Minimum Data Set (MDS) 2.0© Canadian Version

QUARTERLY ASSESSMENT

**** Status in last 7 days, unless other time frame indicated.***

Addressograph

SECTION AA and A: IDENTIFICATION INFORMATION			
AA1	UNIQUE REGISTRATION IDENTIFIER		
A1	RESIDENT NAME		
A2	ROOM NUMBER	a. Unit ____ b. Room # ____	
AA2	SEX	M. Male F. Female O. Other	
A3	ASSESSMENT REFERENCE DATE	Year ____ Month ____ Day ____	
AA3a	BIRTH DATE	Year ____ Month ____ Day ____	
AA3b	ESTIMATED BIRTH DATE?	Birth date is estimated 0. No 1. Yes	
AA4	ABORIGINAL IDENTITY	Person identifies self as First Nations, Métis or Inuit 0. No 1. Yes a. First Nations b. Métis c. Inuit	
A5	MARITAL STATUS	1. Never married 4. Separated 2. Married 5. Divorced 3. Widowed 9. Unknown	
AA6	FACILITY NUMBER	Prov./Terr. ____ Facility Number ____ (See manual for province/territory codes)	

AA5a	HEALTH CARD NUMBER	a. Enter the resident's health card number, or enter "0" if unknown or "1" if not applicable.
AA5b	PROVINCE/ TERRITORY ISSUING HEALTH CARD NUMBER	b. Enter the Province/Territory code issuing health card number (See manual for province/ territory abbreviations)
A6a	HEALTH RECORD NUMBER	
A6b	HEALTH REGISTER NUMBER	
AA8	REASON FOR ASSESSMENT	Primary reason for assessment 05. Quarterly review assessment 10. Significant correction of prior quarterly assessment
A11	DECISION-MAKER FOR PERSONAL CARE AND PROPERTY	1. Person 2. Other a. Personal Care b. Property
A12	ADVANCE DIRECTIVES	0. Not in Place 1. In Place a. Advance Directives for Not Resuscitating a. Advance Directives for Not Hospitalizing

SECTION B: COGNITIVE PATTERNS

B1	**COMATOSE**	*(Persistent vegetative state or no discernible consciousness)* 0. No 1. Yes (Skip to item G1)	
B2	**MEMORY**	*(Recall of what was learned or known)* a. Short-term memory OK—seems or appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK—seems or appears to recall long past 0. Memory OK 1. Memory problem	
B3	**MEMORY/ RECALL ABILITY**	*(Check all that resident was normally able to recall during the LAST 7 DAYS.)* a. Current season b. Location of own room c. Staff names and faces d. That he/she is in a facility e. *NONE OF ABOVE* recalled	a b c d e
B4	**COGNITIVE SKILLS FOR DAILY DECISION MAKING**	*(Made decisions regarding tasks of daily life.)* 0. INDEPENDENT—decisions consistent and reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues or supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions	
B5	**INDICATORS OF DELIRIUM-PERIODIC DISORDERED THINKING/ AWARENESS**	*(Code for behaviour in LAST 7 DAYS.) Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behaviour over this time.* 0. Behaviour not present 1. Behaviour present, not of recent onset 2. Behaviour present, over last 7 days appears different from resident's usual functioning (e.g. new onset or worsening)	
		a. EASILY DISTRACTED (e.g. difficulty paying attention, gets sidetracked)	
		b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS (e.g. moves lips or talks to someone not present; believes he or she is somewhere else; confuses night and day)	
		c. EPISODES OF DISORGANIZED SPEECH (e.g. speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)	
		d. PERIODS OF RESTLESSNESS (e.g. fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out)	
		e. PERIODS OF LETHARGY (e.g. sluggishness; staring into space; difficult to arouse; little bodily movement)	
		f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY (e.g. sometimes better, sometimes worse; behaviours sometimes present, sometimes not)	
B6	**CHANGE IN COGNITIVE STATUS**	Resident's cognitive status, skills or abilities have 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 C: COMMUNICATION/HEARING PATTERNS

C4	**MAKING SELF UNDERSTOOD**	*(Expressing information content—however able)* 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY OR NEVER UNDERSTOOD	
C6	**ABILITY TO UNDERSTAND OTHERS**	*(Understanding verbal information content—however able)* 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part or intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY OR NEVER UNDERSTANDS	
C7	**CHANGE IN COMMUNI-CATION/ HEARING**	Resident's ability to express, understand, or hear information 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 E: MOOD AND BEHAVIOUR PATTERNS

E1	**INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD**	*(Code for indicators observed in LAST 30 DAYS, irrespective of the assumed cause.)* 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to 5 days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days)	
		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 ("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 facility; anger at care received)	
		e. Self deprecation (e.g. "I am nothing, 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 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 or concerns—non-health (e.g. persistently seeks attention or reassurance regarding schedules, meals, laundry or clothing, relationship issues)	
		SLEEP-CYCLE ISSUES	
		j. Unpleasant mood in morning	
		k. Insomnia or 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 longstanding activities or being with family, friends)	
		p. Reduced social interaction	

SECTION E: MOOD AND BEHAVIOUR PATTERNS (cont'd)

E2	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident in LAST 7 DAYS. 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered		
E3	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		
E4	BEHAVIOURAL SYMPTOMS	*(Code for behaviour in LAST 7 DAYS.)* A. Behavioural symptom frequency in last 7 days 0. Behaviour not exhibited in last 7 days 1. Behaviour of this type occurred on 1 to 3 days in last 7 days 2. Behaviour of this type occurred 4 to 6 days, but less than daily 3. Behaviour of this type occurred daily B. Behavioural symptom alterability in last 7 days 0. Behaviour not present —OR—behaviour was easily altered 1. Behaviour was not easily altered	A	B
		a. **WANDERING** (moved with no rational purpose, seemingly oblivious to needs or safety)		
		b. **VERBALLY ABUSIVE BEHAVIOURAL SYMPTOMS** (others were threatened, screamed at, cursed at)		
		c. **PHYSICALLY ABUSIVE BEHAVIOURAL SYMPTOMS** (others were hit, shoved, scratched, sexually abused)		
		d. **SOCIALLY INAPPROPRIATE or DISRUPTIVE BEHAVIOURAL SYMPTOMS** (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behaviour or disrobing in public, smeared or threw food or feces, hoarding, rummaged in others' belongings)		
		e. **RESISTS CARE** (resisted taking meds or injections, ADL assistance, or eating)		
E5	CHANGE IN BEHAVIOURAL SYMPTOMS	Resident's behavioural status has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days). 0. No change 1. Improved 2. Deteriorated		

SECTION F: PSYCHOSOCIAL WELL-BEING

F1	SENSE OF INITIATIVE/ INVOLVEMENT	a. At ease interacting with others	a
		b. At ease doing planned or structured activities	b
		c. At ease doing self-initiated activities	c
		d. Establishes own goals	d
		e. Pursues involvement in life of facility (e.g. makes and keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e
		f. Accepts invitations into most group activities	f
		g. *NONE OF ABOVE*	g

SECTION G: FUNCTIONING AND STRUCTURAL PROBLEMS

G1 A. ADL SELF-PERFORMANCE *(Code for resident's **PERFORMANCE OVER ALL SHIFTS** during LAST 7 DAYS, not including setup.)*

0. INDEPENDENT. No help or oversight–OR–help/oversight provided only 1 or 2 times during last 7 days.

1. SUPERVISION. Oversight, encouragement or cueing provided 3 or more times during last 7 days–OR–Supervision plus physical assistance provided only 1 or 2 times during last 7 days.

2. LIMITED ASSISTANCE. Resident highly involved in activity; received physical help in guided maneuvering of limbs, or other nonweight-bearing assistance 3 or more times–OR–More help provided only 1 or 2 times during last 7 days.

3. EXTENSIVE ASSISTANCE. Although resident performed part of activity, over last 7-day period, help of the following type(s) was provided 3 or more times:
- weight-bearing support
- full staff performance during part (but not all) of last 7 days.

4. TOTAL DEPENDENCE. Full staff performance of activity during entire 7 days.

8. ACTIVITY DID NOT OCCUR during entire 7 days.

B. ADL SUPPORT PROVIDED
(*Code for **MOST SUPPORT PROVIDED OVER ALL SHIFTS** during LAST 7 DAYS; code regardless of resident's self-performance classification.)*

0. No setup or physical help from staff
1. Setup help only
2. One-person physical assist
3. Two+ persons physical assist
8. ADL activity did not occur during entire 7 days

			A SELF-PERFORMANCE	B SUPPORT PROVIDED
G1a	BED MOBILITY	How resident moves to and from lying position, turns from side to side, and positions body while in bed		
G1b	TRANSFER	How resident moves between surfaces–to and from: bed, chair, wheelchair, standing position (EXCLUDE to and from bath and toilet)		
G1c	WALK IN ROOM	How resident walks between locations in own room		
G1d	WALK IN CORRIDOR	How resident walks in corridor on unit		
G1e	LOCOMOTION ON UNIT	How resident moves between locations in own room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
G1f	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		
G1g	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning and removing prosthesis		
G1h	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition)		
G1i	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfers on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
G1j	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair; brushing teeth; shaving; applying makeup; washing and drying face, hands, and perineum (EXCLUDE baths and showers)		

SECTION G: PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS (cont'd)

G2	BATHING	How resident takes full-body bath or shower, sponge bath, and transfers in and out of tub or shower (EXCLUDE Washing of back and hair). *Code for most dependent in self-performance.* Bathing self-performance codes are: 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. Bathing did not occur during the entire 7 days	A (SELF-PERFORMANCE)
G3	TEST FOR BALANCE	*(Code for ability during test in the LAST 7 DAYS.)* 0. Maintained position as required in test 1. Unsteady, but able to rebalance without physical support 2. Partial physical support during test or doesn't follow directions 3. Not able to attempt test without physical help	
		a. Balance while standing	
		b. Balance while sitting–position, trunk control	
G4	FUNCTIONAL LIMITATION IN RANGE OF MOTION	*(Code for limitations during LAST 7 DAYS that interfered with daily functions or put resident at risk of injury.)* **A. RANGE OF MOTION** 0. No limitation 1. Limitation on 1 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	
G6	MODES OF TRANSFER	*(Check all that apply during LAST 7 DAYS.)*	
		a. Bedfast all or most of the time	a
		b. Bed rails used for bed mobility or transfer	b
		f. *NONE OF ABOVE*	f
G7	TASK SEGMENTATION	Some or all of ADL activities were broken into sub-tasks during LAST 7 DAYS so that resident could perform them.	
		0. No 1. Yes	
G9	CHANGE IN ADL FUNCTION	Resident's ADL Self-Performance status has changed as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days).	
		0. No change 1. Improved 2. Deteriorated	

SECTION H: CONTINENCE IN LAST 14 DAYS

		CONTINENCE SELF-CONTROL CATEGORIES *(Code for performance over all shifts.)*	
		0. CONTINENT–Complete control 1. USUALLY CONTINENT—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. OCCASIONALLY INCONTINENT—BLADDER, 2+ times a week but not daily; BOWEL, once a week 3. FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g. on day shift); BOWEL, 2 or 3 times a week 4. INCONTINENT—Had inadequate control. BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time	
H1a	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if used	
H1b	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g. foley) or continence programs, if used	

SECTION H: CONTINENCE IN LAST 14 DAYS (cont'd)

H2	BOWEL ELIMINATION PATTERN	*(Check all that apply in LAST 14 DAYS.)*	
		c. Diarrhea	c
		d. Fecal impaction	d
		e. *NONE OF ABOVE*	e
H3	APPLIANCES AND PROGRAMS	*(Check all that apply in LAST 14 DAYS.)*	
		a. Any scheduled toileting plan	a
		b. Bladder retraining program	b
		c. External (condom) catheter	c
		d. Indwelling catheter	d
		i. Ostomy present	i
		j. *NONE OF ABOVE*	j
H4	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 behaviour status, medical treatments, nurse monitoring, or risk of death. Do not list inactive diagnoses.)

I1	DISEASES	*(If none of I1a–I1tt apply, CHECK item I1vv.)*	
		ENDOCRINE/METABOLIC/NUTRITIONAL	
		a. Diabetes mellitus	a
		MUSCULOSKELETAL	
		m. Hip fracture	m
		NEUROLOGICAL	
		q. Amyotrophic lateral sclerosis (ALS)	q
		s. Aphasia	s
		t. Cerebral palsy	t
		u. Cerebrovascular accident (stroke)	u
		v. Dementia other than Alzheimer's disease	v
		w. Hemiplegia/Hemiparesis	w
		x. Huntington's chorea	x
		y. Multiple sclerosis	y
		bb. Quadriplegia	bb
		PSYCHIATRIC/MOOD	
		gg. Depression	gg
		hh. Bipolar Disorder	hh
		ii. Schizophrenia	ii
		OTHER	
		ss. Gastrointestinal disease	ss
		tt. Liver disease	tt
		vv. *NONE OF THE ABOVE*	vv

SECTION I: DISEASE DIAGNOSES (cont'd)

I2	INFECTIONS	*(If none of !2a-!2m apply, CHECK item I2n.)*	
		a. Antibiotic resistant infection (e.g. Methicillin resistant staph)	a
		b. Cellulitis	b
		c. Clostridium difficile	c
		d. Conjunctivitis	d
		e. HIV infection	e
		f. Pneumonia	f
		g. Respiratory infection	g
		h. Septicemia	h
		i. Sexually transmitted diseases	i
		j. Tuberculosis (active)	j
		k. Urinary tract infection in last 30 days	k
		l. Viral hepatitis	l
		m. Wound infection	m
		n. *NONE OF ABOVE*	n

I3	OTHER CURRENT DIAGNOSIS AND ICD-10-CA CODES	a	
		b	
		c	
		d	
		e	
		f	

SECTION J: HEALTH CONDITIONS

J1	PROBLEM CONDITIONS	*(Check all problems present in last 7 days UNLESS OTHER TIME FRAME IS INDICATED.)*	
		INDICATORS OF FLUID STATUS	
		a. Weight gain or loss of 1.5 or more kilograms in last 7 days (3 lbs.)	a
		b. Inability to lie flat due to shortness of breath	b
		c. Dehydrated; e.g. output exceeds intake	c
		d. Insufficient fluid; did NOT consume all or almost all liquids provided during last 3 days	d
		OTHER	
		e. Delusions	e
		f. Dizziness/vertigo	f
		g. Edema	g
		h. Fever	h
		i. Hallucinations	i
		j. Internal bleeding	j
		k. Recurrent lung aspirations in last 90 days	k
		l. Shortness of breath	l
		m. Syncope (fainting)	m
		n. Unsteady gait	n
		o. Vomiting	o
		p. *NONE OF ABOVE*	p

SECTION J: HEALTH CONDITIONS (cont'd)

J2	PAIN SYMPTOMS	*(Code for the highest level of pain present in LAST 7 DAYS)*	
		a. FREQUENCY with which resident complains or shows evidence of pain:	
		0. No pain *(Skip to J4)* 1. Pain less than daily 2. Pain daily	
		b. INTENSITY of pain: 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating	

J4	ACCIDENTS	*(CHECK all that apply.)*	
		a. Fell in past 30 days	a
		b. Fell in past 31 to 180 days	b
		c. Hip fracture in last 180 days	c
		d. Other fracture in last 180 days	d
		e. *NONE OF ABOVE*	e

J5	STABILITY OF CONDITIONS	*(Check all that apply.)*	
		a. Conditions or diseases make resident's cognitive, ADL, mood, or behaviour patterns unstable (fluctuating, precarious, or deteriorating)	a
		b. Resident experiencing an acute episode or a flare-up of a recurrent or chronic	b
		c. End-stage disease; 6 months or less to live	c
		d. *NONE OF ABOVE*	d

SECTION K: ORAL/NUTRITIONAL STATUS

K1	ORAL PROBLEMS	*(Check all that apply in last 7 days.)*	
		a. Chewing problem	a
		b. Swallowing problem	b
		d. *NONE OF ABOVE*	d

K2	HEIGHT AND WEIGHT	*(a. Record height in centimetres)* a. HEIGHT	
		(b. Record weight in kilograms) b. WEIGHT	
		Base weight on most recent measure in LAST 30 DAYS; measure weight consistently in accord with standard facility practice (e.g. in AM after voiding, before meal, with shoes off, and in nightclothes).	

K3	WEIGHT CHANGE	**a. Weight loss**—5% or more in LAST 30 DAYS or 10% or more in LAST 180 DAYS. 0. No 1. Yes	
		b. Weight gain—5% or more in LAST 30 DAYS or 10% or more in LAST 180 DAYS 0. No 1. Yes	

K4	NUTRITIONAL PROBLEMS	*(Check all that apply in LAST 7 DAYS.)*	
		c. Leaves 25% or more of food uneaten at most meals	c
		d. *NONE OF ABOVE*	d

K5	NUTRITIONAL APPROACHES	*(Check all that apply in LAST 7 DAYS.)*	
		a. Parenteral/IV	a
		b. Feeding tube	b
		f. Dietary supplement between meals	f
		g. Plate guard, stabilized built-up utensil, etc.	g
		h. On a planned weight change program	h
		i. *NONE OF ABOVE*	i

SECTION K: ORAL/NUTRITIONAL STATUS (cont'd)

K6	PARENTERAL OR ENTERAL INTAKE	*(Skip to Section M if neither 5a nor 5b is checked.)* a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days 0. None 2. 26% to 50% 4. 76% to 100% 1. 1% to 25% 3. 51% to 75% b. Code the average fluid intake per day by IV or tube in the last 7 days 0. None 3. 1001 to 1500 c 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 M: SKIN CONDITION

M1	ULCERS (due to any cause)	*(Record the **number** of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply in LAST 7 DAYS. Code 9 for 9 or more.)* **Requires a full body exam.** a. **Stage 1**–A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved b. **Stage 2**–A partial thickness loss of skin layers that presents clinically as an abrasion, blister or shallow crater c. **Stage 3**–A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissue d. **Stage 4**–A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone	
M2	TYPE OF ULCER	*(For each type of ulcer, code for the **highest stage** in LAST 7 DAYS using scale in item M1—i.e., 0 = none; stages 1, 2, 3, 4.)* a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
M4	OTHER SKIN PROBLEMS OR LESIONS PRESENT	*(Check all that apply during LAST 7 DAYS.)* a. Abrasions, bruises b. Burns (second or third degree) c. Open lesions other than ulcers, rashes or cuts (e.g. cancer lesions) d. Rashes (e.g. intertrigo, eczema, drug/heat rash, herpes) e. Skin desensitized to pain or pressure f. Skin tears or cuts (other than surgery) g. Surgical wounds h. *NONE OF ABOVE*	a b c d e f g h
M5	SKIN TREATMENTS	*(Check all that apply during LAST 7 DAYS.)* a. Pressure relieving device(s) for chair b. Pressure relieving device(s) for bed c. Turning or repositioning program d. Nutrition or hydration intervention to manage skin problems e. Ulcer care f. Surgical wound care g. Application of dressings (with or without topical medications) other than to feet h. Application of ointments or medications (except to feet) i. Other preventative or protective skin care (except to feet) j. *NONE OF ABOVE*	a b c d e f g h i j

SECTION M: SKIN CONDITION (cont'd)

M6	FOOT PROBLEMS AND CARE	*(Check all that apply during LAST 7 DAYS.)* a. Resident has one or more foot problems (e.g. corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems) b. Infection of the foot (e.g. cellulitis, purulent drainage) c. Open lesions on the foot d. Nails or callouses trimmed during LAST 90 DAYS e. Received preventative or protective foot care (e.g. used special shoes, inserts, pads, toe separators) f. Application of dressings (with or without topical meds) g. *NONE OF ABOVE*	a b c d e f g

SECTION N: ACTIVITY PURSUIT PATTERNS

N1	TIME AWAKE	*(Check appropriate time periods over LAST 7 DAYS.)* Resident awake all or most of the time (i.e. naps no more than 1 hour per time period) in the: a. Morning [a] c. Evening [c] b. Afternoon [b] d. *NONE OF ABOVE* [d]	
		(If resident is comatose, skip to Section O.)	
N2	AVERAGE TIME INVOLVED IN ACTIVITIES	*(When awake and not getting treatment or ADL care)* 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 3. None	

SECTION O: MEDICATIONS

O1	NUMBER OF MEDICATIONS	*(Record the NUMBER of different MEDICATIONS used in the LAST 7 DAYS. Enter "00" if none used.)*	
O3	INJECTIONS	*(Record the NUMBER OF DAYS injections of any type were received during the LAST 7 DAYS. Enter "0" if none used.)*	
O4	DAYS RECEIVED THE FOLLOWING MEDICATION	*(Record the NUMBER OF DAYS during LAST 7 DAYS; enter "0" if not used. N.B. Enter "1" for long-acting meds used less than weekly.)* a. Antipsychotic b. Antianxiety c. Antidepressant d. Hypnotic e. Diuretic f. Analgesic	

SECTION P: SPECIAL TREATMENTS AND PROCEDURES

P1 SPECIAL TREATMENTS, PROCEDURES AND PROGRAMS

***a. SPECIAL CARE**—(Check treatments or programs received in LAST 14 DAYS.)*

TREATMENTS

a. Chemotherapy	a
b. Renal dialysis	b
c. IV medication	c
d. Intake/output	d
e. Monitoring acute medical condition	e
f. Ostomy care	f
g. Oxygen therapy	g
h. Radiation	h
i. Suctioning	i
j. Trach. Care	j
k. Transfusions	k
l. Ventilator or respirator	l

PROGRAMS

m. Alcohol or drug treatment program	m
n. Alzheimer's or dementia special care unit	n
o. Hospice care	o
p. Pediatric unit	p
q. Respite care	q
r. Training in skills required to return to the community (e.g. taking medications, housework, shopping, transportation, ADLs)	r
s. *NONE OF ABOVE*	s

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 DAYS. Enter "0" if none or less than 15 minutes daily.) Note: Count only post-admission therapies.*

Box **A = # of days** administered for 15 minutes or more

Box **B = total # of minutes** provided in last 7 days

	A	B
a. Speech—language pathology, audiology Service		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		
f. Recreation therapy		

SECTION P: SPECIAL TREATMENTS AND PROCEDURES

P3 NURSING REHABILITATION/ RESTORATIVE CARE

(Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the LAST 7 DAYS. Enter "0" if none or less than 15 minutes daily.)

a. Range of motion (passive)	
b. Range of motion (active)	
c. Splint or brace assistance	
Training and skill practice in:	
d. Bed mobility	
e. Transfer	
f. Walking	
g. Dressing or grooming	
h. Eating or swallowing	
i. Amputation or prosthesis care	
j. Communication	
k. Other	

P4 DEVICES AND RESTRAINTS

(Use the following codes for the LAST 7 DAYS.)

0. Not used 1. Used less than daily 2. Used daily

a. Full bed rails on all open sides of bed	
b. Other types of side rails used (e.g. half rail, 1 side)	
c. Trunk restraint	
d. Limb restraint	
e. Chair prevents rising	

P7 PHYSICIAN VISITS

In the LAST 14 DAYS (or since admission, if less than 14 days in facility), how many days has the physician (or authorized assistant or practitioner) examined the resident? *(Enter "00" if none.)*

P8 PHYSICIAN ORDERS

In the LAST 14 DAYS (or since admission, if less than 14 days in facility), on how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change. (Enter "00" if none.)*

SECTION Q: DISCHARGE POTENTIAL AND OVERALL STATUS

Q2 OVERALL CHANGE IN CARE NEEDS

Resident's overall level of self-sufficiency has changed significantly as compared to status of 90 DAYS AGO (or since last assessment if less than 90 days ago).

0. No change
1. Improved—receives fewer supports, needs less restrictive level of care
2. Deteriorated—receives more support

SECTION R: ASSESSMENT INFORMATION

SIGNATURES OF THOSE COMPLETING THE ASSESSMENT

Provider Type | **Assessor ID #**

_____

Signature of Assessment Coordinator (sign on above line)

R2b. Date Assessment Coordinator signed as complete

Year | Month | Day

Other Signatures	Title	Sections	Date	Provider Type	Assessor ID #

SECTION U: MEDICATION LIST

List all medications that the resident received during the LAST 7 DAYS. Include scheduled medications that are used regularly, but less than weekly

1. **Medication name and dose ordered.**

2. **Route of administration (RA)**. Code the route of administration using the following codes:
   01 = by mouth (PO) 02 = sublingual (SL) 03 = intramuscular (IM) 04 = intravenous (IV) 05 = subcutaneous (SC)
   06 = rectally (PR) 07 = topical 08 = inhalation 09 = enteral tube 10 = other

3. **Frequency.** Code the number of times per day, week or month that the medication is administered using the following list:
   prn = as necessary q1h = every 1 hour q2h = every 2 hours q3h = every 3 hours q4h = every 4 hours
   q6h = every 6 hours q8h = every 8 hours od = once a day hs = at bedtime bid = two times daily
   tid = three times daily qid = four times daily eod = every other day 1wk = once a week 2wk = twice a week
   3wk = three times a week 4wk = four times a week 5wk = five times a week 6wk = six times a week 1mo = once a month
   2mo = twice a month cont = continuous othr = other

4. **Amount Administered.** Record the number of tablets, capsules, suppositories, or liquid (any route) per dose administered to the resident. Code 999v9 for topicals, eyedrops, inhalants and oral medications that need to be dissolved in water.

5. **PRN—number of doses**. If the frequency code for the medication is "PRN" record the number of times during the last 7 days that each PRN medication was given. Code "99" for STAT medications given once.

6. **DIN Number—**Drug Information Number for each medication given. Be sure to enter the correct DIN for the drug name, strength and form. The DIN must match the drug dispensed by the pharmacy.

	1. Medication Name and Dose Ordered	2. RA	3. Frequency	4. Amount Administered	5. PRN Number of Doses	6. DIN Number
A						
B						
C						
D						
E						
F						
G						
H						
I						
J						
K						
L						
M						
N						
O						
P						
Q						
R						
S						
T						