals-at 42 CFR 482.66.

- Individuals residing in non-certified units of long term care facilities or licensed only facilities. This does not preclude a **State from** mandating the **RAI** for residents who live in these units.

12.4 Types of RAI Assessments and Timing of Assessments

Although the **RAI** assessments **discussed** in the following; section must occur at specific times by Federal regulation, a facility's obligation to meet each resident's needs through ongoing assessment is not neatly confined to these mandated time frames. Likewise, completion of the **RAI** in the prescribed time frame does not necessarily **fulfill** a facility's obligation to **perform** a comprehensive assessment. Facilities are responsible for assessing areas that are relevant to individual residents regardless of whether these areas are included in the RAI.

Comprehensive RAI assessments require completion of the **MDS** and review of triggered RAPs, followed by development or review of the comprehensive care plan within 7 days of completion of the **RAI**. The following table summarizes the **different** types of Federally mandated assessments:

TYPE OF ASSESSMENT	TIMING OF ASSESSMENT	REGULATORY REQUIREMENT HCFA "F" TAG
Admission (Initial) Assessment	Must be completed by 14th day of resident's stay.	42 CFR 483.20 (b)(4)(i)/F 273
Annual Reassessment	Must be completed within 12 months of most recent full assessment.	42 CFR 483.20 (b)(4)(v)/F 275
Significant Change in Status Reassessment	Must be completed by the end of the 14th calendar day fol- lowing determination that a significant change has occurred.	42 CFR 483.20 (b)(4)(iv)/F 274
Quarterly Assessment	Set of MDS items, mandated by State (contains at least HCFA established subset, of MDS items). Must be completed no less frequently than once every 3 months.	42 CFR 483.20 (b)(5)/F 276

ADMISSION (INITIAL) ASSESSMENTS

The admission or **initial** assessment for a new resident must be completed by the **end** of the **14th calendar day following admission to the facility if this is the resident's first stay in the facility or if the resident returns to the facility after being discharged with no expectation of return.** The 14 day calculation does include weekends. When **calculating** when the **RAI** is due, the day of admission is **counted** as day **"0"**. For example, if a resident is admitted at **8:30 a.m.** on Wednesday, a completed **RAI** is required by the end of the day Wednesday, two weeks after admission. **If** a resident dies or is discharged within 14 **days** of admission, then whatever portions of the **RAI** that have been completed must be maintained in the resident's discharge **record.**³ **In** closing the record, the facility **may** wish to note why the **RAI** was not completed. (**MDS** items that were not completed prior to the day of death or **discharge** are left blank. [Sections AA, AD (if relevant), and R are signed.] - See **Section 2.5 regarding necessary signatures.**)

The interdisciplinary team may start and complete the initial assessment at any time prior to the end of the 14th day. If desired by the facility, the MDS could be completed in entirety on the day of admission. However, this requires the staff to rely on resident and family reporting of information and transfer documentation to a large degree as a source of information on the resident's status during the time periods used to code each MDS item, as opposed to allowing a period for facility observation.; Facilities may find early completion of the MDS and RAPs particularly beneficial for individuals with short lengths of stay, when the assessment and care planning process is often accelerated.

EXAMPLES

Miss A. is admitted on Friday, September 1. Staff establish the Assessment Reference Date as September 8, which means that September 8 is the final day of the observation period for all MDS items (i.e.; count back 7 days to determine the period of observation for 7 day items, count back 14 days for 14 day items, and so on). **As this** is an initial assessment, staff must rely on the resident and family's verbal history **and transfer documentation** accompanying Miss. A. to complete items requiring longer than a 7 day period of observation. Staff complete the MDS by **September 12** (note that the Assessment Reference Date (**A3a**) does not need to be the same as the Date RN Assessment Coordinator Signed as Complete (**R2b**)). Staff take an additional 3 days to assess the resident using triggered **RAPs** and to complete **all** related documentation, which is noted

³ The **RAI** is considered part of the resident's clinical record and is treated as such by the RAI Utilization Guidelines. e.g., portions of the RAI that are "started" must be saved.

as a **date field** that accompanies the signature of the **RN Coordinator** for the RAP Assessment Process on the RAP Summary form (**VB2**).

Miss L. is admitted on Monday morning. Staff review the admitting documentation, talk with the physician, and have a brief conversation with her on that day. More information is gathered **from** the resident and her sister over the next 7 days. In **this** case, the Assessment Reference Date (**A3a**) is set as Tuesday of the following week, and observations by all relevant team members are completed as of that date. The MDS and **RAPs** are completed on Wednesday of that week, nine days after admission, with Wednesday being the date the RN Assessment **Coordinator** signs off on the MDS (**R2b**). In this case, Wednesday is also the day the RN Coordinator signs the RAP Summary form as complete (**VB2**).

If a resident goes to the hospital' and returns during the 14 day assessment period and most of the initial assessment was completed prior to the hospitalization, then the facility may wish to continue with the original assessment, provided the resident did not have a significant change in status. Otherwise the assessment should be reinitiated and completed **within** 14 days after readmission, from the hospital. The portion of the resident's **record** that was previously completed should be stored on the resident's record with a notation that the, assessment was reinitiated because the resident was hospitalized.

Good clinical practice dictates that some MDS items be assessed within the first hours after admission although not necessarily documented at that **time** (e.g., nutritional status and needs). Other MDS items can best be observed with the passage of time (e.g., resident or staff interaction patterns). The resident's needs will dictate the order **and** manner in which the interdiiciplii team proceeds throughout the assessment. For example, if a new resident is admitted short of breath and **hypotensive**, it is imperative to conduct an assessment of the resident's acute cardiorespiratory needs. Likewise, a new resident who is angry with his or her family for admitting him or her to the nursing home, and is actively grieving over losses, will benefit **from** an early assessment of Customary Routine, **Psychosocial** Well-Being, and Depression, Anxiety, Sad Mood MDS items.

ANNUAL REASSESSMENTS

The annual RAI reassessment must be complete **within** 12 months of the most recent full assessment. The annual reassessment may be initiated **at any** point prior to the end of the 1-year follow-up date, but must be completed by the end of the **365th** calendar day after the most recent full **RAI** assessment (i.e., **the** date the RN Coordinator has certified the completion of the assessment on the **RAP** Summary form under VB2). If a significant change reassessment is completed in the interim, the clock "restarts," with the next assessment due **within** 365 days of the significant change reassessment. Routinely **scheduled** RAI assessments may be scheduled **early** if a facility wants to stagger due dates for **assessments**.

SIGNIFICANT CHANGE IN STATUS ASSESSMENTS

Facilities have an ongoing responsibility to assess resident status and intervene to assist the resident to meet his or her highest practicable level of physical, mental, and psychosocial well-being. If interdisciplinary team members identify a **significant** change (either improvement or decline) in a resident's condition they should share this information with the resident's physician, who they may consult **about the** permanency of change. **The** facility's medical director may also be consulted when differences of opinion about a **resident's** status occur among team members.

Document the initial identification of a significant change in terms of the resident's clinical status in the progress notes. Complete a full comprehensive assessment as soon as needed to provide appropriate care to the individual, but in no case, later than 14 days of determining a significant change has occurred.

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

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

A condition is defined as "self-limiting" when the condition will normally **resolve** itself without further intervention or by staff implementing standard **disease** related clinical interventions. For example, normally 'a 5% unplanned weight loss would trigger a "significant change" reassessment. (See **GUIDELINES FOR DETERMINING CHANGE IN RESIDENT STATUS below.**) **However,** if a resident had the flu and experienced nausea **and** diarrhea for a week, a 5 % weight loss may **be** an expected outcome. **In** this situation, staff should **monitor** the resident's status and attempt various interventions to rectify the **immediate weight** loss. **If the resident** did not become dehydrated and started to regain weight after the symptoms subsided, a comprehensive assessment would not be required. The amount of time **that** would be appropriate for a facility to monitor a resident depends on the clinical situation and severity. of symptoms experienced by the resident. **Generally,** if the condition has not resolved **within** approximately 2 weeks, staff should begin a comprehensive **RAI** assessment. This time frame is not meant to be prescriptive, but rather should be driven by clinical judgment and the resident's needs.

Other conditions may not be permanent but would have **such** an impact on the resident's overall status that they would require a comprehensive assessment and care plan revision. For **example,** a hip fracture may be viewed as a transient condition but **it** would generally have a major impact **on** the resident's functional status in more than one area (e.g., ambulation, toileting, elimination patterns, activity patterns). Changes in the resident's condition that would affect **the** resident's functional capacity and day to day routine should be **investigated** in a holistic manner through the

RAI reassessment. Therefore, concepts associated with significant change are “major” or “appears to be permanent” but a change does not need to be both major and permanent.

A significant change assessment is appropriate if there is a consistent pattern of changes, with either two or more areas of decline, or two or more areas of improvement. This may include two changes within a particular domain (e.g., two areas of ADL decline or improvement). Any determination about whether a resident has experienced a significant change in status is a **clinical** decision.

**GUIDELINES FOR DETERMINING SIGNIFICANT CHANGE IN RESIDENT STATUS.
(Please note this is not an exhaustive list.)**

Decline:

- Resident's decision making changes from 0 or 1 to 2 or 3 for B4 of the MDS;
- Emergence of sad or anxious mood pattern **as a** problem that is not easily altered (**E2** of the **MDS**);
- Increase in the **number** of areas where Behavioral Symptoms are coded as “not easily altered” (i.e., an increase in the number of code “1”s for **E4B** of the **MDS**);
- Any decline in an ADL physical functioning area where a resident is newly coded as **3, 4, or 8** (Extensive assistance, Total dependency, Activity did not occur) for **G1A** of the MDS;
- Resident's incontinence pattern changes from 0 or 1 to **2, 3 or 4** (**H1a** or b of the **MDS**), or there was placement of an indwelling catheter (**H3d** of the MDS);
- Emergence of unplanned weight loss problem (5% change in 30 days or 10% change in 180 days) (**K3a** of the MDS);
- Emergence of a pressure ulcer at Stage **II** or higher, when no ulcers were previously present at Stage **II** or higher (**M2a** of the MDS);
- Resident begins to use trunk restraint or a chair **that** prevents rising when it was not used before (**P4c** and e of the MDS);
- Overall deterioration of resident's condition; resident receives more support (e.g., **in ADLs** or decision-making) (item **Q2 = 2** on the MDS);
- Emergence of a **condition or** disease in which a resident is judged to be unstable (item **J5a on the MDS**).

EXAMPLE

Mr. T. no longer responds to verbal requests to alter his screaming behavior. It now occurs daily and has neither lessened on its own nor responded to treatment. He is also starting to resist his daily care, pushing staff away from him as they attempt to assist with his **ADLs**. This is a significant change and reassessment 'is required since there has been a deterioration in **the** behavioral symptoms to the point where it is occurring **daily** and new approaches are needed to alter the behavior. Mr. **T.'s** behavioral symptoms could **have** many causes, and reassessment will provide an opportunity for staff to consider illness, **medication** reactions, environmental stress, and other possible sources of Mr. **T.'s** disruptive behavior.

Improvement

- Any improvement in an ADL physical functioning area where a resident is newly coded as 0, 1, or 2 when previously scored as a 3, 4, or 8 (**G1A** of the MDS);
- Decrease in the number of areas where Behavioral Symptoms or Sad or Anxious Mood are coded as "not easily altered" (**E2** and **E4B** of the **MDS**);
- Resident's decision-making changes from 2 or 3 to 0 or 1 (**B4** of the MDS);
- Resident's incontinence pattern changes from 2, 3, or 4 to 0 or 1 (**H1a** or b of the MDS);
- Overall improvement of resident's condition; resident receives fewer supports (item Q2 = 1 on the MDS).

EXAMPLE

Mrs. G. has been in the facility for 5 weeks, following an 8 week acute hospitalization. On admission she was very frail, had trouble thinking, was confused, and had many behavioral complications. The course of treatment led to steady improvement and she is now stable. She is no longer confused or agitated. All concerned - the resident, her family, and staff - agree that she has made **remarkable** progress. A reassessment is required at this time. The resident is not the person she was at admission; her initial problems have resolved. Reassessment will permit the interdisciplinary team to review her needs and plan a new course of care for the future.

While a facility may choose to perform more frequent comprehensive assessments than mandated by HCFA, reassessments are not required for minor, or temporary variations in resident status. However, staff must note these transient **changes** in the resident's status **in the resident's** record and implement necessary clinical **interventions**, even though a reassessment

is not required. In these cases the resident's condition is **expected** to return to baseline within a short period of time, such as 1-2 weeks.

GUIDELINES FOR **WHEN** A CHANGE IN **RESIDENT STATUS IS NOT SIGNIFICANT**
(Please note **this is** not an exhaustive list)

- Discrete and easily reversible cause(s) documented **in the** resident's record and for which the interdisciplinary team can initiate corrective action (e.g., an anticipated **side** effect of introducing a psychoactive medication while attempting to establish a **clinically** effective dose level. Tapering and monitoring of dosage **would** not require a significant change reassessment).
- Short-term acute illness such as a mild fever **secondary** to a cold from which the interdisciplinary team expects the resident to fully **recover**.
- Well-established, predictable cyclical patterns of **clinical** signs and symptoms associated with **previously** diagnosed conditions (e.g., depressive **symptoms** in a resident previously diagnosed with bipolar disease would not precipitate a **significant** change assessment).
- Instances in which the resident **continues** to make **steady** progress under the current course of care. Reassessment is required only when the **condition** has stabilized.
- Instances in which the resident has stabilized but is **expected** to be **discharged** in the immediate future. The facility has engaged in discharge **planning** with the resident and family, and a comprehensive reassessment is not necessary to **facilitate** discharge planning.
- 'In an end-stage disease status, a full reassessment **is** optional, depending on a clinical determination of whether the resident would benefit **from** it. The facility is still responsible for providing necessary care and services to assist **the** resident to achieve his or her highest practicable well-being. However, provided that **the** facility identifies and responds to problems and needs associated with the terminal **condition**, a comprehensive re-assessment is not necessarily indicated. (Documented at item **J5c** on the resident's most current MDS.)

EXAMPLES

Mr. M. has been in this facility for two and one-half years. He has been a favorite of staff and other residents and his daughter has been an active volunteer on the unit. Mr. M. is now in the end stage of his course of chronic dementia — diagnosed as probable Alzheimer's. He experiences recurrent pneumonias and swallowing **difficulties**, his prognosis is guarded, and family are fully aware of his status. He is on a special dementia unit, staff have detailed palliative care protocols for all such end stage residents, and there has been active involvement of his daughter in the care planning process. As changes have occurred, staff have responded in a timely, appropriate manner. In this case, Mr. M.'s care **is** of a high quality, and as his physical state has declined, there is no need for staff to complete a new **MDS** assessment for this bedbound, highly dependent terminal resident.

Mrs. K. came into the facility with identifiable problems and has steadily responded to treatment. Her condition has improved over time and plateaued. She will be discharged within **5** days. The initial **RAI** helped to set goals and start care. Care was **modified** as necessary to ensure continued improvement. The interdisciplinary team's treatment response reversed the causes of the resident's condition. A reassessment need not be Completed in view of the imminent discharge. **Remember, facilities have 14 days to complete a reassessment once the resident's condition has stabilized, and if Mrs. K. is discharged within this period, a new assessment is not required. If the resident's discharge plans change or if she is not discharged, a reassessment is required by the end of the allotted 14 day period.**

Mrs. P., too, has responded to care. Unlike Mrs. K., however, she continues to improve. Her discharge date has not been specified. She is benefiting from her care and full restoration of her functional abilities seems possible. In this case, treatment is focused appropriately, progress is being made, staff are on top of the situation, and there **is** nothing to be gained by requiring an MDS reassessment at this time. However, if her condition were to stabilize and her discharge was not imminent, a reassessment would be in order.

ASSESSMENTS ON RETURN STAY/READMISSION

If a facility has discharged a resident without the expectation that the resident would return, then the returning resident is considered a new admission (return stay) and would require an initial admission **RAI** comprehensive assessment **including** Sections **AB** (Demographic Information) and **AC** (Customary Routine) within 14 days of admission.

If a resident returns to a facility following a temporary absence for hospitalization or therapeutic **leave, it is considered a readmission. Facilities are not required to assess a resident if they are readmitted, unless a significant change in the resident's condition has occurred. In these situations follow the procedures for significant change assessments. (See SIGNIFICANT CHANGE IN STATUS ASSESSMENTS above.)** It is not necessary to complete Sections **AB** (Demographic

Information) or AC (Customary Routine) of the MDS if this information has previously been collected and entered into the resident's record.

QUARTERLY ASSESSMENTS

The Quarterly Assessment is used to track resident status between comprehensive assessments, and to ensure monitoring of critical indicators of the gradual onset of significant changes in resident status. At a minimum, **three quarterly reviews and one full assessment are required in each 12 month period.**

Although a review of **key mandated items is required in each 3 month period**, facilities may vary or stagger their schedules (e.g., a facility may **choose** to review all residents in **February, May, August and November**, while another facility may choose to stagger their quarterly assessments for residents by reviewing some in January, **others** in February and **the remainder** in March, with the first group reviewed again in April).

The resident's status must be assessed for each of the **key mandated items of the Quarterly Assessment** using the State-specified form. There is **now** a mandated form from HCFA,⁴ which must be used for all quarterly assessments, unless **your** State has specified another form. In conducting Quarterly Assessments, facilities must also **assess** any additional items required for use by the State. Based on the Quarterly Assessment, the resident's care plan is revised if necessary.

Once Federal or State computerization requirements are **effective**, facilities must complete Section **AA**, Identification Information on the Basic Assessment Tracking form, as well as the items listed in the table below:

⁴HCFA's Quarterly Assessment Form is found in Appendix B. A three-page optional Quarterly Assessment Form for use in RUGs-III payment systems may be required by your State (also in Appendix B).

KEY MANDATED MDS ITEMS FOR QUARTERLY ASSESSMENT**Section A: Identification and Background Information**

- Item 1 - Resident Name
- Item 2 - Room Number
- Item 3a - Assessment Reference Date
- Item 4a - Date of Reentry
- Item 6 - Medical Record Number

Section B: Cognitive Patterns

- Item 1 - Comatose
- Item 2 - Memory
- Item 4 - Cognitive Skills for Daily Decision-making
- Item 5 - Indicators of Delirium-Periodic Disordered Thinking/Awareness

Section C: Communication/Hearing Patterns

- Item 4 - Making Self Understood
- Item 6 - Ability to Understand Others

Section E: Mood and Behavior Patterns

- Item 1 - Indicators of Depression, Anxiety, Sad Mood
- Item 2 - Mood Persistence
- Item 4 - Behavioral Symptoms'

Section G: Physical Functioning and Structural Problems

- Item 1 - ADL Self-Performance
- Item 2 - Bathing
- Item 4 - Functional Limitation in Range of Motion
- Items 6a, band f - Modes of Transfer

Section H: Continence in Last 14 Days

- Item 1 - Continence Self-Control
- Item 2d and e - Bowel Elimination Pattern
- Items 3a, b, c, d, i and j - Appliances and Programs

Section I: Disease Diagnoses

Items 2j and m - Infections

Item 3. - **Other Current Diagnoses and ICD-9 Codes**

(Note only those diseases diagnosed in the last 90 days **that** have a relationship to **current** ADL status, cognitive status, mood and behavior status, medical treatments, **nursing** monitoring or risk of death.)

Section J: Health Conditions

Items lc, i, and p - Problem Conditions

Item 2 - Pain Symptoms

Item 4 - Accidents

Item 5 - Stability of Conditions

Section K: Oral/Nutritional Status

Item 3 - Weight Change

Items 5b, h, and i - Nutritional Approaches

Section M: Skin Condition

Item 1 - Ulcers

Item 2 - Type of Ulcer

Section N: Activity Pursuit Patterns

Item 1 - **Time Awake**

Item 2 - Average Time Involved in Activities

Section O: Medications

Item 1 - Number of **Medications**

Item 4 - Days Received the Following Medications

Section P: Special Treatments and Procedures

Item 4 - Devices and Restraints

Section Q: Discharge Potential

Item 2 - Overall **Change** in Care Needs

Section R: Assessment/Discharge Information

Item 2 - Signatures of Persons Completing the Assessment

2.5 Completion of the RAI Assessment and Certification of Accuracy and Completeness

PARTICIPANTS IN THE ASSESSMENT PROCESS

Federal regulations⁵ require that the RAI assessment must be conducted or coordinated with the appropriate participation of health professionals. Although not required, completion of the **RAI** is best accomplished by an interdisciplinary team that includes facility staff with varied clinical backgrounds. Such a team brings their combined experience and knowledge together for a better understanding of the strengths, needs and preferences of each resident to ensure the best possible quality of care and quality of life. In general, participation by all relevant interdisciplinary team members will encourage more active and appropriate assessment and care planning processes.

Facilities have flexibility in determining who should participate in the assessment process as long as it is accurately conducted. A facility may assign responsibility for completing the RAI to a number of qualified staff members. In most cases, participants in the assessment process are licensed health professionals. It is the facility's responsibility to ensure that all participants in the assessment process have the requisite knowledge to complete an accurate and comprehensive assessment.

The **RAI** must be conducted or coordinated by an **RN** who signs and certifies the completion of the assessment⁶. If a facility does not have an RN on its staff (i.e., has an RN waiver granted under 42 CFR 483.30 (c) or (d) -- F354) it must still provide an RN to complete the **RAI**. This requirement can be met by hiring an RN specifically for this purpose. In this situation, the LPN responsible for the care of the resident should participate in the resident assessment process and the development of the resident's care plan.

The attending physician is also an important participant in the RAI process. The facility needs the physician's evaluation and orders for the resident's immediate care as well as for a variety of treatments and laboratory tests. Furthermore, the attending physician may provide valuable input on sections of the **MDS** and **RAPs** and is a member of the mandated **interdisciplinary** team that prepares the resident's comprehensive care plan.

While some aspects of the assessment process are dictated by regulation, much flexibility remains for facilities to determine how to integrate the RAI into their day-to-day operations. For example, facilities should develop their own policies and procedures to accomplish the following:

⁵ 42 CFR 483.20 (c)(1)(i)-(F 278)

⁶ 42 CFR 483.20 (e)(1)(ii)-(F 278)

- Train facility staff on the **circumstances** that require a comprehensive assessment and the staff that should be involved.
- Assign responsibility for completing sections of the MDS to staff who have clinical knowledge about the resident, such as staff nurses, attending physicians, social workers, activities specialists, physical, **occupational**, or speech therapists, dietitians and pharmacists.
- Assure that residents and their families are actively involved in the information sharing and decision-making processes.
- Assure that the insights of all **non-licensed** persons who regularly provide **direct** care to the resident (e.g., nursing assistants, activity aides, volunteers) are included in the assessment process.
- Assure that key clinical personnel on all shifts (including nursing assistants) are knowledgeable about the information found in the resident's most current assessment and report changes in the resident's status that may affect the accuracy of this information or the need to perform a significant change reassessment.
- Instruct staff on how to integrate MDS information with existing facility resident assessment and care **planning** practices.

CERTIFYING ACCURACY AND COMPLETENESS

Each individual team member who completes a portion of the assessment must sign and certify its **accuracy**.⁷ Each interdisciplinary team member who completes a portion of the MDS assessment signs, dates, and indicates the portion of the assessment he or she completed. The RN Coordinator is **required** to sign to **certify** that the **MDS is complete**.⁸ The RN Coordinator must not sign and attest to completion of the assessment until all other individual team members participating in the assessment have **finished** their portions of the MDS. If the RN does all of the **MDS**, then the nurse alone would sign and be responsible for certifying accuracy and completeness.

The RN Coordinator must also sign the RAP Summary form to **signify** completion of the RAI assessment. **For the** admission assessment, the RN Coordinator must sign and date the RAP Summary form within 14 days of the resident's admission to the facility. There is no Federal requirement that each individual team member completing a RAP sign and date the RAP Summary form to certify its accuracy. It is assumed that other team members' documentation for a RAP will be signed wherever it appears in the **clinical** record. However, if desired, individual team

⁷ 42 CFR 483.20 (c)(2)-(F 278)

⁸ 42 CFR 483.20 (c)(1)(ii)-(F 278)

members may indicate which **RAP(s)** they completed, list their credentials, and the date it was completed by signing the form wherever there **is** room to do so in a legible manner.

It is never permissible to certify or backdate **RAI** forms for another individual on the interdisciplinary team. If an individual who completed a portion of the **MDS** is not available to sign it, then another team member should review the information and sign the form. Facilities should establish a policy regarding accountability for the **RAI** when these situations occur.

The staff member entering the care planning decision information must also sign and date the RAP Summary form (**VB3** and 4). The facility has 7 days after completing the assessment to complete the care plan. **The** date for entering of the care plan information may be up to 7 days **after** the **RAPs** are completed (i.e., the date on which the RN coordinator signed the RAP Summary form to indicate completion of the RAP assessment process - **VB2**).

REPRODUCTION OF **THE** RAI IN THE **RESIDENT'S** RECORD AND **MAINTENANCE OF THE RAI**

Facilities are required to produce a hard copy of each **RAI (including** the MDS and RAP Summary form) conducted on **admission**, after a significant change in the resident's status, **at least annually, as well as** intervening quarterly **assessments**.

Facilities are required to maintain 15 months of assessment data in **the** resident's active **clinical** record according to HCFA policy. This **includes all** MDS forms, **RAP** Summary forms and Quarterly Assessment Forms as required during the previous 15 month period. **Assessment** data need not be stored in one **binder**. Rather, facilities may choose to maintain assessment and care planning information in a separate binder or kardex system, as long as the information is kept in a centralized location and is accessible to all professional staff members (**including consultants**) who need to review the information in order to provide care to the resident. **After the 15 month period, RAI** information may be thinned from the clinical record and stored in the medical **records** department, provided that it is easily retrievable. if **requested** by clinical staff or State **agency** Surveyors.

The 15 month **period** for maintaining assessment data does not restart **with** each readmission to the facility. In some cases when a resident is out of the facility for a short period (i.e., hospitalization), the facility must **close** the record because of bed hold policies. When the resident then returns to the facility and is "**readmitted**", the facility must open a new record. The facility may copy the previous RAI and **transfer** a copy to the new record. In this case, the facility should also copy the previous 15 months of assessment data and place it on the new record. Facilities may develop their own specific policies regarding how to handle readmissions, but the 15 month requirement for maintenance of the **RAI** data does not restart with each new admission.

If a facility has an electronic clinical record (i.e., does not maintain any paper records), the facility does not need to maintain a hard copy of the **RAI**, if the system meets the following minimum criteria:

- The system must maintain 15 **months' worth** of assessment data according to HCFA policy and must be able to print all assessments **for** that period upon request;
- The facility must have a back-up system to prevent data loss or damage;
- The information must always be readily available and accessible to staff and surveyors; **and**
- The system must comply with HCFA requirements for safeguarding the confidentiality of clinical **records**.⁹

12.6 Sources of Information for Completion of the RAI

The process for performing an accurate and comprehensive assessment requires that information about **residents** be gathered **from** multiple **sources**. It is the role of the individual **interdisciplinary** team members completing the assessment to validate the **information** obtained **from** the resident, resident's family, or other health care team members through observation, interviewing, reviewing lab results, and so forth to ensure accuracy. Similarly, information in the resident's record is validated by interacting with the resident and direct care staff.

The following sources of information must be used in completing the RAI. 'Although not required, the review sequence for the assessment process generally **follows** the order below:

- Review of the resident's record. Depending on whether the assessment is an admission or follow-up assessment, **the** review could include: preadmission, admission or transfer notes; current plan of care; recent physician notes or orders; documentation of services **currently** provided; results of recent diagnostic or other test procedures; monthly nursing **summary** notes and medical consultations for the previous 60 day period; and a record of medications administered for the prior 30 day period.
- Communication with and observation **of** the resident.
- **Communication** with direct-care staff (e.g., nursing assistants, activity aides) **from** all **shifts**.
- Communication with licensed **professionals** (from all disciplines) who have **recently** observe@, evaluated, or treated the resident. Communication can be based on discussion or licensed staff can be asked to **document** their impressions of the resident.
- Communication with the resident's physician.

⁹ See confidentiality requirements at 42 CFR 483.75 (n)(4)(i-iii) --F516

- Communication with **the** resident's family. Not all residents will have family. For some residents, family members may be unavailable or the resident may request that you not contact them. Where the family is not involved, someone else may be very close to the resident, and the resident may wish that this person be contacted.

REVIEW OF THE RESIDENT'S RECORD

The resident's record provides a starting point in the assessment process to review information about the resident in written staff notes across all shifts over multiple days. Starting with the resident's record, however, does not indicate that it is the most critical source of information, but only a convenient source.

At admission, record review includes an examination of notes written in the first 2 weeks (assuming the full 14 day period is used to complete the assessment), **documentation** that came with the resident at admission, facility intake forms (e.g., social service notes), and any preadmission test results including copies of the MDS and **RAPs** from another nursing home if the resident was transferred. Obviously, transcribing the previous facility's MDS is inappropriate.

Subsequent reassessments should focus on recorded information from earlier MDS assessments and quarterly assessments, written information from the previous 3 month period, and notes made during the prior 30 day period.

The following are important considerations when reviewing the resident's record:

- **Review the information documented in the record, keeping in mind the required MDS definitions.** Make sure that assumptions based on the record are compatible with MDS definitions (e.g., resident self-performance is evaluated with appliances if used, such as locomotion with a walker; similarly, according to the **MDS**, a resident, who stays "dry" with a catheter may be considered continent).
- **Make sure that the information taken from the record covers the same observation period as that specified by the MDS items.** The **MDS** refers to specific time frames for each item; for example ADL status is based on resident performance over a 7 day period. To ensure uniformity, the MDS has an Assessment Reference Date (**A3a**) that establishes a common reference end-point for all items. **Consequently, it is necessary to pay careful attention to the notes regarding time frame-s for each section of the MDS and also to the Item- by Item instructions in Chapter 3.**
- **Be aware of discrepancies and view the record information as preliminary only.** Clarify and validate all such information during the assessment process. Be alert to information in the record that is not consistent with verbal information or physical assessment findings. Discuss **discrepancies** with other interdisciplinary team members (e.g., nurses, social workers, therapists). The extent to which the record can be relied upon for information will depend on the comprehensiveness of the record system. Note what information the record usually contains (e.g., current service notes, care plans, flow sheets, medication sheets); where

different types of information are maintained in the clinical record; and more importantly, what information is missing.

- **Where information in the record is sufficiently detailed and conforms to MDS descriptions and time periods, complete the MDS items.** A few MDS items can be completed in full from information found in the record. Comprehensive and accurate assessment of most items, however, requires information from other sources (i.e., the resident, the resident's family, and facility staff). Where information is incomplete or contradictory, make a note of the issues in question. This note can help plan contacts with the resident, facility staff and resident's family. There is no requirement that such a note be maintained as part of the resident's permanent record; it is a work tool only.
- **As you observe, talk with, and discuss the resident with other staff members, verify the accuracy of what you learned from reviewing the record.**

COMMUNICATION WITH AND OBSERVATION OF THE RESIDENT

The resident is a primary source of information and may be the only source of information for many items (e.g., customary routine, activity preferences, vision, hearing, identification with past roles, and, in some instances, problem conditions). Many MDS items will not be documented elsewhere in the clinical record, and the completed MDS may ultimately be the single source of documentation about these issues.

Become familiar with the MDS items to make communication and observation of the resident an **ongoing** everyday activity in the facility. For example, an RN can observe and interact with a **resident** when medications are given, during **meals**, or when the resident comes to ask a question. Interaction with the resident may be a crucial factor in config staff judgments of resident problems. Weigh what the resident says, and what is observed about the resident against other **information** obtained from the resident record and facility staff.

To be most **efficient**, organize a framework for how to interview and observe the resident. Allow flexibility to accommodate the resident. Carefully listen and observe the resident to get guidance **as** to how to pursue the necessary information gathering. Try to interact with the resident, even if the resident may have difficulty responding. The degree and character of the difficulty in responding, as well as nonverbal responses (e.g., fearfulness) provide important information. Sensitive staff judgment is necessary in gathering information. (See Appendix D for further information on **"Interviewing Techniques"**.)

COMMUNICATION WITH DIRECT CARE STAFF

- Direct care staff (e.g., nursing assistants and activity aides) have daily, intimate contact with residents and are often the most reliable source of information ~~at~~ the resident. Direct care staff **talk** with and listen to the resident. They observe and assist the resident's performance of **ADLs**

and involvement in activities. They **observe the** resident's physical, cognitive and psychosocial status daily during all shifts, seven days a week. Key considerations when communicating with direct care staff are:

- Be sure to speak with a person who has first-hand knowledge of the resident. Plan for **sufficient** time to talk with direct care staff person(s).
- Start by asking about the resident's performance on **ADLs** and activities. What can the resident do without assistance? What do staff members do for the resident? What might the resident be able to do that he or she is not doing now? Continue by asking about communication and memory skills, body control, activity preferences, and the presence of mood or other behavioral symptoms.
- Talk with direct care staff across all shifts, if possible. The information from other shifts may be obtained in other ways as well (e.g., from change-of-shift reports if direct care staff comments are included).

(See Appendix D for **further** information on "Interviewing **Techniques**".)

COMMUNICATION WITH LICENSED PROFESSIONALS

Licensed practical nurses (**LPNs**), **RNs**, social workers, activities professionals, occupational therapists, physical therapists, speech therapists, pharmacists, and other professionals who have observed, evaluated, or treated the resident should be interviewed about their knowledge of resident capabilities, performance patterns and problems. Their special expertise will enhance the accuracy and comprehensiveness of the resident assessment.

COMMUNICATION WITH THE RESIDENT'S PHYSICIAN

The physician's role is central to the overall management and outcome of resident care. The MDS assessment process should include a review of the physician's examination of the resident, plan of care, hospital discharge plan, goals of care, and medication and treatment orders. **At the** Quarterly Assessments and Annual assessments, review the most recent physician orders and notes. Also, review the MDS with the resident's attending physician to share and validate pertinent information. If there is difficulty obtaining information or input for the assessment **from** the attending physician (or transferring institution), the facility's medical director should be asked to intervene.

COMMUNICATION WITH THE **RESIDENT'S FAMILY**

The resident's family (or person closest to the resident) can be a valuable source of information about the resident's health history, history of strengths and problems in various functional areas,

and customary routine prior to first **nursing home** admission. Using this source obviously depends on the presence of family members, their willingness to participate, and the resident's preferences. In most instances, family will not be the sole source of information but will supplement information **from** other sources. The RAI assessment process provides an excellent opportunity for caregivers to develop trusting, working relationships with the resident and family.

2.7 Completing the MDS Form - Coding and Correction of Errors

Utilizing appropriate information gathered **from** all of the areas discussed in Section 2.6 above, the individual completing the assessment is required to make a best judgment about each item in each section of the MDS form. The MDS is Part of the medical record and should **always** be typed or prepared in ink.

CODING CONVENTIONS

The following table specifies the coding conventions to be used when preparing the **MDS** form:

MDS CODING CONVENTIONS

- **Each section of the MDS contains one or more items labeled sequentially. For instance, the third item in Section B (Memory/Recall Ability) is labeled "B3", the second item in Section E (Mood Persistence) is labeled "E2".**

- **Use the following coding conventions to enter information on the MDS form:**

Use a check mark for white boxes with lower case letters, if specified condition is met; otherwise these boxes remain blank (e.g., N4, General Activity Preferences - 'boxes a. - m.).

Use a numeric response (a number or preassigned value) for blank white boxes (e.g., H1a, Bowel Incontinence.)

Darkly shaded areas remain blank; they are on the form to set off boxes visually.

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

- **USE PRINTED CAPITAL LETTERS to respond** to items that require an **open-ended** response. **Print** legibly (e.g., for “Lifetime Occupations”, a line is provided to fill in the resident’s previous occupation(s)).
- **Dates** - Where **recording** month, day, and year, enter two digits for the **month** and the day, but four digits for the year. For example, the third day of January in the year 1996 is recorded as :

0	1	0	3	1	9	9	6
Month		Day		Year			

- **The standard no-information code is either a “circled” dash or an “NA”.** This code indicates that all available sources of information have been **exhausted**; that is the information is **not available, and despite exhaustive probing, it remains unavailable.** Although the “circled dash” was originally conceived for use on computerized versions of the MDS, it is also the recommended method of coding on manual forms to “set-off these responses on the forms.
- **NONE OF ABOVE** is a response item to several items (e.g., I2, Infections, box m). Check this item where none of the responses apply; it should not be used to signify lack of information about the item.
- **“Skip” Patterns** - There are a few instances where scoring on one item will govern how scoring is completed for one or more additional items. The instructions direct the assessor to “skip” over the next item (or several items) and go on to another (e.g., B1, Comatose, directs the assessor to “skip” to Section G. if B1 is answered “1” - “Yes”. The intervening items from B2 - F3 would not be scored. If B1 was recorded as “0” - “No”, then the assessor would continue with item B2.).

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

- The **“8”** code is for use in Section G., Physical Functioning and Structural Problems **only**. The use of this code is **limited** to situations where the ADL activity was not **performed** and therefore an objective assessment of the resident’s performance is not possible. Its primary use is with bed-bound residents who neither transferred **from bed** nor moved **between** locations over the entire 7 day period of observation. When the “8” code is entered for **self-performance**, it should also be entered for support.

CORRECTION OF ERRORS

Facilities may not “change” a previously completed MDS form as the resident’s status changes during the course of the nursing home stay. Minor changes in the resident’s **status** should be noted in the resident’s record (e.g., in progress notes), in accordance with standards of clinical practice and documentation. Such monitoring and documentation is a part of the facility’s responsibility to provide necessary care and services. Completion of a new MDS to reflect changes in the resident’s status is not required unless the resident has had a significant **change** in status (See Section 2.4 for information on Significant Change in Status Assessments).

The following procedures apply to the correction of errors in either paper or automated MDS 2.0 systems:

- Within a paper environment, facilities should “close” the MDS within regulatory time frames (i.e., within 14 days after admission, etc.). This is done by having the RN Coordinator sign and date the MDS at **R2a** and **b**. Amendments **may** be made **to any items during the next 7 day period, provided that the same Assessment Reference Date is used (A3a)**. To make revisions, enter the correct response, draw a line through the previous response without obliterating it, and initial and date the corrected entry. This procedure is similar to how an entry in the medical record is corrected.
- **The concept of “factual errors,” which allowed for “correction” of the paper form in certain instances at any time, has been eliminated.** Facilities operating in **computerized States** should seek guidance on State specific policies related to “key changes” and transmission of data for payment purposes.

The following procedures apply when a facility’s MDS data are computerized¹⁰:

1. The clinical assessment process must be completed **within** the standard time frames (i.e., **within** 14 days after admission, etc.).
2. After completing the clinical assessment process, the facility has the next 7 days to **encode** the MDS in a computerized file, ensure that all MDS items pass **HCFA/State edits¹¹** and to

¹⁰A number of States have already established automated systems and State **specific** requirements. **These** States are encouraged to modify their existing systems to conform to the above HCFA policies. However, until national specifications are established, facilities should contact their State regarding State **specific** requirements. HCFA is currently in the process of developing additional policies for computerization at both the facility and State level. These policies are expected to go into effect sometime in 1996.

¹¹HCFA edits should be incorporated in all software products and are available to vendors and facilities through a World Wide Web site accessed through the Internet. Its address is: http://linear.chsra.wisc.edu/mds_info.htm. Vendors and facilities should also contact their State for any specific requirements.

“lock” the computer record. “**Locking**” the record means that no changes can be made to the MDS (i.e., either paper or electronic versions).

- **Encoding process:** The facility is responsible for verifying that all responses in the computer file match the responses on the paper form. Any discrepancies must be corrected in the computer file during this 7 day period.
- **Editing process:** The facility is responsible for running encoded MDS data against HCFA and State specific edits (which all software vendors are responsible for building into MDS Version 2.0 computer systems). For each MDS item, the response must be within the required range and also be consistent with other item responses. During this 7 day period, the facility may “correct” item responses in order to meet edits. An assessment is considered complete only if 100% of the required edits are passed. For “corrected” items, the facility must use the same “period of observation” as that used for the original item completion (i.e., the same Assessment Reference Date- **A3a**). Any corrections must be accurately reflected in both the electronic and paper copies of the **MDS** (i.e., the paper version of the MDS must be corrected).
- **“Locking” process:** After passing the edits, a record is then “locked.” Individual **MDS** records must pass 100% of the edits for the record to be “locked.”¹² At this point, the record cannot be changed by the facility.

After the **MDS** is “locked,” the facility may come to realize that items in the “locked” assessment (paper or electronic versions) are in error. The facility may come to such knowledge on its own or it may have been notified by the State that the assessment record failed edits or **failed** other reviews at the State level. In any event, the record is “locked” and cannot be changed. The facility then has the following options:

1. A new comprehensive “significant change in status” assessment would be performed (i.e., the full MDS and RAPS) if **both** of the following conditions are met:
 - (1) The assessment in error is the most recent assessment; and
 - (2) A significant change has actually occurred (i.e., there has been a significant change in the resident’s clinical status between the time of the original assessment and the time of the new assessment).

In this case, there has been a change in the resident’s status that meets the Significant Change guidelines and a new comprehensive assessment is therefore required. However, the original assessment was also in error. This new assessment requires a new observation period, a new Assessment Reference Date (**A3a**), and “significant change in status

¹²“Locked” records will be transferred to the State within a time frame to be determined by HCFA/State policy, pending publication of HCFA’s final rule on computerization.

assessment” is coded as the reason for assessment (**AA8a = 3**). The “Previous Record Date”¹³ in the Control Section of the new MDS record must contain the Assessment Reference Date from the original assessment that was in error.

2. If a “significant change in status” has not occurred **clinically** but the erroneous data in the prior MDS is major enough to warrant correction, then the facility may optionally choose to perform a new comprehensive “significant correction of prior assessment” if both of the following conditions are satisfied:

- (1) The assessment in error is the most recent assessment; and
- (2) The resident did not experience an actual “significant change in status” between the time of the original assessment and the new comprehensive assessment. However, the resident’s clinical condition is different from that depicted in the assessment in error and it would otherwise appear that there had been a significant change-in status.

If the facility chooses to perform a “significant correction” assessment, then a new MDS and **RAPs** are **required**,¹⁴ with the new MDS performed using a new observation period (i.e., a new Assessment Reference Date (**A3a**)), “significant correction of prior assessment” is coded as the reason for assessment (**AA8a = 4**), and the “Previous Record Date” in the Control Section of the new MDS record must contain the Assessment Reference Date from the original assessment that was in error.

12.8 RAPs and Care Plan Completion

RAPs

After completing the **MDS** portion of the RAI assessment, the assessor(s) then proceed to further identify and evaluate the resident’s strengths, problems, and needs through use of the **Resident Assessment Protocol Guidelines (RAPs)** described in detail in Chapter 4 of this manual and through further investigation of any resident-specific issues not addressed in the RAI.

Completed along with the MDS, the RAPs provide the foundation upon which the care plan is formulated. There are 18 problem-oriented RAPs, each of which include MDS-based “trigger” conditions that signal, the need for additional assessment and review. Triggers and their definitions for each RAP appear in **Appendix C**. Also in **Appendix C** are the **RAP Guidelines**

¹³The “Control Section” is part of the **standardized** record layout made available to facilities and vendors for development and programming of MDS data systems. It provides information that will **be used** when the MDS data is transferred from the facility to the State. It is not a **part** of the clinical MDS form.

¹⁴**New RAPs are required** because the prior inaccurate description of the resident could have misguided staff in the triggering and problem identification activities_

for additional assessment and review to determine if a care plan is appropriate to address the triggered condition.

The triggers and their definitions should provide facility staff with information to better understand the underlying cause of a problem. Often staff may be aware that a problem, warranting care planning, exists before reviewing the RAP Guidelines for a triggered condition. The Guidelines should help staff to identify the factors that have caused the resident's problem and provide direction as to what additional information is needed about the resident's problem. **After reviewing triggered RAPs, the RAP Summary form is used to document decisions about care planning and to specify where key information from the assessment for triggered RAP conditions is noted in the record.**

LINEAGE OF MDS AND RAPs TO FORMULATION OF THE CARE PLAN

For an admission (initial) assessment, the resident enters the facility on day 1 with a set of physician-based treatment orders. Facility staff typically review these orders. Questions may be raised, modifications **discussed**, and change orders issued. Ultimately, of course, it is the attending physician who is responsible for the orders at admission, around which significant segments of the care **plan** is constructed.

On day 1, facility staff also begin to assess the resident and to identify problems. Both activities provide the core of the MDS and RAP process, as staff look at issues of safety, nourishment, medications, **ADL** needs, continence, psychosocial status and so forth. Facility staff determine whether there are problems that require immediate intervention (e.g., providing supplemental nourishment to reverse weight loss or attending to a resident's sense of loss at entering the nursing home). For each problem, facility staff will focus on causal factors and implement an initial plan of care based on their understanding of factors affecting the resident.

The MDS and **RAPs** provide the clinician with additional information to assist in this **preliminary** care planning process. The MDS ensures that staff have timely access to a wide range of assessment data. The **RAPs** provide criteria that trigger review of possible problem conditions to ensure that staff identify problems in a consistent and systematic manner. Use of the RAP Guidelines helps ensure that the full range of relevant causal factors is considered.

If the admission MDS is not completed until the last date possible (i.e., at the end of calendar day 14 of the residency period), interventions will **already** have been implemented to address priority problems. Many of the appropriate RAP problems will have been identified, causes will have been considered, and a preliminary care plan initiated. The **final** written care plan, however, is not required until 7 days after the RAI assessment is completed.

For triggered problems that have already resulted in a care plan intervention, the final RAP review will ensure that all causal factors have been considered. For RAP conditions for which facility staff have not yet initiated a care program, the RAP review will focus on whether these conditions are, in fact, problems that require facility intervention. For any triggered problem, staff will apply the RAP Guidelines to evaluate the resident's status and

determine whether a situation exists that warrants care planning. If it does, the **RAP** Guidelines will next be used to help identify **the** factors that should be considered for developing the care plan.

For an Annual reassessment or a Significant Change in Status assessment, the process is basically the same as that described for newly admitted residents. In these cases, however, **the** care plan will already be in place, and staff are unlikely to be actively instituting a new approach to care as they simultaneously complete the MDS and **RAPs**. Here, review of the **RAPs** when the MDS is complete will raise questions about the need to modify or continue services. The condition that originally triggered the **RAP** may no longer be present because it was resolved, or consideration of alternative causal factors may be necessary because the initial approach to a problem did not work, or was not fully implemented.

CARE PLAN COMPLETION

Facilities have 7 days after the completion of the RAI assessment to develop or revise the resident's care plan. The RN **coordinator** should sign and date **the** RAP Summary form **after all triggered RAPs have been reviewed to certify completion of the comprehensive assessment (VB1 and 2)**. **Facilities should use this date to determine the date by which the care plan must be completed.**

The 7 day requirement for completion or modification of the care plan applies to **the** Admission, Significant Change in Status, or Annual RAI Assessment. A new care plan does not need to be developed after each significant **change** of status or annual reassessment. Rather, the facility may revise an existing care plan using the results of the latest comprehensive assessment. Facilities should also evaluate the appropriateness of the care plan after each quarterly assessment and modify the care plan if necessary. (See **Chapter 5 for more information on Care Planning.**)

Chapter 3: Item-by-item Guide to MDS Version 2.0

3.1 Mandated Assessments, and Associated Forms

The following rules apply to HCFA's **RAI**, Version 2.0, as used by all nursing homes certified to participate in Medicare or Medicaid. Copies of all required forms are in Appendix B.

The content of the Minimum Data Set (**MDS**) Version 2.0 Nursing Home Resident Assessment is recorded on the following mandated forms: [See Appendix B for copies of all forms.]

1. The **Basic Assessment Tracking Form**. This form includes Section AA (**Identification Information**) Items 1-9. This form must be submitted with every **Full Assessment**, **Quarterly Assessment**, and State required assessment. This form provides "key" information necessary to identify and track residents in automated systems.
2. **MDS Version 2.0 Full Assessment Form**. **This** form contains MDS Sections A (**Identification and Background Information**) through **Section R** (**Assessment Information**). The full assessment is to be completed at admission, annually, and at the time of significant change in resident status. The **Full Assessment** is required more frequently by States participating in the Nursing Home Case-Mix and Quality Demonstration (**NHCMQ**) as well as by some other States. Contact your State **RAI** representative if you have any questions about when assessments are required. Additional items (if any) required by your State may appear in Section S. **NHCMQ** State-required material appears in Sections T and U.
 - **Background (Face Sheet) Information at Admission**. **This** form contains MDS **Section AB** (**Demographic Information**), **Section AC** (**Customary Routine**), and **Section AD** (**Face Sheet Signatures**). This form is to be completed at the time of the resident's initial admission to the nursing home.
3. **MDS Version 2.0 Quarterly Assessment Form**. **This** form contains a mandated subset of MDS items from **Section A** (**Identification and Background Information**) through **Section R** (**Assessment Information**). This form is to be completed no less frequently than once every three months between annual full assessments. Some States have mandated an expanded **Quarterly Assessment Form**, such as the optional version for **RUG III** found in Appendix B.
4. **RAP Summary Form**. Considered **Section V** of the MDS, this form is used to document triggered **RAPs**, the location of documentation describing the resident's clinical status and factors that impact the care planning decision, and whether a care plan has been developed for

the triggered **RAP**. A **Rap Summary Form** must be completed each time an **RAI** is required (Le., under the Federal schedule, each tie a full MDS is completed).*

With MDS Version 2.0, two new forms have been developed for future use in each **nursing home's** computerized information system to track each resident's "whereabouts" in the health care system. Once HCFA's MDS computerization requirement is in place, facilities shall use these forms. Each of these tracking forms contain Section AA (Identification Information) Items 1 through 7, and a subset of codes from Item 8, Reason for Assessment. In a computerized information system, MDS Items AA1 through 7 need to be completed only once (at admission) and saved in the system files. However, this identification information must be verified prior to "closing" the assessment record for each subsequent assessment. For each discharge from or reentry to the nursing home, it is anticipated that nursing home staff (e.g., clerk) will record the move in Item AA8, Reason for Assessment. The computer will then generate the appropriate information to accompany the type of assessment **being** completed. The following-two forms are included in this resident tracking system:

1. **The Discharge Tracking Form.** This form includes Section **AA** (Identification Information) Items 1-9, but only the 3 discharge codes from Item 8, Reason for Assessment. It also contains Items **AB1-2**, **A6**, and **R3-4**. In a computerized system, this form must be completed whenever a resident is discharged from the facility for reasons other than a temporary visit home. This is the only form that must always be completed at the time of any discharge **from** the nursing home. The following is the only condition when other forms shall accompany the **Discharge Tracking Form**:
 - If the resident was discharged for any reason within 14 days of admission and you were able to complete a **Full Assessment Form** before the resident was discharged, the resident's MDS computerized file would contain a **Basic Assessment Form**, a **Background (Face Sheet) Information at Admission Form**, a **Full Assessment Form**, and a **Discharge Tracking Form**. **In this scenario**, enter a code of "1" Admission Assessment (required by day 14) for Item 8 (Reason for Assessment) on both the **Basic Assessment Form** and the **Full Assessment Form**; enter a code of either "6" Discharged-return not anticipated, or "7" Discharged (return anticipated) as appropriate, for Item 8 on the **Discharge Tracking Form**.
2. The **Reentry Tracking Form.** This form includes Section AA (Identification Information) Items 1-9, but only one code (ie., code designating Reentry) from Item 8, Reason for Assessment. It also contains items **A4a** and **b**, and **6**. In a computerized system, this form is completed whenever a resident reenters the nursing home following temporary admission to a hospital or other health care setting. This is the only form that must always be completed at the time of reentry to the nursing home. The following is the only condition when other forms shall accompany a **Reentry Tracking Form**:

*Some States require completion of the full MDS each quarter or more frequently for payment purposes. The RAP Summary Form does not need to be completed on these occasions.

- If the resident reenters the nursing home following a temporary admission to a hospital or other health care setting AND also meets significant change criteria, a **Full Assessment** must be completed. In this case, the resident’s file should contain a **Reentry Tracking Form**, a **Basic Assessment Tracking Form**, and a **Full Assessment** (significant change). In this scenario, enter a code of “9” Reentry for Item 8 (Reason for Assessment) on the, Reentry Tracking Form; enter a code of “3” Significant Change Assessment for Item 8 (Reason for Assessment) on both the **Basic Assessment Tracking Form** and the **Full Assessment** form. Completion of a **Full Assessment** may also be required by the State.

3.2 Overview to the Item-by-Item Guide to MDS Version 2.0 1

This Chapter is to be used in conjunction with Version 2.0 of the MDS, which can be found in Chapter 1 beginning on page 1-6 and in Appendix B. Also included in this chapter are the instructions for the supplemental items in MDS Sections S and T used in the NHCMQ demonstration States.

The changes in Version 2.0 of HCFA’s MDS were made in response to comments and suggestions regarding the first version of the MDS. They were received from the nursing home industry, health professionals, advocacy groups, surveyors, etc. A few items were dropped, others modified, and still others added. This chapter includes significant new material, many more examples, and refined definitions, as compared to HCFA’s original RAI Training Manual that was published in December 1990.

This chapter provides information to facilitate an **accurate and uniform resident** assessment. **Item-by-item instructions focus on:**

- The intent of items included on the MDS.
- Supplemental definitions and instructions for completing MDS items.
- Reminders of which MDS items require observation of the resident for other than the standard 7day observation period.
- Sources of information to be consulted in completing specific MDS items.

3.3 How Can This Chapter be Used?

Use this chapter alongside the MDS Version 2.0 form, keeping the form in front of you at all times. The MDS form itself contains a wealth of information. Learn to rely on it for many of the definitions and procedural instructions necessary for good assessment. The amplifying information in this chapter should facilitate successful use of the MDS form. The items from the

MDS forms are presented in a **sequential basis** in this chapter. Where items are presented on a form other than the full MDS **assessment** form, this fact is noted in the text.

The chart that follows summarizes the recommended approach to assist you in becoming familiar with MDS Version 2.0. The initial time investment in this multi-step review process will have a major payback.

If you are familiar with the MDS and are reviewing this Chapter for new items that appear in Version 2.0 of the MDS, review the MDS form beginning on page 1-6 of Chapter 1 for new items.

New materials of the following types are presented in this Chapter: Item definitions, examples, and process recommendations regarding how to complete the assessment. Thus, you will find much useful new information regarding many of the items that were in the original MDS.

Recommended Approach for Becoming Familiar with the MDS

- A) First, review the MDS form itself.**
- **Notice** how sections are organized and where information is to be recorded.
 - Work through one section at a time.
 - Examine item definitions and response categories.
 - Review procedural instructions, time frames, and general coding conventions.
 - Are ***the definitions and instructions clear? Do they differ from current practice at your facility? What areas require further clarification?***
 - Complete the MDS assessment for a resident at your facility. Draw only on your knowledge of this individual. Enter the appropriate codes on the MDS form. Where your review could benefit from additional information, make note of that fact. ***Where might you secure additional information?***

(Continued on next page)

Recommended Approach for Becoming Familiar with the MDS (Continued)

(B) Complete the initial pass through this chapter.

- **Go on to this** step only after **first** reviewing the MDS form and trying to complete all items for a resident who is well known to you.
- As you read this **chapter**, clarify questions that arose as you used the MDS for the first time to assess a resident. Note sections of this manual that help to clarify coding and procedural questions you may have had.
- **Once again, read the instructions that apply to a single section of the MDS. Make sure you understand this information before going on to another section. Review the test case you completed. Would you still code it the same? It will tie time to go through all this material. Do it slowly. Do not rush. Work through the Manual one section at a time.**
- **Are you surprised by any MDS definitions, instructions, or case examples? For example, do you understand how to code ADLs? Or Mood?**
- **Do any definitions or instructions differ from what you thought you learned when you reviewed the MDS form?**
- **Would you now complete your initial case differently?**
- **Are there definitions or instructions that differ from current practice patterns in your facility?**
- Make notations next to **any** section(s) of this Manual you have questions about. Be prepared to discuss **these** issues during any formal training program you attend, or contact your State MDS **resource** person (see Appendix A).
- Read and complete the test cases at the end of this chapter.

(Continued on next page)

Recommended Approach for Becoming Familiar with the MDS (Continued)

In a second pass through this chapter, focus on issues that were more difficult or problematic in the first pass.

- **Make notes on the MDS form of issues** that warrant attention.
- **Further familiarize** yourself with definitions and procedures that differ from **current practice patterns** or seem to raise questions.
- Reread each of the case examples presented throughout this chapter.

(D) The **third pass through this chapter may occur during the formal MDS training program at your facility** and will provide you with another opportunity to review the material in this chapter. If you have questions, raise them during the training session.

(E) **Future use of information in this chapter:**

- Keep this chapter at hand during the assessment process.
- Where necessary, review the intent of each item in question.
- **This Manual is** a source of information. Use it to increase the accuracy of your assessments.

3.4 What is the Standard Format Used in this Chapter?

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

Intent: Reason(s) for including the item (or set of items) in the MDS, including discussions of how the information will be used by clinical staff to **identify** resident problems and develop the plan of care.

Definition: Explanation of key terms.

Process: Sources of **information** and methods for determining the correct 'response for an item. Sources include:

- Discussion with facility staff — licensed and nonlicensed staff members
- Resident interview and observation
- Clinical records, facility records, transmittal records (at admission) — physician orders, laboratory data, medication records, treatment sheets, flow sheets (e.g., vital signs, weights, intake and output), care plans, and any similar documents in the facility record system
- Discussion with the resident's family
- Attending physician.

Coding: Proper method of recording each response, with explanations of individual response categories.

3.5 Item-by-Item Instructions for the MDS Form

This section of item-by-item instructions follows the sequence of items on the HCFA MDS, Version 2.0. Notice that an MDS section designation appears at the top of the pages that follow; this will facilitate your use of this chapter as a reference tool in the future.

IDENTIFICATION INFORMATION SECTION AA

This section provides the key **information** to uniquely identify each resident, the home in **which** he or she resides, and the reasons for assessment. A copy of this **form** must accompany each Full or Quarterly Assessment submitted for computer entry in a State or Federal archiving system.

AA. IDENTIFICATION INFORMATION

1. Resident Name

De finition: Legal name in record.

Coding: Use printed letters. Enter in the following order — a.) first name, b.) middle initial, c.) last name, d.) **Jr./Sr.** If the resident goes by his or her middle name, enter the full middle name. If the resident has no middle initial, leave item **(b)** blank.

2. Gender

Coding: Enter “1” for Male or “2” for Female.

3. Birth date

Coding: Fill in the boxes with the appropriate **number**. Do not leave any boxes blank. If the month or day contains only a single digit, **fill** the first box in with a “0”. For example: **January 2, 1918** should be entered as:

0	1	0	2	1	9	1	8
Month		Day		Year			

4. Race/Ethnic@

Process: Enter the race or ethnic category the resident uses to identify him- or herself. Consult the resident, as necessary. For example, if parents are of two different races, consult with resident to determine how he or she wishes to be classified.

Coding: 'Choose only one answer.

5. Social Security and Medicare Numbers

Intent: To record resident identifier numbers.

Process: Review the resident's record. If these numbers are missing, consult with your facility's business office.

Coding: Begin writing one number per box starting with the left most box. Recheck the number to be sure you have written the digits correctly.

Social Security Number — If no Social Security **number** is available for the resident (e.g., if the resident is a recent immigrant or a child), enter the standard "no information" code, "NA" or a circled dash **⓪**.

Medicare number (or comparable railroad insurance number) — Approximately 98% of persons age 65 or older have a Medicare number. Enter the resident's Medicare number. This number occasionally changes with marital status. If a question arises, check with your facility's business office or social worker.

In rare instances, the resident will have neither a **Medicare** number nor a Social Security **number**. **When** this occurs, another type of basic identification number (e.g., railroad retirement insurance number) may be substituted. In such cases, place a "C" in the-left most Medicare Number box, and continue entering the number itself, one digit per box, beginning with the second box.

6. Facility Provider Numbers

Intent: To record the facility identifier numbers.

Definition: The identification numbers assigned to the nursing home by the Medicare and Medicaid programs. Some facilities will have only a Federal (Medicare) identification number; others will have Federal (Medicare) and State (Medicaid) identification numbers. Medicaid only facilities have a Federal as well as a State number. The Medicaid Federal number has a "letter" in the third box.

Process: You can obtain the facility's Medicare and Medicaid numbers from the facility's business office. Once **you** have these numbers, they apply to all residents of that facility.

Coding: Begin writing in the left-hand box. Enter one digit per box. Recheck the number to be sure you have entered the digits **correctly**. **There** must be at least one type of facility number entered, but there may be more than one.

7. Medicaid Number (if applicable)

Coding: Record this number if the resident is a Medicaid recipient. Begin writing one number per box in the left hand box. Recheck the number to make **sure** you have entered the digits correctly. Enter a **“+” in the left most box if the number is pending. If not applicable because the resident is not a Medicaid recipient, enter “N” in the left most box.**

8. Reasons for Assessment [This item also appears and must be completed on the MDS Full Assessment Form, Section A, Item 8.]

a. **Primary** Reason for Assessment

Intent: To document the reason for completing the assessment using the various categories of assessment types mandated by Federal regulation. Most of the types of assessments listed below will require completion of the MDS, review of triggered RAPs, and development or review of a comprehensive care plan within seven days of completing the MDS and RAPs. **[Note — assessment type 5, the Quarterly review assessment, requires you to **complete** only a limited number of MDS items — see **Appendix B** for the Quarterly Assessment Form.]** Please note that it is possible to select a code **from** both 8a (**Primary** reason for assessment) and 8b (Special codes).

Minimum Discharge Assessment Requirement. With the release of Version 2.0 of the MDS, a minimal list of MDS items must be completed for all discharges and facility reentries in States that are automated. These items are referenced on their own forms and item 8 (Reason for Assessment) also appears on these forms. It is listed as Item 8a in Section AA of the **Discharge Tracking and Reentry Tracking Form** and Item AA8a on the **Identification Information Form**.

Definition: 1. **Admission assessment_ A comprehensive assessment using the MDS and RAPs** required by day 14 of the resident's stay. **[Note — this code is used if resident is being readmitted subsequent to a discharge where return was not anticipated_]**

2. **Annual assessment** — A comprehensive reassessment required within 12 months of **the** most recent full assessment. If significant change is noted, **code “3”** (significant change in status assessment). **DO NOT** code as an **Annual** assessment.
3. **Significant change in status assessment** — A comprehensive reassessment prompted by a “major change” that is not self-limited, that impacts on more than one area of the resident’s **clinical** status, and that requires **interdisciplinary** review or revision of the care plan to ensure that appropriate care is given. **When** there is a significant change, the assessment must be completed by the end of the 14th calendar day following the determination that a significant change has occurred. -See **procedure described later in this chapter under item A8 for assessing whether a significant change (either improvement or decline) has occurred.**
4. **Significant correction of prior assessment** -A comprehensive assessment completed at the facility’s prerogative, **because** the previous assessment was inaccurate or completed incorrectly. This differs from a significant change in status assessment, in which there has **been** an actual change in the resident’s health status.
5. **Quarterly Review Assessment** -The subset of MDS items specified on HCFA’s Quarterly **Assessment Form**, which **must** be completed no less frequently than once every 3 months (i.e., between **required** full assessments). This assessment ensures that the care plan is correct and up to date. It also should identify **instances** where significant changes in resident status have occurred. If a significant change is noted, use Code “3” (Significant change in status assessment). **DO NOT CODE** as a Quarterly review assessment.
6. **Discharged — return not anticipated** — **[This is not a code used on this form; it is used on the Discharge Tracking Form only.]** Use this code when a resident is permanently discharged **from** a nursing home. This provides a means of “closing” the record of any resident at the point of discharge from the facility (without an anticipated return). Note — until HCFA’s **ADP** requirement **is** effective, this code is **used** only in nursing homes that are required to submit data to the State.
7. **Discharged — return anticipated** — **[This is not a code used on this form, it is used on the Discharge Tracking Form only.]** Use this code when a resident is temporally discharged to a hospital (or other therapeutic setting). Note — until **HCFA’s ADP requirement is effective, this code is used only in facilities that are required to submit data to the State.**

8. Discharged prior to completing initial assessment — [This is not a code used on this form, it is used on *the Discharge Tracking Form* only.] Use this code when a resident is discharged during the first 14 days of residency AND the MDS assessment remains incomplete. A subset of information is entered for all residents regardless of length of stay. **Even 'a very short stay resident (e.g., a person who stayed for even one day) must be tracked by the MDS system.** At the same time, remember that you have **14** days to complete the full **MDS** admission assessment, and by using this code you are identifying residents who have been discharged, transferred or died prior to day 14, thereby prohibiting your completion of a **full** assessment. Note — until HCFA's ADP requirement is effective, this code is used only **in** facilities that are required to submit data to the State.
9. Reentry — [This is not a code used on this form; it is used on the *Reentry Form only.*] **Use this code** when a resident of your facility is readmitted from a temporary discharge to a hospital or other therapeutic setting (other than for a therapeutic leave). Note — **until HCFA's** ADP requirement is effective, **this** code is used only in facilities that are required to submit data to the State.
0. NONE OF ABOVE — Use this code when your state requires you to complete one of the additional assessment types referenced in Item **AA8b** (below). It indicates that the assessment has been completed to comply with State-specific requirements (e.g., **Case-Mix** payment). Select the code under item b (below) that indicates the primary reason for assessment.
 - b. Special codes for use with supplemental assessment types in Case-Mix Demonstration States or other States where required. It is possible to select a code from both **8a** and **8b** (e.g., Item **8a** coded "3" (Significant Change in Status assessment), and Item **8b** coded "3" (60day assessment)).
 1. 5 day assessment — Required for payment reason prior to the Federally mandated admission assessment **required by** day 14 (Code 1., for item a).
 2. **30** day assessment
 3. **60** day assessment — In following this cycle of assessments, the initial Quarterly review assessment would be due at 90 days.
 4. Quarterly assessment using full MDS form — Assessment completed within a 3-month interval from the last assessment, using a full (not quarterly) MDS assessment form as required by the State or NHCMQ demonstration. For Case-Mix Demonstration States, the initial Quarterly

Assessment would be due at 90' days after admission, in addition to completion of the **60-day** assessment.

5. Readmission/return assessment — A full reassessment (i.e., MDS and RAPs) **required** only for residents in NHCMQ demonstration facilities (or as required by the State) who are hospitalized for more than 72 hours, or who are discharged and later readmitted to the facility from the hospital.
6. Other **state** required assessment — An example is a Utilization Review assessment. 'States may issue additional instructions.

Example

Mr. X resides in a nursing home in Kansas, a Case-Mix Demonstration State. He was admitted to the nursing home from an acute care hospital **on 1/20/95**. At the time of the **admission** assessment, he still exhibited some **signs** of delirium that had begun post-operatively in the hospital. Functionally he required extensive assistance with all **ADLs**. It is now time for his **60-day** assessment. Cognitively, Mr. X's confusion has cleared to the point that the decisions he makes are now consistent and reasonable. His **ADL** performance has improved in all areas; he is either independent or receives some supervision.

Coding: Enter the number corresponding to the primary reason for assessment. For item a (**Primary reason** for assessment), for **codes** 1-9, leave first box blank, placing correct digit in the second box.

9. Signatures of Persons Completing These Items

Coding: Staff who completed parts of Section AA. Identification Information must enter their signatures, titles, and date they completed the section.

**BACKGROUND (FACE SHEET)
INFORMATION AT ADMISSION
SECTIONS AB, AC, AD**

AB. DEMOGRAPHIC INFORMATION

1. Date of Entry

Intent: Normally, the MDS Face Sheet (Sections AB and AC) is completed once, when an individual first enters the facility. However, the face sheet is also required if the person is reentering your facility after a **discharge** where return had not previously been expected. Do not complete the face sheet following temporary discharges to hospitals or after therapeutic leaves/home visits. **Given this definition, enter the date the person first became a resident/patient in your facility.**

Admission and “bed-hold” policies vary among nursing homes across the country. Likewise, the way in which facilities “open” and “close” resident’s medical records also varies. Some facilities choose to “close” a record when a resident is transferred for an overnight stay at an acute care hospital? and “open” a new record when the resident returns to the nursing facility. Other nursing homes maintain the resident’s clinical record as open (current) even when the resident is transferred for a temporary hospital stay. For MDS purposes, the date of entry is the date the resident entered the facility for care, **regardless of how the facility chooses to “open” or “close” its medical records during the course of the stay.**

Definition: Date the stay began — The date the resident was most recently admitted to your facility. For example: if the resident was **officially** discharged in the past without the expectation of return (e.g., discharged home or to another nursing facility), enter the most recent admission date. However, if your facility begins a new record on each return from a temporary hospital stay or temporary leave, you will complete the face sheet only at the original assessment. Do not complete the face sheet at **the** time of return from a temporary leave, even if you are required to complete the remainder of the form (e.g., a significant change assessment is required).

Process: Review the clinical record. If dates are unclear or unavailable, ask the admissions office or medical record department at your facility.

Coding: *Use all boxes.* For a one-digit month or day, place a zero in the first box. For example: February 3, 1994, should be entered as:

0	2	0	3	1	9	9	4
Month		Day		Year			

Example

Mrs. F, a diabetic, had been living with her daughter when she fractured her left hip during a fall off a footstool. She spent a few days in the local hospital after surgery, followed by an admission to a nursing facility on **5/26/94** for rehabilitation. **Three** weeks later (**6/16/94**), Mrs. F was transferred back to the hospital for an infected incision site over her left hip and general state of decline. Mrs. F returned to the nursing home eight days later. In this instance, code the following date on the original face sheet.

0	5	2	6	1	9	9	4
---	---	---	---	---	---	---	---

Rationale: The face sheet sections of the **MDS — AB** and AC are completed **only** when the resident first becomes a resident of the facility. In this case there is no need to complete a new face sheet upon return readmission from a temporary hospital stay where the resident is expected to return to the nursing home.

2. Admitted From (At Entry)

Intent: To facilitate care planning by documenting the place from which the resident was admitted to the nursing home on the date given in item **AB1**. For example, if the admission was from an acute care hospital, an immediate review of current medications might be warranted since the resident could be at a higher risk for delirium or may be recovering from delirium associated with acute **illness**, medications or anesthesia. Or, if admission was from home, the resident could be grieving due to losses **associated with** giving up one's home and independence. Whatever the individual circumstances, the resident's prior location can also suggest a list of contact persons who might be available for issue clarification. For example, if the resident was admitted from a private home with home health services, telephone contact with a Visiting Nurse can yield insight into the resident's situation that is not provided in the written records.

Definition: **Private** home or apartment — Any house, condominium, or apartment in the community whether owned by the resident or **another** person. Also included **in this** category are retirement communities, and independent housing for the elderly.

Home health services — Includes skilled nursing, **therapy** (e.g., physical, occupational, speech), nutritional, medical, psychiatric and home health aide services delivered in the home. Does not include the following services unless provided in conjunction with the services previously named: homemaker/personal care services, home delivered meals, telephone reassurance, transportation, respite services or adult day care.

Assisted Living — A non-institutional community residential setting that includes services of the following types: . home health services, homemaker/personal care services, or meal services.

Other — Includes hospices and chronic disease hospitals.

Process: Review admission records. Consult the resident and the resident's family.

Coding: Choose only one answer.

Example

Mr. F, who had been living in his own home with his wife, was admitted to an acute care hospital with a CVA. From the hospital, Mr. F was transferred to this nursing home for rehabilitation. Because Mr. F was admitted to your facility from the acute care hospital, **"5"** is the appropriate code.

3. Lived Alone (Prior to Entry)

Intent: To document the resident's living arrangements prior to admission.

Definition: In other facility — Any institutional/supportive setting, such as a nursing home, group home, sheltered care, board and care home.

Process: Review admission records. Consult the resident and the resident's family.

Coding: If living in another facility (i-e., nursing facility, group home, board and care, assisted living) prior to admission to the nursing home, enter "2".

If the resident was not living in another facility prior to admission to the nursing home, enter "0" or "1", as appropriate.

Examples

- Mrs. H lived on her own and her daughters took turns sleeping in her home so she would never be alone at night. **Code "0" for No (did not live alone).** If, **however**, her daughters stayed with her only 3-4 nights per week, **Code "1" for Yes (lived alone).**
- Mr. J lived in his own second-floor apartment of a **two-family** home and received constant attention from his family, who lived on the first floor. **Code "0" for No (did not live alone).**
- Mr. D lived with his wife in housing for the elderly prior to ~~admission~~. **Code "0" for No (did not live alone).**
- Mrs. X was the primary caregiver for her two young grandchildren, who lived with her after their parent's divorce. **Code "0" for No (did not live alone).**
- Mrs. K was admitted directly from an acute care hospital. She had been living alone in her own apartment prior to hospital stay. **Code "1" for Yes (lived alone).**
- Mr. M, who has been blind since birth, was admitted to the nursing home with his seeing eye dog, Rex. Mr. M. and Rex lived together for the past 10 years in housing for the elderly. **Code "1" for Yes (lived alone).**
- Mr. G lived in a board-and care home. **Code "2" (In other facility).**

4. Zip Code of Prior Primary Residence

Definition: **Prior primary residence.** The community address where 'the resident last resided' prior to nursing home admission. A primary residence includes a primary -home or apartment, board and care home, assisted living, or group home. If the resident was admitted to your facility from another nursing home or institutional setting, the prior primary residence is the address of the resident's home prior to entering the other nursing home, etc.

Process: Review resident's admission records and transmittal records as necessary. Ask -resident and family members as appropriate. Check with your facility's admissions office.

Coding: Enter one digit per box beginning with the left most box. For example, Beverly Hills, CA **90210** should be entered as:

9	0	2	1	0
---	---	---	---	---

Examples

- **Mr. T** was admitted to the nursing home from the local hospital. Prior to hospital admission he lived with his wife in a trailer park in Jensen Beach, Florida. Enter the zip code for Jensen Beach.
- **Mrs. F** was admitted to the nursing home's Alzheimer's Special Care Unit after spending 3 years living with her daughter's family in Newton, MA. Prior to moving in with her daughter, Mrs. F lived in Boston, MA for 50 years with her husband until he died. Enter the Newton, MA zip code. Rationale: Her daughter's home was Mrs. F's primary residence prior to nursing home admission.
- **Ms. Q** was admitted from a state psychiatric hospital in Illinois where she had spent the previous 16 years of her life. Prior to that, Ms. Q lived with her parents in Kansas City, Kansas. Enter the Kansas City zip code.

5. Residential History 5 Years Prior to Entry

Intent: To document the resident's previous experience living in institutional or group settings.

Definition: Prior stay **'at this nursing home** — Resident's prior stay was terminated by discharge (without an expected return) to the community, another long-term care facility, or (in some cases) a hospitalization.

Stay in other nursing home — Prior stay in one or more nursing homes other than current facility.

Other residential facility — Examples include board and care home, group home, and assisted living.

MH/psychiatric setting — Examples include mental health facility, psychiatric hospital, psychiatric ward of a general hospital, or psychiatric group home.

MR/DD setting — Examples include mental retardation 'or developmental disabilities facility (including **MR/DD** institutions), intermediate care facilities for the mentally retarded (**ICF/MRs**), and group homes.

Process: Review the admission record. Consult the resident or family. Consult the resident's physician.

Coding: Check all institutional or group settings in which the resident lived for the five years prior to the current date of entry (as entered in **AB1.**). Exclude limited stays for treatment or rehabilitation when the resident had a primary residence to return to (i.e., the place the resident called "home" at that time). If the resident has not lived in any of these settings in the past five years, check **NONE OF ABOVE**,

6. Lifetime Occupation

Intent: To identify the resident's role or past role 'in life and to establish familiarity in how staff should address the resident. For example, a physician **might** appreciate being referred to as "Doctor". Knowing a person's lifetime occupation is also helpful for care-planning purposes. For example, a carpenter might enjoy pursuing hobby shop activities.

Coding: Enter the job title or profession that describes the resident's main occupation(s) before retiring or entering the facility. Begin printing in the left-most box.

The lifetime occupation of a person whose primary work was in the home should be recorded as "Homemaker." When two **occupations are identified, place a slash (/) between each occupation.** A person who had two careers (e.g., carpenter and night watchman) should be recorded as "Carpenter/Night Watchman". **For a resident who is a child or an MR/DD adult resident who has never been employed, record as "NONE."**

7. Education (Highest Level Completed)

Intent: To record the highest level of education the resident attained. Knowing this information is useful for assessment (e.g., interpreting cognitive patterns or language skills), care planning (e.g., deciding how to focus a planned activity program), and planning for resident education in self-care skills.

Definition: The highest level of education attained.

Technical or Trade School: Include schooling in which the resident received a non-degree certificate in any technical occupation or trade (e.g., carpentry, plumbing, acupuncture, baking, secretarial, practical/vocational nursing, computer programming, etc.).

Some College: Includes completion of some college courses, junior (community) college, or associate's degree.

Bachelor's degree: Includes any undergraduate bachelor's level college degree.

Graduate Degree: Master's degree or higher (M.S., Ph.D., M.D., J.D., etc.).

Process: Ask the resident and significant other(s). Review the resident's record.

Coding: Code for the best response. For MR/DD residents who have received special education services, code "2" (8th grade/less).

8. Language

Definition: a. **Primary language** — The language the resident primarily speaks or understands.

Process: Interview the resident and family. Observe and listen. Review the clinical record.

Coding: Enter "0" for English, "1" for Spanish, "2" for French, "3" for Other. If the resident's primary language is not listed, code "3" for Other and print the resident's primary language in item 8b beginning with the left most box.

Example

Mrs. F emigrated with her family from East Africa several years ago. She is able to speak and understand very little English. She depends on her family to translate information in Swahili.

a. Primary Language — "3" Other

b. If other, specify

S	W	A	H	I	L	I		
---	---	---	---	---	---	---	--	--

9. Mental Health History

Intent: To document a primary or secondary diagnosis of psychiatric illness **or** developmental disability.

Definition: Resident has one of the following:

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

AND

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

AND

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

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

Coding: Enter "1" for Yes or "0" for No.

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

- Intent:** To document conditions associated *with* mental retardation or **developmental** disabilities.
- Definition:** For item **10e**, “Other organic condition related to **MR/DD**” — Examples of diagnostic conditions include congenital rubella, prenatal infection, congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia; **neuronal** lipid storage diseases, phenylketonuria (**PKU**), neurofibromatosis, microcephalus, macrencephaly, **meningomyelocele**, **congenital** hydrocephalus, etc.
- Process:** Review the resident’s record only. For any item (**10b** through **10f**) to be checked, the condition must be documented in the clinical record.
- Coding:** Check all conditions related to **MR/DD** status that were present before age **22**. When age of onset is not specified, assume that the **condition** meets this criterion AND is **likely** to continue **indefinitely**.
- If an **MR/DD** condition is not present, check item **10a** (“Not Applicable — No **MR/DD**”) and skip to item **AB-1** 1.
 - If an **MR/DD** condition is present, check each condition that applies.
 - If an **MR/DD** condition is present but the resident does not have any of the specific conditions listed, check item **10f** (“**MR/DD** with No Organic Condition”).

11. Date Background Information Complete

- Intent:** For tracking purposes, this item should reflect the date that the **Background (Face Sheet) Information At Admission** form **is** completed or amended.
- Coding:** Enter the date the **Background (Face Sheet) Information At Admission** form is originally completed. In some circumstances (e.g., if a knowledgeable family member is not available during the M-day assessment period), it is difficult to fill in all the background information requested on this form. However, the information is often obtained at a later date. As new or clarifying information becomes available, the facility may record additional information on the form or enter data into the computerized record. This item (**AB 11**) should then reflect the date that new information is recorded or existing information is revised.

Examples

Mr. B **was** admitted to your facility on **12/3/94** in a comatose state and therefore, unable to communicate in his own behalf. By reviewing transmittal records that accompanied him from the acute care hospital, you **find** that you are only able to partially complete Section A13 (Demographic Information), and you are unable to complete Section AC (Customary Routine) because the records are scanty in these areas. You decide to complete what you can by the 14th day of Mr. B's residency (the date the MDS assessment is to be completed) and enter the date **12/17/94** for item **AB 11**. On **12/24/94** Mr. B's only relative, a daughter, visits and you are able to obtain more information from her. Enter the new information (e.g., demographic or customary routines) on the form and then enter the date **12/24/94** for item AB 11.

AC. CUSTOMARY ROUTINE

1. Customary Routine (In the year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home)

Intent: These items provide information on the resident's usual community lifestyle and daily routine in the year prior to DATE OF ENTRY (**AB1**) to your nursing home. If the resident is **being** admitted from another nursing home, review the resident's routine during the **last** year the resident lived in the community. The items should initiate a flow of information about cognitive patterns, activity preferences, nutritional preferences and problems, ADL scheduling and performance, psychosocial well-being, mood, continence issues, etc. The resident's responses to these items also provide the interviewer with "clues" to understanding other areas of the resident's function. These clues can be further explored in other sections **of** the **MDS** that focus on particular functional domains. Taken in their entirety, the data **gathered** will be extremely useful in designing an individualized plan of care.

Process: Engage the resident in conversation. A comprehensive review can be facilitated by a questioning process such as described in Guidelines for Interviewing-Resident that follow. Also see in Appendix D.

If the resident cannot respond (e.g., is severely demented or aphasic), ask a family member or other representative of the resident (e.g., legal guardian). For some residents you may be unable to obtain this information (e.g., a

demented resident who first entered the facility many years ago and has no family to provide accurate information)

Guidelines for Interviewing Resident

Staff should regard this step in the assessment process as a **good** time to get to know **the** resident as an individual and an opportunity to set a positive tone for the **future** relationship. It is also a useful starting point for building trust prior to asking **difficult** questions about urinary incontinence, advance directives, etc.

The interview should be done in a quiet, private area where you are not **likely** to be interrupted. Use a conversational style to put **the** resident at ease. Explain at the outset why you are asking these questions (“Staff want to know more about you so you can have a comfortable stay with us.” “These are things that many older people **find** important.” “I’m going to ask a little bit about how you usually spend your day.”)

Begin with a general question — e.g., “Tell me, how did you spend a typical day **before** coming here (or before going to the first nursing facility)?” or “What were some of **the** things you liked to **do**?” Listen for specific information about sleep patterns, eating patterns, preferences for timing of baths or showers, and social and leisure activities involvements. As the resident becomes engaged in the discussion, probe for information on each item of the Customary Routine section (i.e., cycle of daily events, eating patterns, ADL patterns, involvement patterns). Realize, however, that a resident who has been in an institutional setting for many years prior to coming to your facility **may** no longer be able to give an accurate description of pre-institutional routines. Some residents will persist in describing their experience in the long-term care setting, and **will** need to be reminded by the interviewer to focus on their usual routines prior to admission. Ask **the** resident, “Is this what you did **before** you came to live here?”

If the resident has **difficulty** responding to prompts regarding particular items, backtrack by reexplaining that you are **asking** these **questions** to help you ‘understand how the resident’s usual day was spent and how certain things were done. It may be necessary to ask a **number** of open-ended questions in order to obtain the necessary information. Prompts should be highly individualized.

Walk the resident through atypical day. Focus on usual habits, involvement with others! and activities. Phrase questions in the past tense. Periodically reiterate to the **resident** that you are interested in **the** resident’s routine before nursing home admission, and that you want to know what he or she actually did, not what he or she might like to do.

(continued **on next page**)

Guidelines for Interviewing Resident (continued)

For example:

- After you retired from your job, did you get up at a regular time in the **morning?**
- When did you usually get up in the morning?
- What was the first thing you did after you arose?
- What time did you usually have breakfast?
- What kind of food did you like for breakfast?
- What happened after breakfast? (Probe for naps or regular post-breakfast activity such as reading the paper, taking a walk, doing chores, washing dishes.)
- When did you have lunch? Was it usually a big meal or just a snack?
- What did you do after lunch? Did you take a short rest? Did you often go out or have friends in to visit?
- Did you ever have a drink before dinner? Every day? Weekly?
- What time did you usually bathe? Did you usually take a shower or a tub bath?
- How often did you bathe? Did you prefer AM or PM?
- Did you snack in the evening?
- What time did **you usually go to bed?** Did you usually wake up during the night?

Definition: **Goes out 1+ days a week** — Went outside for any reason (e.g., **socialization**, fresh air, clinic visit).

Use of tobacco products at least daiiy — **Smoked any type of tobacco** (e.g., **cigarettes, cigars, pipe**) **at least once daily**. This item also includes sniffing or chewing tobacco.

Distinct food preferences — This item is checked to indicate the presence of specific food preferences, with details recorded elsewhere in the clinical record (e.g., was a vegetarian; observed kosher dietary laws; avoided red meat for health reasons; hates hot dogs; allergic to wheat and avoids bread). **Do not check this item for simple likes and dislikes.**

Use of alcoholic beverage(s) at least weekly — Drank at least one alcoholic drink per week.

Wakens to toilet all or most nights — Awoke to use the toilet at least once during the night all or most of the time.

Has irregular bowel movement pattern — Refers to an unpredictable or variable pattern of bowel elimination, regardless of whether the resident prefers a different pattern.

Bathing in **PM** — **Took** shower or bath in the evening.

Daily contact **with** relatives/close friends — Includes visits and telephone calls. Does not include exchange of letters only.

Usually attends church, temple, synagogue (etc.) — Refers to interaction regardless of type (e.g., regular churchgoer, watched TV evangelist, involved in church or temple committees or groups).

Daily animal companion/presence — Refers to involvement with animals (e.g. house pet, seeing-eye dog, fed birds daily in yard or park).

Unknown — If the resident cannot provide any information, no family members are available, and the admission record does not contain relevant information, check the last box in the category (“UNKNOWN”), leave all other boxes in Section AB blank.

Coding:

Coding is limited to selected routines in the year prior to the resident's first admission to a nursing facility. **Code the resident's actual routine rather than his or her goals or preferences (e.g., if the resident would have liked daily contact with relatives but did not have it, do not check “Daily contact with relatives/close friends”).**

Under each major category (Cycle of Daily Events, Eating Patterns, ADL Patterns, and Involvement Patterns) a **NONE OF ABOVE** choice is available. For example, if the resident did not engage in any of the items listed under Cycle of Daily Events, indicate this by checking **NONE OF ABOVE** for Cycle of Daily Events.

If an individual item in a particular category is not known (e.g. “Finds strength in faith,” under Involvement Patterns), enter “NA” or a circled dash **⊖**.

If information is unavailable for all the items **in the** entire Customary Routine section, check the final box “UNKNOWN” — Resident/family unable to provide information”. If UNKNOWN is checked, no other boxes in the Customary Routine section should be checked.

AD. FACE SHEET SIGNATURES

a. Signature of RN Assessment Coordinator

Coding: The RN Assessment Coordinator who worked on the *Background (Face Sheet) Information at Admission sections* of the MDS must enter his or her signature on the day this part of the MDS form is complete. Also, to the right of the name enter the date the form was signed.

b-g. Signature of Others Who Completed Part of Background Assessment Sections AB and AC

Coding: Other staff who completed **parts of** the Background sections of **the** MDS must enter their signature, the sections they completed, and the date they completed their assigned sections.

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

FUNCTIONAL ASSESSMENT

Sections A – R

**SECTION A. IDENTIFICATION AND
BACKGROUND INFORMATION**

1. Resident Name

Definition: Legal name in record.

Coding: Print the resident's name in **the** following order — a.) first name, b.) middle initial, c.) last name, d.) **Jr./Sr.** If the resident goes by his or her middle name, enter the full middle name. If the resident has no middle initial, leave item (b) blank.

2. Room Number

Intent: Another identifying number for tracking purposes.

Definition: The number of resident's room in the facility.

Coding: **Start in the left most box, use as many boxes as needed.**

Example

Mr. F lives in Room N305 at your facility. The N stands for New Building in your

N	3	0	5	
---	---	---	---	--

two building complex. The three hundred series of rooms are on the third floor.

3. Assessment Reference Date

Intent: To establish a common temporal reference point for all **participating** in the resident's assessment. Although staff members may work on completing a resident's MDS on different days, establishment of the assessment reference date ensures the commonality of the assessment period (i.e., "**starting** the clock" so that all assessment items refer to the resident's objective performance and health status **during** the same period of time).

Definition: **a. Last day of MDS observation period.** This date refers to a specific end-point in the MDS assessment process. **Almost** all MDS items refer to the resident's status over a designated time period, most frequently the seven day period **ending** on this date. The date sets the designated endpoint of the common observation period, and all **MDS** items refer back in time from this point. Some cover the 14 days ending on this day, some 30 days ending on this date; and so forth.

Coding: The first coding task is to enter the observation reference date (i.e., the end point date of the observation period). For an admission assessment, this date can be any day up to the 14th day following admission (the last possible date for completing the admission assessment). For a **followup** assessment, select a common reference date within the period the assessment must be completed. This date is the endpoint to which all **MDS** items must refer.

For an admission assessment, staff may begin to gather some information on the day of admission. An observation end date will be set, often a date prior to day 14.

RAPs must be completed within regulatory required time frames for completion of the RAI.

Examples of Assessment Reference Date for an Admission Assessment

Mrs. M was admitted to your facility on **8/20/94**. Your facility's policy **states** that all MDS assessments for new admissions shall be completed by the 7th day of residency. Therefore, staff decided to conduct their observations, tests, interviews with resident, family and other staff, and chart reviews during the **first** 7 days of the resident's stay. -During this time they record pertinent findings in the resident's record and, where appropriate, on the MDS form. They record the endpoint of the MDS observation period as follows, giving staff another 7 days in which to complete the **RAPs**:

0	8	2	6	1	9	9	4
Month		Day		Year			

Mr. S was admitted to your facility on **8/20/94**. Your facility's **policy states** that all MDS assessments for new admissions shall be **completed** by the 14th day of residency. The interdisciplinary team on the new resident's unit decides to take the full 14 days to complete the assessment. Of course they conduct observations, tests, necessary interviews, and chart reviews necessary for care planning. During this time they record pertinent findings in the resident's record. They record the endpoint of the MDS observation period as follows, with the stipulation that the **RAPs** must also be completed on that date:

0	9	0	2	1	9	9	4
Month		D a y		Year			

Rationale: As **9/2/94** is the 14th day of residency, the period of review for the MDS items will be the 7 days prior to that date, plus the period that ends on that date (or the period from **8/27** through **9/2/94**).

For an annual assessment, staff are likely to have extensive data on hand. In such cases, a designated observation period of seven days is usually established. The date on which the observation period ends is the Assessment Reference Date. All staff who participate in the assessment must, however, agree that their description of the resident reflects the resident's status in this seven day period.

For the month and day of the assessment, enter two digits each, using zero, ("0") as a filler. Use four digits for the year.

5. Marital Status

Coding: Choose the answer that describes the current marital status of the resident.

6. Medical Record Number

Definition: This number is the unique identifier assigned by **the** facility for the resident. Get it from the facility's admissions office, business **office**, or medical records department.

7. Current Payment Source(s) for Nursing Home Stay

Intent: To **determine** payment source(s) that cover the daily **per** diem or ancillary services for the resident's stay in the nursing facility over the **last** 30 days.

Definition: Per diem — Room, board, nursing care, activities, and services included in the routine daily charge.

Ancillary — Services such as medications, equipment, for treatments, or supplies billed outside of the daily routine per diem charge.

Self (or family) pays — full — Includes **full** private pay by resident or family.

Self (or' family) pays — co-pay — The resident is responsible for a co-payment.

Private insurance — The resident's private insurance company is covering daily charges.

Other — Examples include **Commission** for **the** Blind, Alzheimer's Association.

Process: Check with the **billing office** to review current payment **sources**. Do not rely exclusively on information recorded in the resident's, clinical record, as the resident's **clinical** condition may trigger different sources of payment over time. Usually business offices track such information.

Coding: For each payment source, check the corresponding answer box.

Example of Current Payment Sources

Mr. F. was recently admitted to your facility **from** an acute care hospital. Medicare (**Part A**) has partially covered his per diem and ancillary services, and private insurance **has** covered the remainder of his charges. Mr. F. does not belong to a managed' care program.

Check "b", Medicare **per diem**, "c", Medicare **ancillary**, and "i", Private insurance.

8. Reasons for Assessment

a. Primary Reason for Assessment

Intent: To document the key reason for completing the assessment, **using** the various categories of assessment types mandated by **Federal** regulation. Most of the types of assessments listed below will require completion of the MDS, review of triggered RAPs, and development or review of a comprehensive care plan within seven days of completing the **RAI**. [**Note** — assessment type 5 requires you to complete only a limited number of MDS items.] Please note that it is possible to select a code from both 8a (**Primary** reason for assessment) and 8b (Special codes).

Minimum Discharge Assessment Requirement. With the release of Version 2.0 of the MDS, a minimal **list** of **MDS** items must be completed for all discharges and facility reentries. These items are referenced on their own forms and item 8 also appears on these forms — it is listed as Item 8 in Section AA of the **Tracking and Reentry Tracking Forms**; it is also Item AA8 on the **Basic Assessment Tracking Form**.

- Definition:**
- 1. Admission assessment.** A comprehensive assessment using the MDS **and** RAPs **required** by day 14 of the resident's stay. Note, this code is used if the resident is being readmitted subsequent to a discharge where return was not anticipated.
 - 2. Annual assessment** — A comprehensive reassessment required within 12 months of the most recent **full** assessment. **If** significant change is noted, code **"3"** (significant change in status assessment). **DO NOT code** as an Annual assessment.
 - 3. Significant change in status assessment** — A comprehensive reassessment prompted by a "major change" that is not self-limited, that impacts on more than one area of the resident's health status, and that requires interdisciplinary review or revision of the care plan to ensure that

appropriate care is given. When there is a significant change, the assessment must be completed by the end of the 14th calendar day following the determination that a significant change has occurred. See procedure described below for assessing **whether** a significant change (either improvement or decline) has occurred.

4. Significant correction of prior assessment — **A** comprehensive assessment completed at the facility's prerogative, because the previous assessment was inaccurate or completed incorrectly. This differs from a significant change in status assessment, in which case there has been an actual change in the resident's health status.
5. Quarterly Assessment - The subset of MDS items specified on HCFA's Quarterly Assessment Form, which must be completed no less frequently than once every 3 months (Le., between required full **assessments**). This assessment ensures that the care plan is correct and up to date. It also should identify instances where significant changes have occurred. If significant change is noted, Code "3" (Significant change in status assessment). **DO NOT CODE** as Quarterly review assessment.

Minimum Discharge Information — Until HCFA's ADP requirement is effective, this code is used only by facilities that are already required to submit data to the State. A subset of MDS items must be completed for all residents who are discharged or are out of the facility over night. Differentiate whether **return** is anticipated, not anticipated, or whether the resident has been discharged prior to completing an initial assessment. These items are referenced below.

6. **Discharged — return not anticipated** — [This is not a code used on this form; it is used 'on the **Discharge Tracking Form only.**] Use this code whenever a resident is permanently discharged from a nursing facility. This is a means of "closing" the record of any resident at the point of **discharge** from the facility (without an anticipated return). Note — until **HCFA's ADP requirement is effective, this code is used only in facilities that are required to submit data to the State.**
7. **Discharged — return anticipated** — [This is not a code used on this form; it is used on the **Discharge Tracking Form only.**] Use this code when a resident is temporarily discharged to a hospital (or other therapeutic setting). Also use this code when a respite patient returns home, with an anticipated return to this facility at a later date. Note — until **HCFA's ADP requirement is effective, this code is used only in facilities that are required to submit data to the State.**

- 8. Discharged prior to completing initial assessment — [This is not a code used on this form; it is used on the *Discharge Tracking Form* only.] Use **this** code when the resident is discharged during the first **14** days of residency AND the **MDS** assessment remains incomplete. A subset of information is entered for all residents regardless of length of stay. **Even a very short stay resident (e.g., a person who stayed for even one day) must be tracked by the MDS system.** At the same time, remember that you have 14 days to complete the full MDS admission assessment, and by using this code you are identifying residents who have been discharged, transferred or died prior to day 14, thereby prohibiting your completion of a full assessment. Note — **until HCFA's ADP requirement is effective, this code is used only in facilities that are required to submit data to the State.**

Miiumum Reentry Information — Until HCFA's ADP requirement is effective, this code is used only by facilities that are already required to submit data to the State. A subset of **MDS** items must be completed for residents "reentering" the facility after a **temporary** absence (other than a therapeutic leave) in order to reenter the resident into the **State** database.

- 9. **Reentry** — [This is not a code used on this form; it is used on the *Reentry Tracking Form* only.] Use this code when a resident of your facility is readmitted from a temporary discharge to a hospital or other therapeutic setting (other than for a therapeutic leave). Note — **until HCFA's ADP requirement is effective, this code is used only in facilities that are required to submit data to the State.**

- 0. **NONE OF ABOVE** — Use this code when your state requires you to complete one of the additional assessment types referenced in Item AA8 (below). It indicates that the assessment has been completed to comply with State-specific requirements (e.g., case-mix payment). Select the code under item b (below) that indicates the **primary** reason for assessment.

b. Special codes for use with supplemental assessment types in Case-Mix. Demonstration States or other States where required. It is possible to select a code from both 8a and 8b (e.g., Item 8a coded "3" (Significant Change in Status assessment), and Item 8b coded "3" (**60-day** assessment)).

- 1. **5 day assessment** — Required for payment reasons prior to the Federally mandated admission assessment required by day 14 (Code 1, for item a).
- 2. 30 day assessment

3. 60 day assessment — In following this cycle of assessments, the initial Quarterly review assessment would be due at 90 days.
4. Quarterly assessment using full MDS form — Assessment completed within a 3-month interval from the last assessment, using a full (not quarterly) MDS assessment form as required by the State or NHCMQ demonstration.
5. Readmission/return assessment — A full reassessment (i.e., **MDS** and **RAPs**) required only for residents in NHCMQ demonstration facilities (or as required by the State) who are hospitalized for more than 72 hours, or who are discharged and later readmitted to the facility **from** the hospital.
6. Other state required assessment — An example is a Utilization Review assessment. States may issue additional instructions.

Coding: Enter the number corresponding to the primary reason for assessment. For item a (Primary reason for assessment), for codes 1-9, leave first box blank, placing correct digit in the second box.

Additional Comments on Significant Change Assessment

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

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

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

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

A significant change may occur at any point during the resident's stay, **although** facilities may most commonly identify that a significant change has occurred while constructing the resident's scheduled quarterly review. Over a six-month period, depending on the resident population, one in five residents typically declines in **two** or more of these areas. The goal

of the significant change reassessment is to ensure that residents are being appropriately monitored and necessary changes in care instituted. Also see discussion in Chapter 2.

SIGNIFICANT CHANGE CRITERIA*

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

DECLINE

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

IMPROVEMENT

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

* **This is not an exhaustive list.**

9. Responsibility/Legal Guardian

intent: **To record who has responsibility for participating in decisions about the resident's health care, treatment, financial affairs, and legal affairs. Depending**

on the resident.5 condition, multiple options may apply. For example, a resident with moderate dementia may be competent to make decisions in certain areas, although in other areas a family member will assume decision-making responsibility. Or a resident may have executed **limited** power of attorney to someone responsible only for legal affairs. Legal oversight such as guardianship, durable power of attorney, and living wills are generally governed by State law. The descriptions provided here “are for general information only. Refer to the law in your State and to the facility’s legal counsel, as appropriate, for additional clarification.

Definition: **Legal guardian** — Someone who has been appointed after a court hearing and is **authorized** to make decisions for the resident, including giving and withholding consent for medical treatment. Once appointed, the decision-making authority of the guardian may be revoked only by another court hearing.

Other legal oversight — Use this category for any other program in your State whereby someone other than the resident participates in or makes decisions about the resident’s health care and treatment.

Durable power of attorney/health care — Documentation that someone other than the resident is legally responsible for health care decisions if the resident becomes unable to make decisions. This document may also provide guidelines for the agent or proxy decision-maker, and may include instructions concerning the resident’s wishes for care. Unlike a guardianship, durable power of attorney/health care proxy terms can be revoked by the resident at any time.

Durable power of attorney/financial — Documentation that someone other than the resident is legally responsible for financial decisions if the resident becomes unable to make decisions.

Family member responsible — Includes immediate family or significant other(s) as designated by the resident. Responsibility for decision-making may be shared by both resident and family.

Patient responsible for self — Resident retains responsibility for decisions. In the absence of guardianship or legal documents indicating that decision-making has been delegated to others, always assume that the resident is the responsible party.

Process: Legal oversight such as guardianship, durable power of attorney, and living wills are generally governed by state law. The descriptions provided here are for general information only. Refer to the law in your State and to the facility’s legal counsel, as appropriate, for additional clarification.

Consult the resident and the resident's family. Review records. Where the legal oversight or guardianship is court ordered, a copy of the legal document must be included in the resident's record in order for the item to be checked on the MDS form.

Coding: Check all that apply.

10. Advanced Directives

Intent: To record the legal existence of directives regarding treatment options for the resident, whether made by the resident or a legal proxy. Documentation must be available in the record for a directive to be considered current and binding. The absence of preexisting directives for the resident should prompt discussion by **clinical** staff **with** the resident and family regarding the resident's wishes. Any discrepancies **between** the resident's current stated wishes and what is said in legal documents in the resident's file should be resolved immediately.

Definition: **Living will** — A document specifying the resident's preferences regarding measures used **to** prolong life when there is a terminal prognosis.

Do not resuscitate — In the event of respiratory or cardiac failure, the resident, family or legal guardian has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods will be used to attempt to restore the resident's respiratory or circulatory function.

Do not hospitalize — A document specifying that the resident is not to be hospitalized even after developing a medical condition that usually requires hospitalization.

Organ donation — Instructions indicating that the resident wishes to make organs available for transplantation, research, or medical education upon death.

Autopsy request — Document indicating that the resident, family or legal guardian has requested that an autopsy be performed upon death. The family **or** responsible party must still be contacted upon the resident's death and **re-**asked if they want an autopsy to be performed.

Feeding restrictions — The resident or responsible party (family or legal guardian) does not wish the resident to be fed by artificial means (e.g., tube, intravenous nutrition) if unable to be nourished by oral means.

— Medication restrictions — The resident or responsible party (**family** or legal guardian) does not wish the resident to receive life-sustaining medications

(e.g., antibiotics, chemotherapy). These restrictions may not be appropriate, however, when such medications could be used to ensure the resident's comfort. In these cases, the directive should be reviewed with the responsible party.

Other treatment restrictions — The resident or responsible party (family or legal guardian) does not wish the resident to receive certain medical treatments. Examples include, but are not limited to, blood transfusion, tracheotomy, respiratory intubation, and restraints. Such restrictions may not be appropriate to treatments given for palliative reasons (e.g., reducing pain or distressing physical symptoms such as nausea or vomiting). In these cases, the directive should be reviewed with the responsible party.

Process: You will need to familiarize yourself with the legal status of each type of directive in your State. In some states only a health care proxy is formally recognized; other jurisdictions allow for the formulation of living wills and the appointment of individuals with durable power of attorney for health care decisions. Facilities should develop a policy regarding documents drawn in other states, respecting them as important expressions of the resident's wishes until their legal status is determined.

Review the resident's record for documentation of the resident's advance directives. Documentation must be available in the record for a directive to be considered current and binding.

Some residents at the time of admission may be unable to participate in decision-making. Staff should make a reasonable attempt to determine whether the new resident has ever created an advance directive (e.g., ask family members, check with the primary physician). Lacking any directive, treatment decisions will likely be made in concert with the resident's closest family members or, in their absence or in case of conflict, through legal guardianship proceedings.

Coding: The following comments provide further guidance on how to code these directives. You will also need to consider State law, legal interpretations, and facility policy.,

- The resident (or proxy) should always be involved in the discussion to ensure informed decision-making. If the resident's preference is known and the attending physician is aware of the preference, but the preference is not recorded in the record, check the MDS item only after the preference has been documented.
- If the resident's preference is in areas that require supporting orders by the attending physician (e.g., do not resuscitate, do not hospitalize, feeding —

restrictions, other treatment restrictions), check the MDS item **only** if the document has been recorded or **after** the physician provides the necessary order. Where a physician's current order is recorded but resident's or proxy's preference is not indicated, discuss with the resident's physician and check the **MDS** item only after documentation confirming that the resident's or proxy's wishes have been entered into the record.

- If your facility has a standard protocol for withholding particular treatments from all residents (e.g., **no** facility staff member may resuscitate or perform CPR on any resident; facility does not use feeding tubes), check the MDS item **only** if the advanced directive is the individual preference of the resident (or legal proxy), regardless of the facility's policy or protocol.

Coding: Check all that apply. If none of the directives are verified by -documentation in the medical records, check NONE OF *ABOVE*.

SECTION B. COGNITIVE PATTERNS

Intent: To determine the resident's ability to remember, think coherently, and **organize** daily self-care activities. These items are crucial factors in many care-planning decisions. Your focus is on resident **performance**, including a demonstrated ability to remember recent and **long-past** events and to perform key decision making skills.

Questions about cognitive **function** and memory can be sensitive issues for some residents who may become defensive or agitated or very emotional. These are not uncommon reactions to performance anxiety and feelings of being exposed, **embarrassed**, or frustrated if the resident knows he or she cannot answer **the** questions cogently.

Be sure to interview the resident in a private, quiet area without distractions — i.e., not in the presence of other residents or family, unless the resident is too agitated to be **left** alone. Using a nonjudgmental approach to questioning will help create a needed sense of trust between staff and resident. After eliciting the resident's responses to the questions, return to the resident's family or others, as appropriate, to **clarify** or validate information regarding the resident's cognitive function over the last seven days. For residents with **limited** communication skills or who are **best** understood by family or specific care givers, you will need to **carefully** consider their insights in this area.

- Engage the resident in general conversation to help establish rapport.
- Actively listen and observe for clues to help you structure your assessment. Remember — repetitiveness, inattention, rambling speech, defensiveness, or agitation may be challenging to deal with during an interview, but they provide important information about cognitive function.
- Be open, supportive, and reassuring during your conversation with the resident (e.g., “Do you sometimes have trouble remembering things? Tell me what happens. We will try to help you”).

If the resident becomes really agitated, sympathetically respond to his or her feelings of agitation and STOP discussing cognitive function. The information-gathering process does not need to be completed in one sitting but may be ongoing during the entire assessment period. Say to the agitated resident, for example, “Let’s talk about something else now,” or “We don’t need to talk about that now. We can do it later”. Observe the resident’s cognitive performance over the next few hours and days and come back to ask more questions when he or she is feeling more comfortable.

1. Comatose

Intent: To record whether the resident’s clinical record includes a documented neurological diagnosis of coma or persistent vegetative state.

Coding: Enter the appropriate number in the box.

If the resident has been diagnosed as comatose **or** in a persistent vegetative state, code “1”. **Skip to Section G.** **If the** resident is not comatose or is semi-comatose, code “0” and proceed to the next item (B2).

2. Memory

Intent: To **determine the** resident’s functional capacity to remember both recent and long-past events (i.e., short-term and long-term memory).

Process: a. Short-Term Memory: Ask the resident to describe a recent event that both of you had the opportunity to remember. Or, you could use a more structured short-term memory test. For residents with limited communication skills, ask **staff** and family about the resident’s memory status. Remember, if there is no positive indication of memory ability, (e.g., remembering multiple items over

time or following through on a direction given five minutes earlier) the correct response is “1”, Memory Problem.

Examples

Ask the resident to describe the breakfast meal or an activity just completed.

Ask the resident to remember three items (e.g., book, watch, table) for a few minutes. After **you** have stated all three items, ask the resident to repeat them (to verify that you were heard and understood). Then proceed to talk about something else — do not be silent, do not leave the room. In five minutes, ask the resident to repeat the name of each item. If the resident is unable to recall all three items, code “1.” For persons with verbal **communication** deficits, non-verbal responses are acceptable (e.g., when asked how many children they have, they can tap out a response of the appropriate number).

b. Long-Term **Memory**: Engage in conversation that is **meaningful** to the resident. Ask questions for which you can validate the answers (from your review of record, general knowledge, ‘the resident’s family). For residents with limited communication skills, ask staff and family about the resident’s memory status. Remember, if there is no positive indication of memory ability, the correct response is “1”, Memory Problem.

Example

Ask the resident, “Where did you live just before you came here?” If “at home” is the reply, ask “What was your address?” If “another nursing home” is the reply, ask “What was the name of the place?” Then ask: “Are you married?” “What is your spouse’s name?” “Do you have any children?” “How many?” “When **is your birthday?**” “In what **year** were you born?”

Coding: Enter the numbers that **correspond** to the observed responses.

3. Memory/Recall Ability

Intent: To **determine** the resident’s memory/recall performance within the environmental setting. A resident may have intact social graces and respond to staff and others with a look of recognition, yet have no idea who they are. This item will enable staff to probe beyond first, perhaps mistaken, impressions.

Definition: **Current season** — Able to identify the current season (e.g., correctly refers to **weather** for the time of year, legal holidays, religious celebrations, etc.).

Location of own room — Able to locate and recognize own room. It is not necessary for the resident to know the room number, but he or she should be able to **find** the way to the room.

Staff names/faces — Able to distinguish staff members from family members, strangers, visitors, and other residents. It is not necessary for the resident to know the staff member's name, but he or she should recognize that the person is a staff member and not the resident's son or daughter, etc.

That he/she is in a nursing home — Able to determine that he or she is currently living in a nursing home. To check this item, it is not-necessary that the resident be able to state the name of the facility, but he/she should be able to refer to the facility by a term such as a "home for older people", a "hospital for the elderly", "a place where older people live", etc.

Process: **Test** memory/recall. **Use** information obtained from **clinical** records or staff. Ask the resident about each item. For example, "What is the current season?" "What is the name of this place?" "What is this kind of place?" **If** the resident is not in his or her room, ask "**Will you show me to your room?**" Observe the resident's ability to **find** the way.

Coding: For each item that the resident can recall, check the **corresponding** answer box. If the resident can recall none, check **NONE OF ABOVE**.

4. Cognitive Skills for Daily Decision-Making

Intent: To record the resident's actual performance in making everyday decisions about tasks or activities of daily living.

Examples

Choosing items of clothing; knowing when to go to scheduled **meals**; using environmental cues to organize and plan (e.g., clocks, calendars, posted listings of upcoming events); in the absence of environmental cues, seeking information appropriately (**i.e.**, not repetitively) from others in order to plan the day; using awareness of one's own strengths and limitations in regulating the day's events (**e.g.**, asks for help when necessary); making the correct decision concerning how to get to the lunchroom; acknowledging **need** to use a walker, and using it faithfully.

Process: Review the clinical **record**. Consult family and nurse assistants. Observe the resident. ***The inquiry should focus on whether the resident is actively making these decisions, and not whether staff believe the resident might be capable of doing so. Remember the intent of this item is to record what the resident is doing (performance).*** Where a staff member takes decision-making responsibility away **from** the resident regarding tasks of everyday living, or the resident does not participate in decision-making., whatever **his** or her level of capability may be, the resident should be considered to have impaired performance in decision-making.

This item is especially important for **further** assessment and care planning in that it can alert staff to a mismatch between a resident's abilities and his or her current level of performance, or that staff may be inadvertently fostering the resident's dependence.

Coding: Enter one number that corresponds to the most correct response.

0. Independent — The resident's decisions in **organizing** daily routine and making decisions were consistent, reasonable, and organized reflecting lifestyle, culture, values.
1. Modified Independence — The resident organized **daily** routine and made safe decisions in familiar situations, but experienced some **difficulty** in decision-making when faced with new task or situations.
2. Moderately Impaired — The resident's decisions were poor; the resident required reminders, cues, and supervision in planning, organizing, and correcting daily routines.
3. Severely Impaired — The resident's decision-making was severely impaired; the resident never (or rarely) made decisions.

5. Indicators of Delirium — Periodic Disordered Thinking/Awareness

Intent: To record behavioral signs that may indicate that delirium is present. Frequently, **delirium** is caused by a treatable illness such as infection or reaction to medications.

The characteristics of delirium are often manifested behaviorally and therefore can be observed. For example, disordered thinking may be manifested by **rambling, irrelevant, or incoherent speech. Other behaviors are described in the definitions below.**

A recent change (deterioration) in cognitive function is indicative of delirium (acute confusional state), which may be reversible if detected and treated in a timely fashion. Signs of delirium can be easier to detect in a person with intact cognitive function at baseline. However, when a resident has a **pre-existing** cognitive impairment or **pre-existing** behaviors such as restlessness, calling out, etc., detecting signs of delirium is more difficult. Despite this difficulty, it is possible to detect signs of delirium in these residents by being attuned to recent changes in their usual functioning. For example, a resident who is usually noisy or belligerent may suddenly become quiet, lethargic, and inattentive. Or, conversely, one who is normally quiet and content may suddenly become restless and noisy. Or, one who is usually able to find his or her way around **the** unit may begin to get lost”.

- Definitions:**
- a. Easily distracted (e.g., difficulty paying attention; gets sidetracked)
 - b. Periods of altered **perception** or **awareness** of surroundings (e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
 - c. Episodes of disorganized **speech** (e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses track of thought)
 - d. Periods of restlessness (e.g., fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out)
 - e. Periods of lethargy (e.g., sluggishness, staring into space; **difficult** to arouse; little body movement)
 - f. Mental function **varies over the course of the day** (e.g., **sometimes** better, sometimes worse; behaviors sometimes present, sometimes not)

Coding: *Code* for resident's behavior in the last seven days regardless of what you believe the cause to be — focusing on when the manifested behavior first occurred.

0. Behavior not present
 1. Behavior present, not of recent onset
 2. Behavior present over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

Case Example 1

Mrs. K is a 92 year old widow of 30 years who has severe functional dependency secondary to heart disease. Her primary nurse assistant has reported during the last two days Mrs. K has “not been herself.” She has been napping more frequently and for longer periods during the day. She is difficult to arouse and has mumbling speech upon awakening. She also has difficulty paying attention to what she is doing. For example, at meals instead of eating as she usually does, she picks at her food as if she doesn't know what to do with a fork. Then stops and closes her eyes after a few minutes. Alternatively, Mrs. K has been waking up at night believing it to be daytime. She has been calling out to staff demanding to be taken to see her husband (although he is deceased). On 3 occasions Mrs. K was observed attempting to climb out of bed over the foot of the bed.

Indicators	Coding
a. Easily distracted	2 (present, new)
b. Periods of altered perception or awareness of surroundings	2 (present, new)
c. Episodes of disorganized speech	2 (present, new)
d. Periods of restlessness	2 (present, new)
e. Periods of lethargy	2 (present, new)
f. Mental function varies over the course of the day	2 (present, new)

Case Example 2

Mr. D has a history of Alzheimer's disease. His skills for decision making have been poor for a long time. He often has difficulty paying attention to tasks and activities and usually wanders away from them. He rarely speaks to others, and when he does it is garbled and the contents are nonsensical. He is often observed mumbling and moving his lips as if he's talking to someone. Although Mr. D is often restless and fidgety this behavior is not new for him and it rarely interferes with a good night's sleep.

Indicators	Coding
a. Easily distracted	1 (present, not new)
b. Periods of altered perception or awareness of surroundings	1 (present, not new)
c. Episodes of disorganized speech	1 (present, not new)
d. Periods of restlessness	1 (present, not new)
e. Periods of lethargy	0 (behavior not present)
f. Mental function varies over the course of the day	1 (present, not new)

6. Change in Cognitive Status

Intent: To document changes in the resident's cognitive status, skills, or abilities as compared to his or her status of 90 days ago (or since last assessment if less than 90 days ago). These can include, but are not limited to, **changes** in level of consciousness, cognitive skills for daily decision-making, short-term or long-term memory, thinking or awareness, or recall. Such changes may be permanent or temporary; their causes may be known (e.g., a new pain or psychotropic medication) or unknown. If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Coding: Record the number corresponding to the most correct response. Enter "0" for No change, "1" for Improved, or "2" for Deteriorated.

Examples of Change in Cognitive Status

Mrs. G experienced delirium (acute confusion) secondary to pneumonia approximately 30 days ago. With appropriate antibiotic therapy, hydration, and a quiet supportive milieu, she recovered. Although Mrs. G's cognitive skills did not increase beyond the level that existed prior to her pneumonia, and she remains unable to make daily decisions, she has steadily improved to her pre-pneumonia status. **Code "0" for No Change.**

Ms. P is intellectually intact. About two and one-half months ago she was informed by her daughter that her neighbor and lifelong friend had died while on a trip to Europe. Ms. P took the news very hard; she was stunned and seemed to be confused and bewildered for days. With support of family and staff, confusion passed. Although she continued to grieve, **her** cognitive status returned to what it was prior to her receiving the bad news. **Code "0" for No change.**

Mr. D was admitted to the nursing home three months ago **upon discharge** from the hospital with signs of post-operative delirium. Since that time he **no** longer requires frequent reminders and **re-orientation** throughout each day. **His** decision-making skills have improved. **Code "1" for Improved.**

Mr. F has Alzheimer's disease. He did well until two months ago, when his primary nurse assistant reported that he can no longer find his way back to his room; which he was able to do **three** months ago. He often gets lost now while trying to find his way to the unit activity/dining room. **Code "2" for Deteriorated.**

(continued on next page)

Examples of Change in Cognitive Status
(continued)

Mrs. F was admitted to the facility six weeks ago. Upon admission she had modified independence in daily decision-making skills, intact short and long term memory, and good recall abilities. Since that time, Mrs. F has had a stroke, which **has** left her with deficits in these areas. Within this Significant Change assessment period, her decisions have become poor. She is not aware of her new physical limitations and has taken unreasonable safety risks in transferring and locomotion. She receives supervision at all times. Code **"2"** for Deteriorated.

MDS Cognitive Performance **Scale**[®]

Many facilities have asked for a system to combine **MDS** cognitive items into an overall Cognitive Performance Scale. Such a scale has been produced — The **MDS Cognitive Performance Scale (CPS)**[®] [see Appendix **F**]. Five MIX items are used in assigning residents to one of seven CPS categories. The CPS categories are highly related to residents' average scores on the Folstein Mini-Mental Status Examination (**MMSE**), which has a score range of zero (worst) to thirty (best). According to Folstein, an MMSE score of 23 or lower usually suggests cognitive impairment but it may be lower for persons with an eighth grade education or less.

SECTION C. COMMUNICATION/HEARING PATTERNS

Intent: To document the resident's **ability to** hear (with assistive hearing devices, if they are used), understand, and communicate with others.

There are many possible causes for the communication problems experienced by elderly nursing home residents. Some can be attributed to the aging process; others are associated with progressive physical and neurological disorders. Usually the communication problem is caused by more than one factor. For example, a resident might have aphasia as well as long standing hearing loss; or he or she might have dementia and word finding **difficulties** and a hearing loss. The resident's physical, emotional, and social situation may also complicate communication problems. Additionally, a noisy or -isolating environment can inhibit opportunities for effective communication.

Deficits in one's ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written), or recognition of facial expressions. Deficits in ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and gesturing.

1. Hearing

Intent: To evaluate the resident's ability to hear (with environmental adjustments, if necessary) during the past seven-day period.

Process: Evaluate hearing ability **after** the resident has a hearing appliance in place, if the resident uses an appliance. Review the clinical record. Interview and observe the resident, and ask about the hearing function. Consult the resident's family, direct care staff, and speech or hearing specialists. Test the accuracy of your **findings** by observing the resident during your verbal interactions.

Be alert to what you have to do to communicate with the resident. For example, if you have to speak more clearly, use a louder tone, speak more slowly, or use more gestures, or if **the** resident needs to see your face to know what you are saying, or **if** you have to take the resident to a more quiet area to conduct the interview — all of these are cues that there is a hearing problem, and should be so indicated in the coding.

Also, observe the resident interacting with others and in group activities. Ask the activities personnel how the resident hears during group leisure activities.

Coding: Enter one number that corresponds to the most correct response.

0. Hears adequately — The resident hears all normal conversational speech, including when using the telephone, watching television, and engaged in group activities.
1. Minimal **difficulty** — The resident hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-on-one situations.
2. Hears in **special** situations only — Although hearing-deficient, the resident compensates when the speaker adjusts tonal quality and speaks distinctly; or the resident can hear only when the speaker's face is clearly visible.

3. Highly impaired/absence of useful hearing — The resident hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks **distinctly**, or is positioned face to face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

2. Communication Devices/Techniques

Definition: **Hearing aid, present and used**— A hearing aid or other assistive listening device is available to the resident and is used regularly.

Hearing aid, present and not used regularly — A hearing aid or other assistive listening device is available to the resident and is not regularly used (e.g., resident has a hearing aid that is broken or is used only **occasionally**).

Other receptive communication technique used (e.g., lip reading) — A mechanism or process is used by the resident to enhance interaction with others (e.g., reading lips, touching to compensate for hearing deficit, **writing** by staff member, use of communication board).

Process: Consult with **the** resident and direct care staff. Observe the resident closely during your interaction.

Coding: Check all that apply. If the resident does not have a hearing aid or does not regularly use compensatory communication techniques, check **NONE OF ABOVE**.

3. Modes of Expression

Intent: To record the types of communication techniques (verbal and non-verbal) used by the resident to make his or her needs and wishes known.

Definition: **Writing messages to express or clarify needs** — Resident writes notes to communicate with others.

Signs/gestures/sounds — **This category** includes nonverbal expressions used by the resident to communicate with others.

- Actions may include pointing to words, objects, people; facial expressions; using physical gestures such as nodding head **twice** for “yes” and once for “no” or squeezing another’s hand in the same manner.

- **Sounds** may include grunting, banging, ringing a bell, etc.

Communication board — An electronic, computerized or other home-made device used by the resident to convey verbal **information**, wishes, or commands to others.

Other — Examples include flash cards or various electronic assistive devices.

Process: Consult with the primary nurse assistant and other direct-care staff from all shifts, if possible. Consult with the resident's family. Interact with the resident and observe for any reliance on non-verbal expression (physical gestures, such as pointing to objects), either in one-on-one communication or in group situations.

Coding: Check the boxes for each method **used** by **the** resident to communicate his or her needs. If the resident does not use any of the listed items, check **NONE OF ABOVE**.

4. Making Self Understood

Intent: To document the resident's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these.

Process: Interact with the resident. Observe and listen to the resident's efforts to communicate with you. Observe his or her interactions with others in **different** settings (e.g., one-on-one, groups) and different circumstances (e.g., when **calm**, when agitated). Consult with the primary nurse assistant (over all shifts) if available, the resident's family, and speech-language pathologist.

Coding: Enter the number corresponding to the most correct response.

0. Understood — The resident expresses ideas clearly.
1. Usually Understood — The resident has difficulty finding the right words or finishing thoughts, resulting in delayed responses; or the resident requires some prompting to make self understood.
2. Sometimes Understood — The resident has limited ability, but is able to express concrete requests regarding at least basic **needs (e.g., food, drink, sleep, toilet)**.

3. **Rarely or Never Understood** — At best, understanding is limited to staff interpretation of highly individual, resident-specific sounds or body language (e.g., indicated presence of pain or need to toilet).

5. Speech Clarity

Intent: To document the quality of the resident's speech, not the content or appropriateness -just words spoken.

Definition: Speech — the expression of articulate words.

Process: Listen to the resident. Confer with primary assigned caregivers.

Coding: Enter the number corresponding to the most correct **response**.

0. Clear speech — utters distinct, intelligible words.
1. **Unclear speech** — utters slurred or mumbled words.
2. No speech — absence of spoken words.

6. Ability to Understand Others

Intent: To describe the resident's ability to comprehend verbal information whether **communicated** to the resident orally, by writing, or in sign language or braille. This item measures not only the resident's ability to hear messages but also to process and understand language.

Process: Interact with the resident. Consult with **primary** direct care staff (e.g., nurse assistants) over all shifts if possible, the resident's family, and speech-language pathologist.

Coding: Enter the number corresponding to the most appropriate response.

0. Understands — The resident clearly comprehends the speaker's message(s) and demonstrates comprehension by words or actions/behaviors.
1. Usually Understands — The resident may miss some part or intent of the message but comprehends most of it. The resident may have periodic **difficulties** integrating information but generally demonstrates **comprehension** by responding in words or actions.

2. **Sometimes Understands** — The resident demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or &r&ions. When staff rephrase or simplify the message(s) and/or use gestures, the resident's comprehension is enhanced.
3. **Rarely/Never Understands** — The resident demonstrates very limited ability to understand communication. Or, staff have difficulty determining whether the resident comprehends messages, based on verbal and nonverbal responses. Or, the resident can hear sounds but does not understand messages.

7. 'Change in Communication/Hearing

Intent: To document any change in the resident's ability to express, understand, or hear information compared to his or her status of 90 days ago (or since last assessment if less than 90 days ago). If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Process: In addition to consulting primary care staff (over all shifts if possible), consulting **the** family of new admissions, and reviewing prior Quarterly reviews when available, ask the resident if he or she has noticed any changes in the ability to hear, talk, or understand others. Sometimes, residents do not complain of changes **being** experienced because they attribute them to "old age". Therefore, it is important that they be asked directly. Some types of deterioration are easily corrected (e.g., by new hearing aid batteries or removal of ear wax).

Coding: . Enter the number corresponding to the most correct response. Enter "0" for No change, "1" for Improved, or "2" for Deteriorated.

Examples of Change in Communication/Hearing

Mrs. L has had expressive aphasia for two years. Although she periodically says a word or phrase that is understood by others, this is not new for her. During the last 90 days her communication status has essentially remained unchanged. Code **"0"** for No change.

Mrs. R's hearing is severely impaired. Five months ago the occupational therapist developed flash cards for staff to use when communicating with her. This was a tremendous boost for both Mrs. R and staff. Her ability to understand others continues to improve. Code **"1"** for Improved.

Mr. S has complained for the last two weeks of ringing in his ears, saying "Please do something, it's driving me crazy! Code **"2"** for Deteriorated.

Upon admission two months ago Mrs. T had difficulty hearing unless the speaker adjusted his or her tone of voice and spoke more distinctly. She has worn hearing aids in the past but lost them during a hospital admission. Since admission to the nursing home, Mrs. T was tested and fitted with new hearing aids. She hears much better with the aids though she is still trying to adjust to wearing them. Code **"1"** for Improved.

**SECTION D.
VISION PATTERNS**

Intent: To record the resident's visual abilities and limitations over the past seven days, assuming adequate lighting and assistance of visual appliances, if used.

1. Vision

Intent: To evaluate the resident's ability to see close objects in adequate lighting, using the resident's customary visual appliances for close vision (e.g., glasses, magnifying glass).

Definition: **"Adequate" lighting** — What is sufficient or comfortable for a person with normal vision.

- Process:*
- Ask direct care staff over all shifts if possible, if the resident has **manifested** any change in usual vision patterns over the past seven days — e.g., is the resident still able to read newspaper, menus, greeting cards, etc.?
 - Then ask the resident about his or her visual **abilities**.
 - Test the accuracy of your findings by asking the resident to look at **regular-size** print in a book or newspaper with whatever visual appliance he or she customarily uses for close vision (e.g., glasses, magnifying glass). Then ask the resident to read aloud, starting with larger headlines and ending with the finest, smallest print.
 - Be sensitive to the fact that some residents are not literate or are unable to read English. In such cases, ask the resident to read aloud individual letters of different size print or numbers, such as dates or page numbers, or to name items in small pictures.
 - If the resident is unable to communicate or follow your directions for testing **vision**, **observe** the resident's eye movements to see if his or her eyes seem to follow movement and **objects**. Though these are gross measurements of visual acuity, they may **assist you** in assessing whether the resident has any visual ability.

Coding: Enter the number corresponding to the most correct response.

0. Adequate — The resident sees **fine** detail, including regular print in newspapers/books.
1. Impaired — The resident sees large print, but not regular print in newspapers/books.
2. Moderately Impaired — The resident has limited vision, is not able to see newspaper headlines, but can identify objects in his or her environment.
3. Highly Impaired — The resident's ability to identify objects in his or her environment is in question, but the resident's eye movements appear to be following objects (especially people walking by).

Note: Many residents with severe cognitive impairment are unable to participate in vision screening because they are unable to follow directions or are unable to tell you what they see. However, many such residents appear to "track" or follow moving objects in their environment with their eyes. For residents who appear to do this, use code "3", Highly Impaired. With our current limited technology, this is the best assessment you can do under the circumstances.

4. Severely Impaired — The resident has no vision; sees only light colors or shapes; or eyes do not appear to be following objects (especially people walking by).

2. Visual Limitations/Difficulties

Intent: To document whether the resident experiences visual limitations or difficulties related to diseases common in aged persons (e.g., cataracts, glaucoma, macular degeneration, diabetic retinopathy, **neurologic** diseases). It is important to identify whether these conditions are present. Some eye problems may be treatable and reversible; others, though not reversible, may be managed by interventions aimed at maintaining or improving the resident's residual visual abilities.

Process: Side vision **problems** — Observe the resident during his or her daily routine (e.g., eating meals, traveling down a hallway). Also, ask the resident about any vision problems (e.g., spilling food, bumping into objects and people). Ask the primary nurse assistant and other direct-care staff on each shift if possible, whether the resident appears to have **difficulties** related to decreased peripheral vision (e.g., leaves food on one side of tray, has difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self).

Experiences any **of the following** — Ask the resident directly if he or she is seeing halos or rings around lights, flashes of light, or “curtains” over the eyes. Ask staff members if the resident complains about any of these problems.

Coding: Check all that apply. If none apply, check **NONE OF ABOVE**.

3. Visual Appliances

Intent: To determine if the resident uses visual appliances regularly.

Definition: Glasses; contact lenses; magnifying glass — Includes any type of corrective device used at any time during the last seven days.

Coding: Enter “1” if the resident used glasses, contact lenses, or a magnifying glass during the past seven days. Enter “0” if none apply.

SECTION E. MOOD AND BEHAVIOR PATTERNS

Mood distress is a serious condition and is associated with, significant morbidity. Associated factors include poor adjustment to the nursing home, functional impairment, resistance to daily care, inability to participate in activities, isolation, increased risk of medical illness, cognitive impairment, and an increased sensitivity to physical pain. It is particularly important to identify **signs** and symptoms of mood distress among elderly nursing home residents because they are very treatable.

In many facilities, staff have not received specific training in how to **evaluate residents** who have distressed mood or behavioral symptoms. Therefore, many problems are underdiagnosed and undertreated. In facilities where such training has not occurred, an in-service program under the direction of a professional mental health specialist is recommended. At a minimum, staff in such facilities have found the various mental health **RAPs** (e.g., Mood, Behavior) to be helpful and these should be carefully reviewed.

1. Indicators of Depression, Anxiety, Sad Mood

Intent: To **record** the frequency of indicators observed in the last 30 days, irrespective of the assumed cause of the indicator (behavior).

Definition: Feelings of psychic distress may be expressed directly by the resident who is depressed, anxious, or sad. However, statements such as "I'm so depressed" are rare in the **older** nursing home population. Rather, distress is more commonly expressed in the following ways:

VERBAL EXPRESSIONS OF DISTRESS

- a. **Resident made negative statements** — e.g., "Nothing **matters**; Would rather be dead; What's the use; Regrets having lived so long; Let me die."
- b. **Repetitive' questions** — e.g., "Where do I go; What do I do?"
- c. **Repetitive verbalizations** — e.g., Galling out for help, ("God help me").
- d. **Persistent anger with self or others** — e.g., **easily annoyed**, anger at placement in nursing home; anger at care received;
- e. **Self deprecation** — e.g., "I am nothing; I am of no use to anyone".

- f. Expressions of what appear **to be unrealistic** fears — e.g., fear of being abandoned, left alone, being with others.
- g. Recurrent **statements that something** terrible is about to **happen** — e.g., believes he or she is about to die, have a heart attack.
- h. Repetitive **health complaints** — e.g., persistently seeks medical attention, obsessive concern with body functions.
- I. Repetitive anxious **complaints/concerns** (non-health related) — e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues.

DISTRESS MAY ALSO BE EXPRESSED NON-VERBALLY AND IDENTIFIED THROUGH OBSERVATION OF THE RESIDENT IN THE FOLLOWING AREAS DURING USUAL DAILY ROUTINES:

SLEEP CYCLE ISSUES — Distress can also be manifested through disturbed sleep patterns.

- j. Unpleasant **mood in morning**
- k. **Insomnia/change in** usual **sleep pattern** — e.g., difficulty **falling** asleep, fewer or more hours of sleep than usual, waking up too early and unable to fall back to sleep

SAD, APATHETIC, ANXIOUS APPEARANCE

- l. **Sad, pained, worried facial expressions** — e.g., furrowed brows
- m. Crying, **tearfulness**
- n. Repetitive **physical movements** — e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST. These items refer to a change in resident's usual pattern of behavior.

- o. **Withdrawal from activities of interest** — e.g., no interest in long standing activities or being with family/friends
- p. Reduced social interaction — e.g., less **talkative, more isolated**

Process: Initiate a conversation with the resident. Some residents are more verbal about their feelings **than** others and will either tell someone about, **their** distress, or tell someone only when directly asked how they **feel**. Other residents may be unable to articulate their feelings (i.e., cannot **find** the words to describe how they feel, or lack insight or cognitive capacity). Observe residents carefully for any indicator. Consult **with direct-care** staff over all shifts; if possible, and family who have direct knowledge of **the** resident's behavior. Relevant information may also be found in the clinical record.

Coding: For each indicator apply one of the following codes based on interactions with and observations of the resident in the last 30 days. Remember, code regardless of what you believe the cause to be.

0. Indicator not exhibited in last 30 days
 1. Indicator of this type exhibited up to five days a week (*i.e., exhibited at least once during the last 30 days but less than 6 days a week*).
 2. Indicator of this type exhibited daily or almost daily (**6, 7** days a week)

Example

Mr. F is a new admission who **becomes** upset and angry when his daughter visits (3 times a week). He complains to her and staff caregivers that 'she put me in this terrible dump.' He **chastizes** her 'for not taking him into her home', and berates her 'for being an ungrateful daughter.' After she leaves, he becomes remorseful, sad looking, **tearful**, and says "What's the use. I'm no good. I wish I **died** when my wife did." Coding **"1"** for **a. (Resident made negative statements), d. (Persistent anger with self or others), e. (Self deprecation), m. (Crying, tearfulness);** remaining Mood items would be coded **"0"**.

2. Mood Persistence

Intent: To identify if 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 the last seven days.

Process: Observe the resident and discuss the situation with direct caregivers over all shifts, if possible, and family members or friends who visit frequently or have frequent telephone contact with the resident.

Coding: Enter **"0"** if the resident did not exhibit any mood indicators over last 7 days, **"1"** if indicators were present and easily altered by staff interactions with the resident or **"2"** if any indicator was present but not easily altered (e.g., behavior persisted despite staff efforts to console resident).

3. Change in Mood

Intent: To document changes **in** the resident's mood as compared to his or her status of 90 days ago (or since last assessment if less than 90 days ago). If the resident is **a new** admission to the facility, this **item includes** changes **during** the period prior to admission.

Definition: **Change in Mood** — Refers to status of any of the symptoms (new onset, improvement, worsening) described in item E1 (verbal expressions of distress, sleepcycle issues, sad apathetic, anxious appearance, loss of interest or other signs) and item E2 (mood persistence). Such changes include:

- increased or decreased **numbers** of expressions or signs of distress
- increased **or decreased frequency** of distress occurrence ~
- **increased** or decreased intensity of expressions or signs of distress

Process: Review the clinical records including the last Quarterly Assessment findings and transmittal records of newly admitted residents. Interview and observe the **resident**. Consult with staff from all shifts, if possible, to **clarify** your observations.

Coding: Code "0" if No Change, "1" if Improved, or "2" if Deteriorated as compared to status of 90 days ago.

Examples of Changes in Mood

Mrs. Y has bipolar disease. Historically, she has responded well to lithium and her mood state has been stable for almost a year. About two months ago, she became extremely sad and withdrawn, expressed the wish that she were dead, and stopped eating. She was transferred to a psychiatric hospital for evaluation and treatment. Since her return to the nursing home three weeks ago, her mood and appetite have improved while on a new lithium dose and an additional antidepressant drug. She is back to her "old self" of 90 days ago. Code "0" for No change.

During the admission assessment period of 90 days ago, Mr. M was tearful and expressed great sadness and anger over entering the nursing home. He had difficulties falling asleep at night, was restless off and on during the night, and awakened too early in the morning, upset that he couldn't fall back to sleep. Since that time, Mr. M has been involved in a twice weekly support group, and has been enjoying socializing in activities with new friends. He is currently sleeping through the night and feels well in the morning. Although he still expresses sadness and anger over his need for nursing home care, it is less frequent and intense. Code "1" for Improved.

Mrs. D has a long history of depression. Two months ago she had an adverse reaction to a psychoactive drug. She expressed fears that she was going out of her mind and was observed to be quite agitated. Her attention span diminished and she stopped attending group activities because she was too restless. After the medication was discontinued, intensity of feelings and behaviors diminished and she has less frequent episodes of agitation. Mrs. D is better than she was, but she still has feelings of sadness. Mrs. D is now better than her worst status two months ago, but she has not fully recovered to her status of 90 days ago. Code "2" for Deteriorated.

During the admission assessment 6 weeks ago, Mrs. Z was very agitated. She had multiple daily complaints of vague aches and pains. She repetitively asked the nurses to "Call the doctor, I'm sick". After no physical problems could be identified, Mrs. Z was evaluated by a psychiatrist who diagnosed a clinical depression and prescribed an antidepressant drug. Its effect on Mrs. Z has been dramatic. During this Significant Change assessment, Mrs. Z had many fewer complaints about her health and was more involved in unit activities. Code "1" for Improved.

4. Behavioral Symptoms

Intent: To identify a.) the frequency and b.) alterability of behavioral symptoms in the last seven days that cause distress to the resident, or are distressing or disruptive to facility residents or staff members. Such behaviors include those that are potentially harmful to the resident himself or herself or disruptive in the environment, even if staff and other residents appear to have adjusted to them (e.g.,

“Mrs. R’s calling out isn’t much different than others on the unit. There are many noisy residents;” or “Mrs. L doesn’t mean to hit me. She does it because she’s confused. ”)

Acknowledging and documenting the resident’s behavioral symptom patterns on the MDS provides a basis for further **evaluation**, care planning, and delivery of consistent, appropriate care towards ameliorating the behavioral symptoms. Documentation in the clinical record of the resident’s current status may not be accurate or valid, and it is not intended to be the one and only source of information. (See Process below). However, once the frequency and alterability of behavioral symptoms is accurately determined, subsequent documentation should more accurately reflect the resident’s status and response to interventions.

Definition: Wandering — Locomotion with no **discernible**, rational purpose.-A wandering resident may be oblivious to his or her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (e.g., a hungry person moving about the unit in search of food). Wandering may be manifested by walking or by wheelchair.

Do not include pacing as wandering behavior. Pacing back and forth is not considered wandering, and if it occurs, it should be documented in Item Eln, “Repetitive physical movements”.

Verbally **Abusive Behavioral Symptoms** — Other residents or staff were threatened, screamed at, or cursed at.

Physically Abusive Behavioral Symptoms — Other residents or staff were hit, shoved, scratched, or sexually abused.

Socially Inappropriate/Disruptive Behavioral Symptoms — Includes disruptive sounds, excessive noise, screams, self-abusive acts, or sexual behavior or disrobing in public, **smearing or** throwing food or feces, hoarding, rummaging through others’ belongings.

Resists care — Resists **taking** medications/injections, ADL assistance or help with eating. This category does not include instances where **the** resident has made an informed choice not to follow a course of care (e.g., resident has exercised his or her right to refuse treatment, and reacts negatively as staff try to reinstitute treatment).

Signs of resistance may be verbal and/or physical (e.g., verbally refusing care, pushing caregiver away, scratching caregiver). These behaviors are not necessarily positive or negative, but are intended to provide information about the resident’s responses to nursing interventions and to prompt further

investigation of causes for care planning purposes (e.g., fear of pain, fear of **falling**, poor comprehension, anger, poor relationships, eagerness for greater participation in care decisions, past experience with medication errors and unacceptable care, desire to modify care being provided).

Process: Take an objective view of the resident's behavioral symptoms. The coding for this item focuses on the resident's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Therefore, it is important to start the assessment by recording any behavioral symptoms. The fact that staff 'have become used to the behavior and minimize the resident's presumed intent ("He doesn't really mean to hurt anyone. He's just frightened.") is not pertinent to this coding. Does the resident manifest the behavioral symptom or not? Is the resident combative during personal care and strike out at staff or not?

Observe the resident. Observe how the resident responds to staff members' attempts to deliver care to him or her. Consult with staff who provide direct care on all **three** shifts. A symptomatic behavior can be present and the RN Assessment Coordinator might not see it because it occurs during intimate care on another shift. Therefore, it is **especially** important that input from all nurse assistants having contact with the resident be solicited.

Also, be alert to the possibility that staff might not think to report a behavioral symptom if it is part of the unit norm (e.g., staff are working with severely cognitively and functionally impaired residents and are used to residents' wandering, noisiness, etc.). Focus staff attention on what has been the individual resident's actual behavior over the last seven days. Finally, although it may not be complete, review the clinical record for documentation.

Coding: **(A) Behavioral symptom frequency in last 7 days.**

Record the frequency of behavioral symptoms manifested by the resident across all three shifts.

Code **"0"** if the described behavioral symptom was not exhibited in last seven days.

For each type of behavior described on the MDS form, Code "0" if the resident did not exhibit that type of symptom in the last seven days. This code applies to residents who have never exhibited the behavioral symptom or those who have previously exhibited the symptom but now no longer exhibit it, including those whose behavioral symptoms are fully managed by psychotropic drugs, restraints, or a behavior-management program. For example: A "wandering" resident who **did** not wander in the last seven days because he

was restricted to a geri-chair would be coded "0" — Behavioral symptom not exhibited in last seven days. The questionable clinical practice of restricting wandering by placing a person in a geri-chair to restrict movement would then be evaluated using the Physical Restraints RAP.

Code "1" if the described behavioral symptom occurred 1 to 3 days, in last 7 days.

Code "2" if the described behavioral symptom occurred 4 to 6 days, but less than daily.

Code "3" if the described behavioral symptom occurred daily or more frequently (i.e., multiple times each day).

(B) Behavioral symptom alterability in last 7 days.

Code "0" if **either** the behavioral symptom was not present or the behavioral symptom was easily altered with current interventions.

Code "1" if the described behavioral symptom occurred with a degree of intensity that is not responsive to staff attempts to reduce the behavioral symptom through limit setting, diversion, adapting unit routines to the resident's needs, environmental modification, activities programming, comfort measures, appropriate drug treatment, etc. For example: A cognitively impaired resident who hits staff during morning care and swears at staff **with** each physical contact on multiple occasions per day, and the behavior is not easily altered, would be coded "1".

Examples for Wandering	(A) Frequency	(B) Alterability
<p>Ms. T has dementia and is severely impaired in making decisions about daily life on her unit. She is dependent on others to guide her through each day. When she is not involved in some type of activity (leisure, dining, ADLs, etc.) she wanders about the unit. Despite the repetitive, daily nature of her wandering, this behavior is easily channeled into other activities when staff redirect Ms. T by inviting her to activities. Ms. T is easily engaged and is content to stay and participate in whatever is going on.</p>	3	0
<p>Mr. W has dementia and is severely impaired in making daily decisions. He wanders all around the residential unit throughout each day. He is extremely hard of hearing and refuses to wear his hearing aid. He is easily frightened by others and cannot stay still for activities programs. Numerous attempts to redirect his wandering have been met with Mr. W hitting and pushing staff. Over time, staff have found him to be most content while he is wandering within a structured setting.</p>	3	- 1

5. Change in Behavioral Symptoms

intent: To document whether the behavioral symptoms or resistance to care exhibited by the resident remained stable, increased or decreased in frequency of occurrence or alterability as compared to his or her status of 90 days ago (or since last assessment if less than 90 days ago). Consider changes in any area, including (but not limited to) wandering, symptoms of verbal or physical abuse or aggressiveness, socially inappropriate behavior, or resistance to care. If the resident is a new admission to the facility, this item includes changes during the period prior to admission.

Definition: Change in **behavioral symptoms** — refers to the status (new onset, improvement, worsening) of any of **the** symptoms described in item E4 (Behavioral Symptoms). Such changes include:

- increased or **decreased numbers** of behavioral symptoms
- increased or decreased frequency of behavioral symptoms occurrence
- increased or decreased intensity of behavioral symptoms
- increased or decreased alterability of behavioral symptoms.

Process: Review nursing notes and resident's records, including the last Quarterly Assessment findings and transmittal records of newly admitted residents. Observe the resident. Consult with direct care staff across all shifts, if possible, and family to clarify your observations.

coding: Code "0" if no change has occurred in behavioral symptoms. This code should also be **used** for the resident who has no behavioral symptoms currently or 90 days ago.

Code "1" (Improved) if **the** behavioral symptoms became fewer, less frequent, less intense, and were not complicated by the onset of additional behavioral symptoms as compared to 90 days ago.

Code "2" (**Deteriorated**) if **the** behavioral symptoms became more frequent or more intense or were complicated by the onset of additional behavioral symptoms **as** compared to 90 days ago.

Examples of Change in Behavioral Symptoms

Despite staff efforts to provide support and structure over the last 90 days, Mrs. H continues to hoard food in her room every day. Staff understand the needs of this formerly homeless woman, but because they have found ants and cockroaches in her room, they feel a need to reevaluate their approach to care. Code "0" for No change since last assessment.

During the seven day assessment period, Mrs. D had a **difficult** time with **bowel** regularity. She had a history of constipation that became worse during an episode of pneumonia and poor fluid intake that resulted in dehydration. During this time Mrs. D was more confused and subdued. She was found on several occasions during the assessment period **disimpacting** herself and smearing feces (Socially Inappropriate/Disruptive Behavior). Upon examination Mrs. D was **found** to have a fecal impaction. She received treatment and was placed on a bowel regimen. The program was successful in eliiting the socially inappropriate behavioral symptoms that was induced by discomfort. However, once Mrs. D started to **feel** better and was more alert, she resumed her former daily wandering (of 4 months ago), pushing others and rummaging through their dresser drawers. Code "0" for No change since **last** assessment.

Mrs. F has always been a quiet passive woman who has never exhibited any behavioral symptoms since her admission to the nursing home. During this Significant Change assessment following Mrs. F's stroke, no problematic behavioral symptoms were noted. **Code "0" for No change since last assessment.**

(continued on next page)

Examples of Change in Behavioral Symptoms
(c o n t i n u e d)

Mr. C wanders in and out of other residents' rooms and rummages through their belongings at least once a day and sometimes more often. Despite this behavior, during the last few weeks, he has been easier to work with now. that he is more familiar with staff. Although wandering and rummaging continue, he no longer screams, curses, and shoves residents and staff who try to stop this behavior as he did 90 days ago. Code "1" for Improved.

Ninety days ago Mrs. R banged her cane loudly and repetitively on the dining/activity room table about once a week. In the past **week**, **staff** have noticed that this socially inappropriate **behavioral** symptom (disruptive sounds) now occurs multiple times daily. Code "2" for Deteriorated.

SECTION F. PSYCHOSOCIAL WELL-BEING

Intent: To determine the resident's emotional adjustment to the nursing facility, including his or her general attitude, adaptation to **surroundings**, and change in relationship patterns..

1. Sense of Initiative/Involvement

Intent: To assess the degree to which the resident is involved in the life of the nursing home and takes initiative in participating in various social **and** recreational programs, including solitary pursuits.

Definitions: At ease interacting **with others** — Consider how the resident behaves during the time you are together, as well as reports of how the resident behaves with other residents; staff, and visitors. A resident who tries to shield himself or herself from being with others, spends most time alone, or becomes agitated when visited, is not "at ease interacting with others."

At ease doing **planned** or structured activities — Consider how the resident responds to organized social or recreational activities. A resident who feels comfortable with the structure or not restricted by it is "at ease doing planned or structured activities, " A resident who is unable to sit still in organized group activities and either acts disruptive or makes attempts to leave, or refuses

to attend any such activities, is not “at ease doing planned or structured activities.”

At ease doing self-initiated activities — These include leisure activities (e.g., reading, watching TV, talking with friends), and work activities (e.g., **folding** personal laundry, organizing belongings). A resident who spends most of his or her time alone and unoccupied, or who is always looking for someone to **find** something for him or her to do, is not “at ease doing self-initiated activities.”

Establishes own goals — Consider statements the resident makes, such as “I hope I am able to walk again,” or “I would like to get up early and visit the beauty parlor.” Goals can be as traditional as wanting to learn how to walk again following a hip replacement, or wanting to live to say good&ye to a loved one. However, some goals may not actually be verbalized by the resident, but inferred in that the resident is observed to have an individual way of living at the facility (e.g., organizing own activities or setting own pace).

Pursues involvement **in life** of facility — In general, consider whether the resident partakes of facility events, **socializes** with peers, and discusses activities as if he or she is part of things. A resident who conveys a sense of belonging to the community represented by the nursing home or the particular nursing **unit** is “involved in the life of the facility.”

Accepts invitations into most group activities — A resident who is willing to try group activities even if later deciding the activity is not suitable and leaving, or who does not regularly refuse to attend group programs, “accepts **invitations** into most group activities.”

Process: Selected responses should be confirmed by objective observation of the resident’s behavior (either verbal or nonverbal) in a variety of settings (e.g., in own room, in unit dig room, in activities room) and situations (e.g., alone, in one-on-one situations, in groups) over the past seven days. The primary source of information is the resident. Talk with the resident and ask about his or her perception (how he or she feels), how he or she likes to do things, and how he or she responds to specific situations. Then talk with staff members who have regular contact with the resident (e.g., nurse assistants, activities personnel, social work staff, or therapists if the person receives active rehabilitation). Remember, it is possible for discrepancies to exist between how the resident sees himself or herself and how he or she actually behaves. Use your best clinical judgment as a basis for planning care.

Coding: Check all that apply. None of the choices are to be construed as negative or positive. Each is simply a statement to be checked if it applies and not checked if it does not apply. If you do not check any items in Section F1, check **NONE**

OF **ABOVE**. For individualized care-planning purposes, remember that **information** conveyed by **unchecked** items is **no** less important than information conveyed by checked items.

2. Unsettled Relationships

Intent: To indicate the **quality** and nature of the resident's interpersonal contacts (i.e., how the resident interacts with staff members, family, and other residents).

Definition: **Covert/open** conflict. with or repeated criticism of staff — The resident chronically complains about some staff members to other staff members, verbally criticizes staff members in therapeutic group **situations** causing disruption within the group, or constantly disagrees with routines of daily life on the unit. Checking this item does not require any **assumption** about why the problem exists or how it might be remedied.

Unhappy with **roommate** — **This category also** includes “bathroom mate” for residents who share a private bathroom. Unhappiness may be manifested by **frequent** requests for roommate changes, or **grumbling** about “bathroom mate” spending too long in **the bathroom**, or complaints about roommate rummaging in one's belongings, or complaints about physical, mental, or behavioral status of roommate. Other examples of roommate compatibility issues include early bedtime vs. staying up and watching TV, neat vs. sloppy maintenance of personal area, roommate spending too **much** time on the telephone, or snoring, or odors from incontinence or poor hygiene.

Unhappy with residents other than roommate — May be manifested by chronic complaints about the behaviors of others, poor **quality** of interaction with other residents, or lack of peers for socialization. This definition refers to conflict or disagreement outside of the range of normal criticisms or requests (i.e., repetitive, ongoing **complaints** beyond a reasonable level).

Openly expresses con&t/anger with family/friends — Includes expressions of feelings of abandonment, **ungratefulness** on part of family, lack of understanding by close **friends**, or hostility regarding relationships with family or friends.

Absence of personal contact with family/friends — Absence of visitors or telephone calls **from others** in the last seven days.

Recent loss of close family member/friend — Includes relocation of family member/friend to a more distant location, even temporarily (e.g., for the winter months), incapacitation or **death** of a significant other, or a significant

relationship that recently ceased (e.g., a favorite nurse assistant transferred to work on another unit).

Does not adjust easily to change in routines — Signs of anger, prolonged confusion, or agitation when changes in usual routines occur (e.g., staff turnover or reassignment; new treatment or medication routines; changes in activity or meal programs; new roommate).

Example

For the past 6 months Mrs. A has been receiving 2 white pills, 1 blue pill, 1 yellow pill and 2 puffs of medication from an orange hand-held aerosol **inhaler**. The drug company that makes the inhaler recently changed its packaging. When Mrs. G is given the new blue inhaler to use and is told that it is the same drug **with** a different color holder, she becomes very agitated and upset. It takes a lot of patience and reassurance by the nurse before Mrs. G uses the new inhaler. This happened for several days **during** the past week.

Process: Ask the resident for his or her point of view. Is he or she generally content in relationships with staff and family, or are there feelings of unhappiness? If the resident is unhappy, what specifically is he or she unhappy about?

It is also important to talk with family members who visit or have frequent telephone contact with the resident. How have relationships with the resident been in the last seven days?

During routine nursing care activities, observe how the resident interacts with staff members and other residents. Do you see signs of conflict? Talk with **direct-care** staff (e.g., nurse assistants, dietary aides who assist in the dining room, social work staff, or activities aides) and ask for their observations of behavior that indicate either conflicted or harmonious interpersonal relationships. Consider the possibility that some staff members describing these relationships may be biased. As the **evaluator**, you are seeking to gain an overall picture, a consensus view.

Coding: Check all that apply over the last seven days. If none apply, check **NONE OF ABOVE**.

3. Past Roles

Intent: To document the resident's recognition or acceptance of feelings regarding previous roles or status now that he **or** she is living in a nursing home.

Definition: **Strong** identification **with past** roles and life status — This may be indicated, for example, when the resident enjoys telling stories about his or her past, or takes pride in past **accomplishments** or **family** life, or continues to be connected with prior lifestyle (e.g., celebrating family events, carrying on life-long traditions).

Expresses sadness/anger/empty feeling over **lost roles/status** — Resident expresses feelings such as “I’m not the man I used to be” or “I wish I had been a better mother to my children” or “It’s no use, I’m not capable of doing things I like -to do anymore.” Resident cries when reminiscing about past failures, accomplishments, memories.

Resident **perceives that daily routine (customary routine, activities) is very different from prior pattern in the community** — In general, the resident’s **pattern** of routines is perceived by the resident not to be comparable with his or her previous lifestyle.

Examples

In the nursing home, resident takes a shower 2 mornings a week vs. taking a daily tub bath before going to bed as she did at home.

The resident now retires at 7 pm whereas at home he stayed up to watch the 11 pm news.

In the community Mrs. L enjoyed multiple daily telephone conversations with her **5** daughters. In the nursing home there is only one public telephone that seems to be in constant use by residents and staff. Mrs. L now speaks with each daughter only once a week.

Process: **Initiate** a conversation with the resident about life prior to nursing home **admission**. It is **often** helpful to use environmental cues to prompt discussions (e.g., family photos, grandchildren’s letters or art work). This information may emerge **from** discussions around other MDS topics (e.g., Customary Routine, Activity Pursuits, **ADLs**). **Direct** care staff and family visitors may also have useful insights.

Coding: Check item if it applies over the last seven days. If none apply, Check **NONE OF ABOVE**.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

Most nursing home residents are at risk of physical decline. Most residents also have multiple chronic illnesses and are subject to a variety of other factors that can severely impact **self-sufficiency**. For example, cognitive deficits can limit ability or willingness to initiate or participate in **self-care** or constrict understanding of the tasks required to complete **ADLs**. A wide range of physical and neurological illnesses can adversely affect physical factors important to **self-care** such as stamina, muscle tone, balance, and bone strength. Side effects of medications and other treatments can also contribute to needless loss of self-sufficiency.

Due to these many, possibly adverse **influences**, a resident's potential for maximum functionality is often greatly underestimated by family, staff, and the resident **himself** or herself. Thus, all residents are candidates for nursing-based rehabilitative care that focuses on **maintaining** and expanding self-involvement in **ADLs**. Individual plans of care can be **successfully** developed only when the resident's self-performance has been accurately assessed and the **amount** and type of support being provided to the resident by others has been **evaluated**.

1. (A) Activities of Daily Living (ADL) Self-Performance

Intent: To record the resident's self-care performance in **activities of daily living** (i.e., what the resident actually did for himself or herself and/or how much verbal or physical help was required by staff members) during the last seven **days**.

Definition: **ADL SELF-PERFORMANCE** — Measures what the resident actually did (not what he or she might be capable of doing) within each ADL category over the last seven days according to a performance-based scale.

Bed Mobility — How the resident moves to and from a lying position, turns side to side, and positions body while in bed.

Transfer — How the resident moves between surfaces — i.e., to/from bed, chair, wheelchair, standing position. Exclude from this **definition** movement to/from bath or toilet, which is covered under Toilet Use and Bathing.

Walk in room — How resident walks between locations in his/her room.

Walk in corridor — How resident walks in corridor on unit.

Locomotion on unit — How the resident moves between locations in his or her room and adjacent corridor on the same floor. If the resident is in a **wheelchair**, locomotion is defined as self-sufficiency once in the chair.

Locomotion off unit — How the resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If the facility has only one floor, locomotion off the unit is defined as how the resident moves to and from distant areas on the floor. If in wheelchair, **self-sufficiency** once in chair.

Dressing — How the resident puts on, fastens, and takes off all items of street clothing, including donning/removing a prosthesis.

Eating — How the resident eats and drinks, regardless of skill. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).

Toilet Use — How the resident uses the toilet room, commode, bedpan, or urinal, **transfers** on/off toilet, cleanses, changes pad, manages ostomy or catheter, and adjusts clothes.

Personal Hygiene — How the resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, and washing/drying face, hands, and perineum. Exclude from this definition personal hygiene in baths and showers, which is covered under Bathing.

Bathing — How the resident takes a full-body bath/shower, sponge bath, and transfers in/out of tub/shower. Exclude washing of back **and** hair.

Process: In order to be able to promote the highest level of **functioning** among residents, clinical staff must first identify what the resident actually does for himself or herself, noting when assistance is received and clarifying the types of assistance provided (verbal cueing, physical support, etc.)

A resident's **ADL** self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (e.g., willing to perform for a nurse assistant he or she lies), and medications. The responsibility of the person completing the assessment; therefore, is to capture the total picture of the resident's **ADL self-performance** over the seven day period, 24 hours a day — i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well.

In order to accomplish this, it is necessary to gather information from multiple sources — i.e., interviews/discussion with the resident and direct care staff on all three shifts, including weekends and review of documentation used to communicate with staff across shifts. Ask questions pertaining to all aspects of the ADL activity definitions. For example, when discussing Bed Mobility with a nurse assistant, be sure to inquire specifically how the resident moves to and from a lying position, how the resident turns from side to side, and how

the resident positions himself or herself while in bed. A resident can be independent in one aspect of Bed Mobility yet require extensive assistance in another aspect. **Since** accurate coding is important as a basis for making decisions on the type and amount of care to be provided, be sure to consider each activity definition fully.

The wording used in each coding option is **intended** to reflect real-world situations in nursing homes, where slight variations are common. Where variations occur, **the coding** ensures that the resident is not assigned to an excessively independent or dependent category. For example, by definition, codes 0, 1, 2, and 3 (Independent, Supervision, Limited Assistance, and Extensive Assistance) permit one or **two** exceptions for the provision of heavier care. This is clinically useful and increases the likelihood that staff will code ADL Self-Performance items consistently and accurately.

Because this section involves a two-part evaluation (Item **G1A**, ADL Self-Performance and Item **G1B**, ADL Support), each using its own scale, it is recommended that you complete the Self-Performance evaluation for all ADL **Self-Performance** activities before beginning the ADL Support **evaluation**.

To **evaluate** a resident's ADL Self-Performance, begin by reviewing the documentation in the clinical record. Talk with clinical staff from each shift to ascertain what the resident does for himself or herself in each ADL activity as well as the type and level of staff assistance being provided. As previously noted, be alert to differences in resident performance from **shift** to shift, **and** apply the ADL codes that capture these differences. For example, a resident may be independent in Toilet Use during daylight hours but receive non-weight bearing physical assistance every evening. In this case, the resident would be coded as "2" (Limited Assistance) in Toilet Use.

The following chart provides general guidelines for recording accurate ADL Self-Performance and ADL Support assessments.

Guidelines for Assessing ADL Self-Performance and ADL Support

- **The scales in Items G1A and G1B** are used to record the resident's actual level of involvement in **self-care** and the type and amount of support actually received during the last seven days.
- Do not record your assessment of the resident's capacity for involvement in **self-care** — i.e., what you believe the resident might be able to do for himself or herself based on demonstrated skills or physical attributes. An assessment of potential capability is covered in Item G8 (**ADL Functional Rehabilitation Potential**).
- Do not record the type and level of assistance that the resident "should" be receiving according to the written plan of care. The type and level of assistance actually provided may be quite different **from** what is indicated in the plan. Record what is actually happening.
- Engage direct care staff **from** all shifts who have cared for the resident over the last seven days in discussions **regarding** the resident's ADL functional **performance**. Remind staff that the focus is on the last seven days only. To clarify your own **understanding** and observations about each ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and **proceeding** to the more specific.

Here is a typical conversation between the RN Assessment Coordinator and a nurse assistant regarding a resident's Bed **Mobility** assessment:

R.N. "Describe to me how Mrs. L positions herself in bed. By that I mean, once she is in bed, how does she move from sitting up to lying down, lying down to sitting up, turning side to side, and positioning **herself**?"

N.A. "She can lay down and sit up by herself, but I help her turn on her side."

R.N. "She lays down and sits up without any verbal instructions or physical help?"

N.A. "No, I have to remind her to use her trapeze every time. But once I tell her how to do things, she can do it herself."

R.N. "How do you help her turn side to side?"

N.A. "She can help turn herself by grabbing onto her siderail. I tell her what to do. But she needs me to lift her bottom and guide her legs into a good position."

R.N. "Do you lift her by yourself or does someone help you?"

N.A. "I do it by myself. "

R.N. "How many days during the last week did you give this type of help?"

N.A. "Every day."

Provided that ADL function in Bed Mobility was similar on all shifts, Mrs. L would receive an ADL Self-Performance Code of "3" (Extensive Assistance) and an ADL Support Provided Code of "2" (one person physical assist).

Now review the first two exchanges in the conversation between the RN Assessment Coordinator **and** nurse assistant. If the RN did not probe further, he or she would not have received enough information to make an accurate assessment of either the resident's skills or the nurse assistant's actual workload, or whether the current plan of care was being implemented.

Coding: For each ADL category, code the appropriate response for the resident's **actual** performance during the past seven days. Enter the code in column (A), labeled "SELF-PERF. " Consider the resident's performance during all shifts, as functionality may vary. In the pages that follow two types of supplemental instructional material are presented to assist you in learning how to use this code: a schematic flow chart for scoring ADL Self Performance and a series of case examples for each ADL.

In your evaluations, you will also need to consider the type of assistance known as "**set-up** help" (e.g., comb, brush, toothbrush, toothpaste have been laid out at the bathroom sink by the **nurse** assistant). Set-up help is recorded under ADL Support Provided (Item **G1B**). But in evaluating **the** resident's ADL **Self-Performance**, include set-up help within the context of the "0" (Independent) code. For example: If a resident grooms independently once grooming items are set up for him, code "0" (Independent) in Personal Hygiene.

- 0. Independent — No help or staff oversight **-OR-** Staff help/oversight provided only one or two times during the last seven days.
- 1. Supervision — Oversight, encouragement, or cueing provided three or more times during last seven days **-OR-** Supervision (3 or more times) plus physical assistance provided only one or two times during last seven days.
- 2. Limited Assistance — Resident highly involved in activity, received physical help in guided maneuvering of limbs or other nonweight-bearing assistance on three or more occasions **-OR-** limited assistance (3 or more times) plus more help provided only one or two times during last seven days.

3. Extensive Assistance — **While** the resident performed part of activity over last seven days, help of following type(s) was provided three or more times:
- Weight-bearing support provided three or more times
 - Full staff performance of activity (3 or more times) during part (but not all) of last seven days
4. **Total Dependence** — Full staff **performance** of the activity during entire seven-day period. Complete non-participation by the resident in all aspects of the ADL definition.

For example: For a resident to be coded as totally dependent in Eating, he or she would be fed all **food** and liquids at all meals and snacks (including tube feeding delivered totally by staff), and never initiate **any subtask** of eating (e.g., picking up **finger** foods, giving self tube feeding or assisting with procedure) at any meal.

8. **Activity did not occur during the entire 7-day period** — Over the last seven days, the ADL activity was **not** performed by the resident or staff. In other words, the particular activity did not occur at all.

For example: The definition of Dressing specifies the wearing of street clothes. During the seven day period, if the resident did not wear street clothing, a code of “8” would apply (i.e., the activity did not occur during the entire seven day period). Likewise, a resident who was restricted to bed for the entire seven day period and was never transferred from bed would receive a code of “8” for Transfer.

However, do not confuse a resident who is totally dependent in an ADL activity (code 4 — Total Dependence) with the activity itself not occurring. For example: Even a resident who receives tube **feedings** and no food or fluids by mouth is engaged in eating (receiving nourishment), and must be evaluated under the Eating category for his or her level of assistance in the process. A resident who is highly involved in giving himself a tube feeding is not totally dependent and should not be coded as “4”.

Each of these ADL Self-Performance codes is exclusive; there is no overlap between categories. Changing **from** one self-performance category to another demands an increase or decrease in the number of times that help is provided. Thus, to move from Independent to Supervision to Limited **Assistance**, non weight-bearing supervision or physical assistance **must** increase from one or two times up to three or more times during the last seven days.

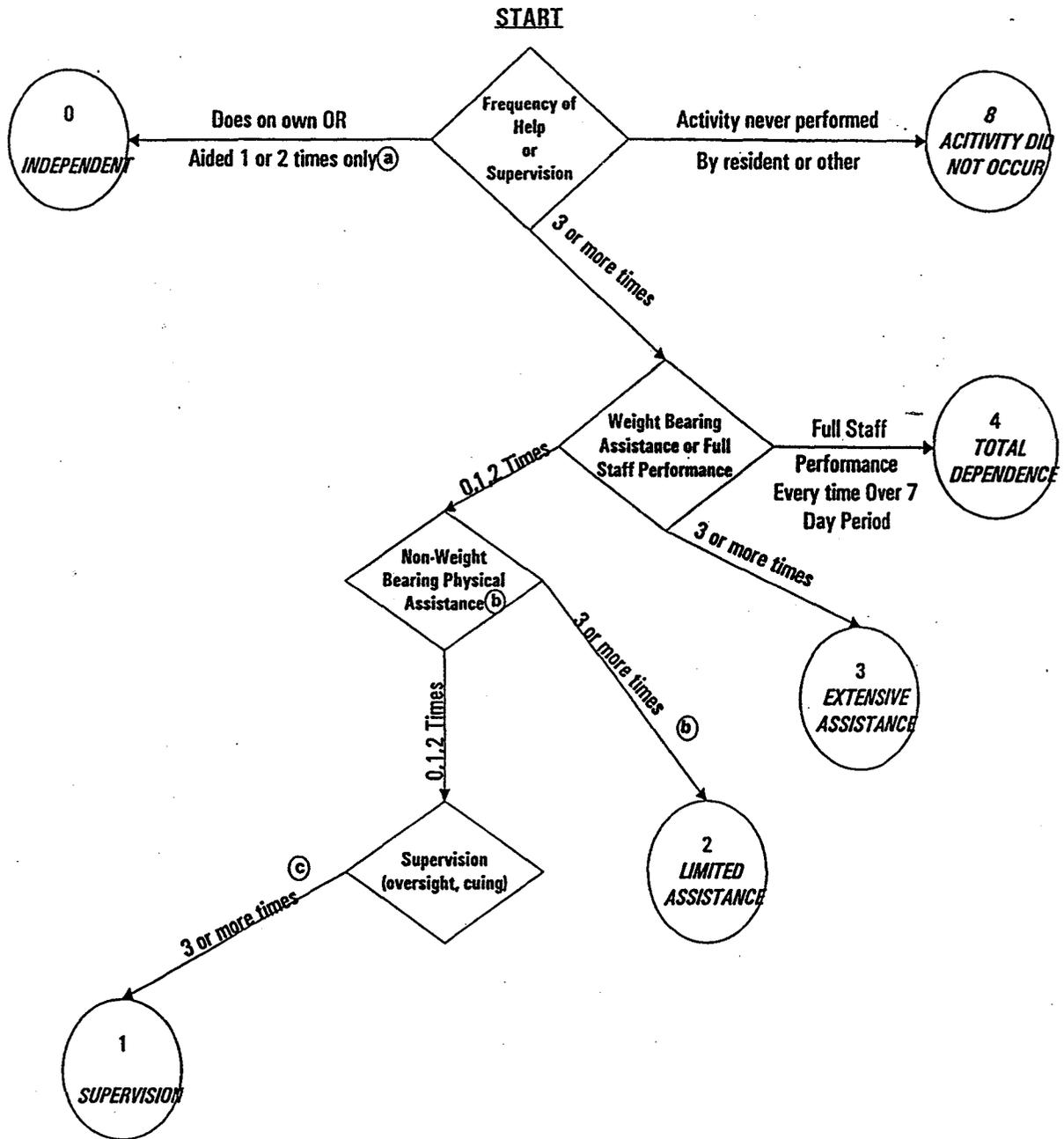
There will be times when no one type or level of assistance is provided to the resident 3 or more times during a 7-day period. However, the sum total of support of various types will be provided 3 or more times. In this case, code for the least dependent self-performance category where the resident received that level or more dependent support 3 or more times during the 7-day period.

Examples

The resident received supervision for walking in the corridor on two occasions and non weight-bearing assistance on two occasions. Code "1" for Supervision in Walking in Corridor. Rationale: Supervision is the least dependent category.

The resident received supervision in dressing on one occasion, non weight-bearing assistance (IE, putting a hat on resident's head) on two occasions, and weight-bearing assistance (IE, lifting resident's arm into a sleeve) on one occasion during the last 7 days. Code "2" for Limited Assistance in Dressing. Rationale: There were 3 episodes of physical assistance in the last 7 days: 2 non-weight-bearing episodes, and 1 weight-bearing episode. Limited Assistance is the correct code because it reflects the least dependent support category that encompasses 3 or more activities that were at least at that level of support.

SCORING ADL SELF PERFORMANCE



a. Can include one or two events where received supervision, non-weight bearing help, or weight bearing help.

b. Can include one or two episodes of weight bearing help—e.g., two events with non-weight bearing plus two of weight bearing would be coded as a "2".

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

1. (B) ADL Support Provided

Intent: To record the type and highest level of support the resident received in each ADL activity over the last seven days.

Definition: **ADL Support Provided** — Measures the highest level of support provided by staff over the last seven days, even if that level of support only occurred once. This is a different scale, and is entirely separate from the ADL Self-Performance assessment.

Set-up help — The type of help characterized by providing the resident with articles, devices or preparation necessary for greater resident self-performance in an activity. This can include giving or holding out an item that the resident takes from the caregiver.

Examples of Setup Help

- **For bed mobility** — handing the resident the bar on a trapeze.
- **For transfer** — giving the resident a transfer board or locking the wheels on a wheelchair for safe transfer.
- **For locomotion:**
 - Walking** — handing the resident a walker or cane.
 - Wheeling** — unlocking the brakes on the wheelchair or adjusting foot pedals to facilitate foot motion while wheeling.
- **For dressing** — retrieving clothes from closet and laying out on the resident's bed; handing the resident a shirt.
- **For eating** — cutting meat and opening containers at meals; giving one food category at a time.
- **For toilet use** — handing the resident a bedpan or placing articles necessary for changing ostomy appliance within reach.
- **For personal hygiene** — providing a wash basin and grooming articles.
- **For bathing** — placing bathing articles at tub side within the resident's reach; handing the resident a towel upon completion of bath.

Process: For each ADL category, code the maximum amount of support the resident received over the last seven days irrespective of frequency, and enter in the "SUPPORT" column. Be sure your evaluation considers all nursing shifts, 24 hours per day, including weekends. Code independently of the resident's Self-Performance evaluation. For example, a resident could have been Independent in ADL Self-Performance in Transfer but received a one-person physical assist one or two times during the seven-day period. Therefore, the ADL Self-Performance Coding for Transfer would be "0" (Independent), and the ADL Support coding "2" (One person physical assist).

Coding: Note: The highest code of physical assistance in this category (other than the "8" code) is a code of "3" not "4" as in Self-Performance.

0. No setup or physical help from staff
1. Setup help only — The resident is provided with materials or devices necessary to perform the activity of daily living independently.
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during the entire 7-days — When an "8" code is entered for an ADL Support Provided category, enter an "8" code for ADL Self-Performance in the same category.

For example, if a resident never left the unit during the assessment period, code "8" for locomotion off unit. The activity did not occur, there was no help provided.

The examples that follow clarify coding for both Self-Performance and Support. The answers appear to the right of the resident descriptions. Cover the answers, read and score the example, and then compare your answers with those provided.

Examples: ADL Self-Performance and Support	Self-Perf.	Support
<i>Bed Mobility</i>		
Resident was physically able to reposition self in bed but had a tendency to favor and remain on his left side. He received frequent reminders and monitoring to reposition self while in bed.	1	0
Resident received supervision and verbal cueing for using a trapeze for all bed mobility. On two occasions when arms were fatigued, he received heavier physical assistance of two persons.	1	3
Resident usually repositioned himself in bed. However, because he sleeps with the head of the bed raised 30 degrees, he occasionally slides down towards the foot of the bed. On 3 occasions the night nurse assistant helped him to reposition by providing weight-bearing support as he bent his knees and pushed up off the footboard.	3	2
To turn over, the resident always began by reaching for a side rail for support. He received physical assistance of one person to guide his legs into position and complete the turn by guiding him with a turn sheet (using weight-bearing assistance).	3	2
Resident independently turned on his left side whenever he wanted. Because of left-sided weakness he received physical weight bearing help of 1-2 persons to turn to his right side or sit up in bed.	3	3
Because of severe, painful joint deformities, resident was totally dependent on two persons for all bed mobility. Although unable to contribute physically to positioning process, she was able to cue staff for the position she wanted to assume and at what point she felt comfortable.	4	3

Examples: ADL Self-Performance and Support	Self-Perf.	Support
<i>Transfer</i>		
<p>Despite bilateral above-the-knee amputations, resident almost always moved independently from bed to wheelchair (and back to bed) using a transfer board he retrieves independently from his bedside table. On one occasion in the past week, staff had to remind resident to retrieve the transfer board. On one other occasion, the resident was lifted by a staff member from the wheelchair back into bed.</p>	0	2
<p>Resident was physically independent for all transfers. However, he would not get up in the morning until the nurse assistant rearranged his bed covers and released the half side rail on his bed.</p>	0	1
<p>Once someone correctly positioned the wheelchair in place and locked the wheels, the resident transferred independently to and from the bed.</p>	0	1
<p>Resident moved independently in and out of armchairs but always received light physical guidance of one person to get in and out of bed safely.</p>	2	2
<p>Transferring ability varied throughout each day. Resident received no assistance at some times and heavy weight-bearing assistance of one person at other times.</p>	3	2

Examples: ADL Self-Performance and Support	Self-Perf.	Support
<i>Walk in room</i>		
Resident walked in his/her room while holding on to furniture for support.	0	0
Resident walked independently during the day and received non-weight bearing physical help of 1 person for getting to the bathroom in room at night.	2	2
Resident received non-weight bearing physical assistance of one person for all walking in own room.	2	2
Resident did not walk but wheeled self independently in own room.	8	8
<i>Walk in corridor</i>		
A timid, fearful resident is usually physically independent in walking. During the last week she was very anxious and fearful of falling, and therefore received reassurance and encouragement from someone walking next to her while walking back to her room from meals in the unit dining room.	1	0
A resident with memory loss ambulated independently on the unit corridor albeit with a walker. Several times a day she left her walker in the bathroom, in the dining room, etc., necessitating that someone return it to her and offer her reminders to use it for safety.	1	1
Resident walked in corridor on unit by supporting self on one side with the handrail along the wall and receiving verbal cues from another person.	1	0
Resident walked twice daily 4-6 feet in the corridor outside his room. He received weight bearing assistance of 1 person for each walk.	3	2
Resident walked in room for short distances with heavy assistance of 2 persons but traveled independently in corridor on unit by wheelchair.	8	8

Examples: ADL Self-Performance and Support	Self-Perf.	Support
<i>Locomotion on unit</i>		
Resident ambulated slowly on unit pushing a wheelchair for support, stopping to rest every 15–20 feet. She has good safety awareness and has never fallen. Staff felt she was reliable enough to be on her own.	0	0
A resident with a history of falling and an unsteady gait always received physical guidance (non-weight-bearing) of one person for all ambulation. Two nights last week the resident was found in his bathroom after getting out of bed and walking independently.	2	2
Resident ambulated independently around the unit “ad lib,” socializing with others and attending activities during the day. Loves dancing and yoga. Because she can become afraid at night, she received contact guard of one person to walk her to the bathroom at least twice every night.	2	2
During last week resident was learning to walk short distances with new leg prosthesis with heavy partial weight-bearing assistance of two persons. He refuses to ride in a wheelchair.	3	3
<i>Locomotion off unit</i>		
Resident independently walked with a cane to all meals in the Main Dining Room (off the unit) and social and recreational activities in the nearby hobby shop. Received no set-up or physical help during the assessment period.	0	0
Resident walked independently to the off unit dining room for all meals. For one visit to a clinic held at the opposite end of the building she was given a ride in a wheelchair by a volunteer. She was wheeled to the clinic and after her session she was wheeled back to her unit.	0	2
Resident is independent in walking about her residential unit. She does get lost and has difficulty finding her room but enjoys stopping to chat with others. Because she would get lost, she was always accompanied by a staff member for her daily walks around the facility.	1	0
Resident did not leave the residential unit during the 7-day assessment period.	8	8

Examples: ADL Self-Performance and Support	Self-Perf.	Support
<i>Dressing</i>		
Resident usually dressed self. After a seizure, she received total help from several staff members once during the week.	0	3
Resident is totally independent in dressing herself except for donning and removing TED stockings. Nurse assistant applied the TED stockings each AM and removed them at bedtime.	3	2
Nurse assistant provided physical weight-bearing help with dressing every morning. Later each day, as resident felt better (joints were more flexible), she required staff assistance only to undo buttons and guide her arms in/out of sleeves every pm.	3	2
A 325 lb. resident received total care by two persons in dressing. He did not participate by putting arms through sleeves, lifting legs into shoes, etc.	4	3
<i>Eating</i>		
Resident arose daily after 9:00 am, preferring to skip breakfast and just munch on fresh fruit later in the morning. She ate lunch and dinner independently in the facility's main dining room.	0	0
Resident on long standing tube feedings via gastrostomy tube was completely independent in self-administration including self-medication via the tube once set up by staff.	0	1
Resident with a history of dysphagia and choking, ate independently as long as a staff member sat with him during every meal (stand-by assistance if necessary).	1	0
Resident is blind and confused. He ate independently once staff oriented him to types and whereabouts of food on his tray and instructed him to eat.	1	1
Cognitively impaired resident ate independently when given one food item at a time and monitored to assure adequate intake of each item.	1	1
Resident fed self solid foods independently at all meals and snacks. Self-administered all fluids and medications via G-tube with supervision once set up appropriately.	1	1
Resident with difficulty initiating activity always ate independently after someone guided her hand with the first few bites and then offered encouragement to continue.	3	2

Examples: ADL Self-Performance and Support	Self-Perf.	Support
<i>Eating continued</i>		
Resident with fine motor tremors fed self finger foods (e.g., sandwiches, raw vegetables and fruit slices, crackers) but always received supervision and total physical assistance with liquids and foods requiring utensils.	3	2
Resident fed self with staff monitoring at breakfast and lunch but tired later in day. She was fed totally by nursing assistant at supper meal.	3	2
Resident who was being weaned from gastrostomy tube feedings continued to receive total care for twice daily tube feedings. Additionally, she ate small amounts of food by mouth with staff supervision.	3	2
Resident received tube feedings via a jejunostomy for all nutritional intake. Feedings were given by a nurse.	4	2
<i>Toileting Use</i>		
Resident used bathroom independently once up in a wheelchair; used bedpan independently at night after it was set up on bedside table.	0	1
In the toilet room resident is independent. As a safety measure, the nurse assistant stays just outside the door, checking with her periodically.	1	0
Resident uses the toilet independently but occasionally required minor physical assistance for hygiene and straightening clothes afterwards. She received such help twice during the last week.	0	2
When awake, resident was toileted every two hours with minor assistance of one person for all toileting activities (e.g., contact guard for transfers to/from toilet, drying hands, zipping/buttoning pants). She required total care of one person several times each night after incontinence episodes.	3	2
Resident received heavy assistance of two persons to transfer on/off toilet. He was able to bear weight partially, and required only standby assistance with hygiene (e.g., being handed toilet tissue or incontinence pads).	3	3
Obese, severely physically and cognitively impaired resident receives a hooyer lift for all transfers to and from her bed. It is impossible to toilet her and she is incontinent. Complete personal hygiene is provided at least every 2 hours by 2 persons.	4	3

Examples: ADL Self-Performance and Support	Self-Perf.	Support
<i>Personal Hygiene</i>		
New resident, in nursing home adjustment phase, liked to sleep in his clothes in case of fire. He remained in the same clothes for 2-3 days at a time. He cleaned his hands and face independently and would not let others help with any personal hygiene activities.	0	0
Once grooming articles were laid out and arranged by staff, resident regularly performed the tasks of personal hygiene by receiving verbal directions from one person throughout each task.	1	1
Resident carried out personal hygiene but was not motivated. She received daily cueing and positive feedback from nursing staff to keep self clean and neat. Once started, she could be left alone to complete tasks successfully.	1	0
Resident shaves self with an electric razor, washes his face and hands, brushes his teeth, and combs his hair. Because he is losing his sight, staff stand-by to hand grooming articles to the resident and return articles to their proper location.	1	1
Resident performed all tasks of personal hygiene except shaving. The facility barber visited him on the unit three times a week to shave his thick beard.	3	2
Resident required total daily help combing her long hair and arranging it in a bun. Otherwise she was independent in personal hygiene.	3	2

2. Bathing

Bathing is the only ADL activity for which the ADL Self-Performance codes in item G1A do not apply. A unique set of Self-Performance codes, to be used only in the Bathing assessment, are described below. The Self-Performance codes for the other ADL items would not be applicable for bathing given the normal frequency with which the bathing activity is carried out during a one-week period. Assuming that the average frequency of bathing during a seven-day period would be one or two baths, the coding for the other ADL Self-Performance items, which permits one or two exceptions of heavier care, would result in the inaccurate classification of almost all residents as "Independent" for Bathing.

The ADL Support Provided codes given in item G1B, however, continue to apply to the Bathing activity.

Intent: To record the resident's Self-Performance and Support provided in bathing, including how the resident transfers into and out of the tub or shower.

Definition: **Bathing** — How the resident takes a full body bath, shower, or sponge bath, including transfers in and out of the tub or shower. The definition does not, however, include the washing of back or hair.

Coding: **A. Bathing Self-Performance Codes** — Record the resident's self-performance in bathing according to the codes listed below. When coding, apply the code number that reflects the maximum amount of assistance the resident received during bathing episodes.

- 0. Independent — No help provided
- 1. Supervision — Oversight help only.
- 2. Physical help limited to transfer only
- 3. Physical help in part of bathing activity
- 4. Total dependence
- 8. Activity itself did not occur during entire 7 days

B. Support — Next, score the maximum amount of support provided in bathing activities using the ADL Support Scale (Item G1B).

Examples: ADL Self-Performance and Support	Self-Perf.	Support
<i>Bathing</i>		
Resident received verbal cueing and encouragement to take twice-weekly showers. Once staff walked resident to bathroom, he bathed himself with periodic oversight.	1	0
On Monday, one staff member helped transfer resident to tub and washed his legs. On Thursday, resident had physical help of one person to get into tub but washed himself completely.	3	2
Resident afraid of hooyer lift. Given full sponge or bed bath by nurse assistant twice weekly. Actively involved in this activity.	3	2
For one bath, resident received light guidance of one person to position self in bathtub. However, due to her fluctuating moods, she received total help for her other bath. <i>Rationale:</i> The coding directions for bathing state, "code for most dependent in self performance and support."	4	2

3. Test for Balance

Residents with impaired balance in standing and sitting are at greater risk of falling. It is important to assess an individual's balance abilities so that interventions can be implemented to prevent injuries (e.g., strength training exercises; safety awareness; restorative nursing; nursing-based rehabilitation).

Intent: To record the resident's capacity of a.) balance while standing (not walking) without an assistive device or assistance of a person, and b.) balance while sitting without using the back or arms of the chair for support.

Process a. Balance While Standing

Preparation:

- Obtain a watch with a second hand to time the test.
- Pick a time to test the resident when he or she is likely to be at his or her best. If the resident refuses, negotiate a better time and try again later.
- Place a chair directly behind the resident in case the resident needs to sit down.
- Stand close to the resident while testing balance in order to catch or balance the resident, if necessary.
- If the resident is heavy or tall or seems frail, ask another staff person to stand by with you in case the resident needs assistance.
- Test balance without assistive devices (but with prostheses, if used). For residents who use walkers, make sure the walker is placed directly in front of the resident within easy reach in case it is needed for rebalancing.

Conducting the tests:

- DO each of the following tests (10 seconds each) on residents who are able to stand without physical help.
- DO NOT attempt to test residents who cannot stand by themselves. Code these residents as "3", Not able to attempt test without physical help.
- For persons with visual impairment who may not be able to see your demonstrations of feet placement, provide rich verbal descriptions.

**Position 1 —**

“I would like you to stand with your feet together, side-by-side, like this (demonstrate as illustrated). [Note, in this and all tests, both feet should be firmly on the floor for support.]

“Do not move your feet until I say stop. Ready, OK, begin.” If the resident is **ABLE** to maintain this position for 10 seconds, proceed to test resident in Position 2. If the resident is **NOT ABLE** to maintain this position for 10 seconds, stop testing here. Do not proceed with Position 2 for balance testing.

**Position 2 —**

“Now I would like you to stand with one foot halfway in front of the other like this” (demonstrate as illustrated).

“You may use either foot, whichever is more comfortable for you. Ready, OK, begin.” If the resident is **ABLE** to maintain this position for 10 seconds, proceed to test resident in Position 3. If the resident is **NOT ABLE** to do this, stop testing here.

**Position 3 —**

“Now I would like you to stand with the heel of one foot in front of you touching the toes of the other foot like this (demonstrate as illustrated). You may use either foot, whichever is more comfortable for you. Ready, OK, begin.”

- Coding:**
0. **Maintained position as required in test — Resident was able to maintain all 3 standing positions for 10 seconds without moving feet out of position.**
 1. **Unsteady, but able to rebalance self without physical support — Resident was unable to maintain one or more standing positions for 10 seconds each without moving feet out of position. Resident was unsteady but was able to rebalance self without physical support from others or from an assistive device in at least the first position.**
 2. **Partial physical support during test, or stands but does not follow directions for test — While the resident performed part of the activity, resident was unable to maintain one or more standing positions without physical support from other(s) or from an assistive device. This category also includes residents who can stand but are unable or refuse to follow your directions to perform a test of balance.**
 3. **Not able to attempt test without physical help — Resident is not able to stand without physical help from another person or an assistive device.**

Examples of Balance Testing

Mrs. R usually walks with a walker. After completing the test preparation steps for safety, which include placing Mrs. R's walker directly in front of her in case she needs it during the test, you briefly explain to Mrs. R what you are going to ask her to do. You also demonstrate the actions. Once Mrs. R is standing, start to test her in Position 1 by giving her the brief directions and your demonstration of the position. You start timing her once you say, "Ready, OK, begin".

Results: During the 10-second test, Mrs. R moves her feet out of position to rebalance herself.

How to proceed: Tell Mrs. R, "That was a good try." STOP the test because the next 2 positions are harder to perform. If Mrs. R cannot maintain Position 1, it is unlikely she will be able to maintain Positions 2 or 3.

Coding: "1", Unsteady, but able to rebalance self without physical support.

Rationale: Mrs. R moved her feet out of position but did not need to hold her walker, or lean against the chair behind her, or receive assistance from you during the 10 seconds.

Mr. C has cognitive and hearing impairment and restlessness. He usually walks independently (wandering) and occasionally stands at the nurses' station to be with the unit secretary. Therefore, you know he can stand, but you do not know if he would be able to maintain his balance if he were asked to "hold" specific standing positions for 10 seconds each. After completing the test preparation, and steps for safety, you give Mr. C the brief directions and demonstration for testing position 1.

Results: During your interaction with Mr. C he becomes agitated, says "No, no" and walks away.

How to proceed: STOP the test.

Coding: "2", Partial physical support during test or stands but does not follow directions for test. **Rationale:** This is the best you can do under the circumstances. Although Mr. C did not need physical help to balance, you really do not know what his true balance capacity is. All you know is that he is able to stand, but you can't test his balance capacity because he refuses and is unable to follow directions.

Ms. M has multiple sclerosis and has been confined to her bed and reclining chair for the last 2 years.

How to proceed: DO NOT perform any standing balance tests. Ms. M cannot stand.

Coding: "3", Not able to attempt test without physical help.

Process: b. Balance while sitting — position, trunk control

Preparation

- Obtain a watch with a second hand to time the test.
- Do not conduct sitting balance in wheelchair. Find a chair with a firm, solid seat to conduct the test.
- The height of the chair seat should be low enough to allow the bottom of the resident's feet to rest on the floor for support. (Of course, this does not apply to persons with bilateral leg amputations.)
- It is safer to use a chair with arms in case the resident needs physical support during the test.
- Stand close to the resident while testing sitting balance in order to catch or balance the resident, if necessary.
- If the resident is heavy or tall or seems frail, ask another staff person to stand by with you in case the resident needs assistance.

Conducting the test:

- DO NOT attempt to test residents who are clearly unable to sit without physical help. Code these residents as "3", Not able to attempt test without physical help.
- Instruct the resident to sit in a chair with arms folded across his or her chest without using the back or arms of the chair for support. Make sure the resident's feet are both flat on the floor for support. Demonstrate the action to the resident. Observe balance for 10 seconds, then ask resident to stop.

- Coding:*
0. Maintained position as required in test — Resident was ABLE to sit for 10 seconds without touching the back or sides of the chair for support.
 1. Unsteady, but able to rebalance self without physical support. — Resident was unable to maintain sitting balance for 10 seconds without touching the back or sides of the chair for support. Resident was unsteady but was ABLE to rebalance self.
 2. Partial physical support by others during test or sits but does not follow directions for test — While resident performed part of activity, resident was UNABLE to maintain sitting balance without physical support from

other(s) or from touching the backs or sides of the chair for support. This category also includes residents who can sit but are unable or refuse to follow your directions to perform this test of sitting balance.

3. **Not able to attempt test without physical help** — Resident is not able to sit without physical help from another, or an assistive/adaptive device, or chair back/arms for support.

Examples of Sitting Balance

Ms. Z spends a lot of time sitting in a wheelchair on a gel cushion for pressure relief. She has a left-sided below-the-knee amputation. She does not have a leg prosthesis. She also has a left-sided hemiparesis from a CVA 1 year ago. You complete the test preparation activities for safety, assist Ms. Z to transfer into a chair with a firm seat, and ask her to place her right foot firmly on the floor. You instruct her to cross her arms over her chest. She cannot lift her left arm across her chest but is able to hold it across her abdomen. You instruct her to "sit up in the chair without leaning on the chair back or arms for support". You demonstrate this activity from another chair. Once the resident begins, you time for 10 seconds.

Results: Ms. Z maintained the position for the full 10 seconds without touching the chair back/arms for support.

How to proceed: Tell Ms. Z, "You did an excellent job. That's all we have to do." STOP testing. The test is complete.

Coding: "0", Maintained position as required in test.

4. Functional Limitation in Range of Motion

(A) Limitation in range of motion.

Intent: **Limitation in the range of motion** — To record the presence of (A) functional limitation in range of joint motion or (B) loss of voluntary movement.

Definition: Limitation that interferes with daily functioning (particularly with activities of daily living), or places the resident at risk of injury.

Process: **Assessing for functional limitations.** This test is a screening item used to determine the need for a more intensive evaluation. It does not need to be performed by a physical therapist. Rather, it can be administered by a member of any clinical discipline in accordance with these instructions.

- Do each of the following tests on all residents unless contraindicated (e.g., recent fracture or joint replacement).
- Perform each test on both sides of the resident's body.
- If the resident is unable to follow verbal directions demonstrate each movement (e.g., Ask the resident to do what you're doing).
- If resident is still unable to perform the activity after your demonstration, move the resident's joints through slow, active assisted range of motion to assess for limitations. In active assistive range of motion exercises, the health professional provides support and direction with the resident performing some of the activity.
- STOP if a resident experiences pain.

Neck — With resident seated in a chair, ask him or her to turn the head slowly, looking side to side. Then ask the resident to return head to center and then try to reach the right ear towards the right shoulder, then left ear towards left shoulder.

Arm — including shoulder or elbow — With resident seated in a chair instruct him or her to reach with both hands and touch palms to back of the head (mimics the action needed to comb hair). Then ask the resident to touch each shoulder with the opposite hand. Alternatively, observe the resident donning or removing a shirt over the head.

Hand — including wrist or fingers — For each hand, instruct the resident to make a fist, then open the hand (useful actions for grasping utensils, letting go).

Leg — including hip or knee — While resident is lying supine in a flat bed, instruct the resident to lift his or her leg (one at a time), bending it at the knee. [The knee will be at a right angle (90 degrees)]. Then ask the resident to slowly lower his or her leg, and extend it flat on the mattress.

Foot — including ankle or toes — While supine in bed, instruct the resident to flex (pull toes up towards head) and extend (push toes down away from head) each foot.

Other limitation or loss — Decreased mobility in spine, jaw, or other joints that are not listed.

Coding: For each body part, code the appropriate response for the resident's active (or assisted passive) range of motion function during the past seven days. Enter