MINIMUM DATA SET (MDS) - ASSISTED HOUSING

Residential Care Level IV PNMI (RCF)
Adult Family Care Home (AFCH)

Table of Contents

Entry Tracking Form

A0100. Type of Record

Enter code ☐

1. **Add a new record**
2. **Modify an existing record**
3. **Inactivate an existing record** → Skip to X0100, Type of Provider

A0200. Facility Information

A. **Facility Name:** _____

B. **National Provider Identifier (NPI):** ☐☐☐☐☐☐☐☐☐☐

C. **State Provider Number (NPI+3)**: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0300. Type of Provider

Enter code ☐

Type of provider

1. **Residential Care Level IV PNMI (RCF)**
2. **Adult Family Care Home (AFCH)**

A0500. Legal Name of Resident

A. **First Name:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

B. **Middle Initial:** ☐

C. **Last Name:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. **Suffix:** ☐☐☐

A0600. Social Security Number

☐☐☐ - ☐☐ - ☐☐☐☐

A0700. Gender

Enter code ☐

1. **Male**
2. **Female**
3. **X**

A0800. Birth Date

☐☐ - ☐☐ - ☐☐☐☐

M M D D Y Y Y Y

A1000. MaineCare Number

Record a "+" if pending and an "N" if not a MaineCare recipient.

☐☐☐☐☐☐☐☐☐

A1200. Most Recent Admission/Entry or Reentry into this Facility

☐☐ - ☐☐ - ☐☐☐☐

M M D D Y Y Y Y

Entry Tracking Form

X0100. Type of Provider *(A0300 on existing record to be modified/inactivated)*

Enter code

Type of provider

1. **Residential Care Level IV PNMI** (*RCF*)
2. **Adult Family Care Home** (*AFCH*)

X0200. Type of Assessment

A. **Reason for assessment** *(A0400A on existing record to be modified/inactivated)*

Enter Code

01. **Admission assessment**
02. **Quarterly review assessment**
03. **Annual assessment**
04. **Significant change in status assessment**
05. **Significant correction to prior comprehensive assessment**
06. **Significant correction to prior quarterly assessment**
99. **None of the above**

B. **Entry/discharge reporting** *(A0400B on existing record to be modified/inactivated)*

Enter Code

01. **Entry tracking record**
02. **Discharge assessment -** return not anticipated
03. **Discharge assessment -** return anticipated
04. **Death in facility -** tracking record
05. **Discharge prior to completion of assessment**
99. **None of the above**

X0300. Legal Name of Resident *(A0500 on existing record to be modified/inactivated)*

A. **First Name:**

B. **Middle Initial**

C. **Last Name:**

D. **Suffix:**

X0400. Social Security Number *(A0600 on existing record to be modified/inactivated)*

___ - __ - ____

X0500. Gender *(A0700 on existing record to be modified/inactivated)*

Enter code

4. **Male**
5. **Female**
6. **X**

X0600. Birth Date *(A0800 on existing record to be modified/inactivated)*

M M - D D - Y Y Y Y

X0700. Assessment Reference Date *(A0900 on existing record to be modified/inactivated)*

M M - D D - Y Y Y Y

X0800. Date of Death or Discharge *(A1800 on existing record to be modified/inactivated)*

M M - D D - Y Y Y Y

X0900. Date of Entry/Reentry *(A1200 on existing record to be modified/inactivated)*

M M - D D - Y Y Y Y

Entry Tracking Form

Z0200. Attestation

B. **Coordinator signature:**

1. _____

Signature Title Date

Section A: Identification and Background Information

A0100. Type of Record

Enter code ☐

1. **Add a new record**
2. **Modify an existing record**
3. **Inactivate an existing record** → Skip to X0100, Type of Provider

A0200. Facility Information

A. **Facility Name:** _____

B. **National Provider Identifier (NPI):**

☐☐☐☐☐☐☐☐☐☐

C. **State Provider Number (NPI+3)**:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0300. Type of Provider

Enter code ☐

Type of provider

1. **Residential Care Level IV PNMI (RCF)**
2. **Adult Family Care Home (AFCH)**

A0400. Type of Assessment

A. **Reason for assessment**

Enter code ☐☐

01. **Admission assessment** (*REQUIRED BY DAY 14*)
02. **Annual assessment**
03. **Semi-annual assessment**
04. **Significant change in status assessment**
05. **Significant correction to prior comprehensive assessment**
06. **Significant correction to prior quarterly assessment**
99. **None of the above**

B. **Entry/discharge reporting**

Enter Code ☐☐

01. **Entry tracking record**
02. **Discharge assessment -** return not anticipated
03. **Discharge assessment -** return anticipated
04. **Death in facility -** tracking record
05. **Discharge prior to completion of assessment**
99. **None of the above**

A0500. Legal Name of Resident

A. **First Name:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

B. **Middle Initial:** ☐

C. **Last Name:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. **Suffix:** ☐☐☐

A0600. Social Security Number

☐☐☐ - ☐☐ - ☐☐☐☐

A0700. Gender

Enter code ☐

1. **Male**
2. **Female**
3. **X**

A0800. Birth Date

☐☐ - ☐☐ - ☐☐☐☐

M M D D Y Y Y Y

Section A: Identification and Background Information

A0900. Assessment Reference Date

Observation end date.

M M	-	D D	-	Y Y Y Y

A1000. MaineCare Number

Record a "+" if pending and an "N" if not a MaineCare recipient.

A1100. Current Payment Sources for Stay

Billing Office to indicate. Check all that apply in the LAST 30 DAYS or since the last admission if LESS THAN 30 DAYS.

- ☐ A. **MaineCare**
- ☐ B. **Other** (*specify*) _____

A1200. Most Recent Admission/Entry or Reentry into this Facility

M M	-	D D	-	Y Y Y Y

A1300. Type of Entry

Enter Code ☐

1. **Admission**
2. **Reentry**

A1400. Date of Admission

On what date did the resident's stay begin? (***Note**: This does not include readmission if the record was closed at the time of temporary discharge to the hospital, etc. In such cases, use the prior admission date*)

M M	-	D D	-	Y Y Y Y

A1500. Admitted From *(at entry)*

Where was the resident admitted from?

Enter Code ☐☐

01. **Home/Community** (*e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care*)
02. **Nursing home** (*long-term care facility*)
03. **Skilled Nursing Facility** (*SNF, swing beds*)
04. **Short-Term General Hospital** (*acute hospital, IPPS*)
05. **Long-Term Care Hospital (LTCH)**
06. **Inpatient Rehabilitation Facility** (*IRF, free-standing facility or unit*)
07. **Inpatient Psychiatric Facility** (*psychiatric hospital or unit*)
08. **ID/DD facility**
09. **Hospice** (*home/non-institutional*)
10. **Hospice** (*institutional facility*)
11. **Critical Access Hospital (CAH)**
12. **Home under the care of an organized home health service organization**
99. **Not listed**

A1600. Lived Alone *(prior to entry)*

Did the resident live alone prior to admission? (*Check only one*)

Enter Code ☐

0. **No**
1. **Yes**
2. **In another facility**

A1700. Prior Primary Residence Zip Code

Provide the zip code for the Resident's primary residence prior to admission.

Section A: Identification and Background Information

A1800. Date of Death or Discharge

		-			-				
M	M		D	D		Y	Y	Y	Y

A1900. Discharge Status

Where was the resident discharged to?

Enter Code

01. **Home/Community** (*e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care*)
02. **Nursing home** (*long-term care facility*)
03. **Skilled Nursing Facility** (*SNF, swing beds*)
04. **Short-Term General Hospital** (*acute hospital, IPPS*)
05. **Long-Term Care Hospital** (*LTCH*)
06. **Inpatient Rehabilitation Facility** (*IRF, free-standing facility or unit*)
07. **Inpatient Psychiatric Facility** (*psychiatric hospital or unit*)
08. **ID/DD facility**
09. **Hospice** (*home/non-institutional*)
10. **Hospice** (*institutional facility*)
11. **Critical Access Hospital** (*CAH*)
12. **Home under the care of an organized home health service organization**
13. **Home with no home health service care**
14. **Deceased**
99. **Not listed**

A2000. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

Enter Code

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?

0. **No**
1. **Yes**

A2100. Provision of Current Reconciled Medication List to Resident at Discharge

Enter Code

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the resident?

0. **No**
1. **Yes**

A2200. Level I Preadmission Screening and Resident Review *(PASRR)*

Enter Code

Has the resident received a level I PASRR?

0. **No** → Skip to A2400, Conditions related to ID/DD
1. **Yes**

A2300. Level II Preadmission Screening and Resident Review *(PASRR)*

Enter Code

A. **Has the resident received a level II PASRR?**
0. **No**
1. **Yes**

Enter Code

B. **Is the resident currently considered by the state level II PASSR to have serious mental illness and/or intellectual disability or a related condition?**
0. **No**
1. **Yes**

Enter Code

C. **Based on Level II PASRR, does the resident have a serious mental illness?**
0. **No**
1. **Yes**

Enter Code

D. **Based on Level II PASRR, does the resident have an intellectual disability?**
0. **No**
1. **Yes**

Enter Code

E. **Based on Level II PASRR, does the resident have other related conditions?**
0. **No**
1. **Yes**

Section A: Identification and Background Information

A2400. Conditions related to ID/DD Status

Check all that apply:

	A.	**Down syndrome**
	B.	**Autism**
	C.	**Epilepsy**
	D.	**Other organic conditions related to ID/DD**
	E.	**ID/DD with no organic condition**
	Z.	**None of the above**

A2500. Marital Status

Enter Code

1. **Never married**
2. **Married**
3. **Widowed**
4. **Separated**
5. **Divorced**

A2600. Legal Guardian

Check all that apply:

	A.	**Does the resident have a legal guardian?**
	B.	**Does the resident have other legal oversight?**
	C.	**Does the resident have a durable power of attorney for health care?**
	D.	**Does the resident have a durable power of attorney for finances?**
	E.	**Is a family member responsible for the resident?**
	F.	**Is the resident responsible for personal decisions?**
	G.	**Does the resident have a legal conservator?**
	H.	**Does the resident have a representative payee?**
	Z.	**None of the above**

A2700. Advanced Directives

Check all that apply:

	A.	**Does the resident have a guardian?**
	B.	**Does the resident have a living will?**
	C.	**Does the resident have a DNR directive?**
	D.	**Does the resident have a directive to not hospitalize?**
	E.	**Does the resident have a directive not to intubate?**
	F.	**Does the resident have feeding restrictions?**
	G.	**Does the resident have a directive to donate organs?**
	H.	**Does the resident have another type of directive?**
	Z.	**None of the above**

A2800. Ethnicity

Is the resident of Hispanic, Latino/a, or Spanish origin? Check all that apply*:*

	A.	**No, not of Hispanic, Latino/a, or Spanish origin**
	B.	**Yes, Mexican, Mexican American, Chicano/a**
	C.	**Yes, Puerto Rican**
	D.	**Yes, Cuban**
	E.	**Yes, another Hispanic, Latino/a, or Spanish origin**
	X.	**Resident unable to respond**
	Y.	**Resident declines to respond**

Section A: Identification and Background Information

A2900. Race

Check all that apply:

☐	A.	**White**
☐	B.	**Black or African American**
☐	C.	**American Indian or Alaska Native**
☐	D.	**Asian Indian**
☐	E.	**Chinese**
☐	F.	**Filipino**
☐	G.	**Japanese**
☐	H.	**Korean**
☐	I.	**Vietnamese**
☐	J.	**Other Asian**
☐	K.	**Native Hawaiian**
☐	L.	**Guamanian or Chamorro**
☐	M.	**Samoan**
☐	N.	**Other Pacific Islander**
☐	X.	**Resident unable to respond**
☐	Y.	**Resident declines to respond**
☐	Z.	**None of the above**

A3000. Language

A. **What is the resident's preferred language?**

B. **Does the resident need or want an interpreter to communicate with a doctor or healthcare staff?**

0. **No**
1. **Yes**

Section B: Hearing, Speech, and Vision

B0100. Hearing

Enter code ☐

Ability to hear with hearing aid or hearing appliances if normally used

0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty in some environments** *(e.g., when a person speaks softly or the setting is noisy)*
2. **Moderate difficulty** - the speaker has to increase the volume and speak distinctly
3. **Highly impaired** - the absence of useful hearing

B0200. Communication Devices & Techniques

Check all that apply during the LAST 7 DAYS:

- ☐ A. **Hearing aid** - present and used
- ☐ B. **Hearing aid** - present and not used regularly
- ☐ C. **American Sign Language**
- ☐ D. **Non-traditional sign or gesture language**
- ☐ E. **Other receptive communication techniques used** *(e.g., lip reading or communication board)*
- ☐ Z. **None of the above**

B0300. Speech Clarity

Enter code ☐

Select the best description of the resident's speech pattern

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

B0400. Makes Self Understood

Enter code ☐

Ability to express ideas and wants, consider both verbal and non-verbal expression.

0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts but is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

B0500. Ability to Understand Others

Enter code ☐

Understanding information content

0. **Understands**
1. **Usually understands** - may miss some part and/or intent of the message
2. **Sometimes understands** - responds adequately to simple direct communication
3. **Rarely/never understands**

B0600. Vision

Enter code ☐

Ability to see in adequate light with glasses or other visual appliances.

0. **Adequate** - sees fine detail, such as regular print in newspapers and/or books
1. **Impaired** - see large print, but not regular print in newspapers and/or 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

B0700. Corrective Lenses

Enter code ☐

Corrective lenses used in completing B0600, Vision

0. **No**
1. **Yes**

Section C: Cognitive Patterns

C0100. Short-term Memory

Enter code ☐

Seems or appears to recall after 5 minutes

0. **Memory OK**
1. **Memory problem**

C0200. Long-term Memory

Enter code ☐

Seems or appears to recall long past

0. **Memory OK**
1. **Memory problem**

C0300. Memory & Recall Ability

Check all that the resident was normally able to recall:

- ☐ A. **Current season**
- ☐ B. **Location of own room**
- ☐ C. **Staff names and faces**
- ☐ D. **That they are in a residential care facility**
- ☐ Z. **None of the above**

C0400. Cognitive Skills for Daily Decision-Making

Enter code ☐

Made decisions regarding tasks of daily living

0. **Independent** *(decisions consistent/reasonable)*
1. **Modified independence** *(some difficulty in new situations only)*
2. **Moderately impaired** *(decisions poor; cues/supervision required)*
3. **Severely impaired** *(never/rarely made decisions)*

C0500. Long-term Memory

Enter code ☐

Resident's cognitive status or abilities now compared to resident's status 180 days ago (*or since admission if less than 180 days*)

0. **No change**
1. **Improved**
2. **Declined**

Section D: Mood

D0100. Indicators of Depression, Anxiety, Sad Mood

A. **Exhibited:** Record the appropriate code for the frequency of the symptom(s) observed in LAST 14 DAYS, irrespective of the assumed cause 0. **Not exhibited at least ONE DAY per week** 1. **Exhibited 1-5 DAYS per week** 2. **Exhibited 6-7 DAYS per week**	B. **Persistence:** Record the appropriate code to indicate how easily altered the indicator of depression, anxiety, or sad mood was over the LAST 14 DAYS 0. **Not exhibited** 1. **Indicator present** *(easily altered)* 2. **Indicator present** *(not easily altered)*

A. **Exhibited**	B. **Persistence**		
☐	☐	a.	**Resident made negative statements, including self-deprecation**
☐	☐	b.	**Repetitive questions -** including repetitive statements, repetitive anxious complaints and/or concerns that are non-health related
☐	☐	c.	**Persistent anger with self or others**
☐	☐	d.	**Repetitive health complaints -** includes repetitive anxious complaints and/or concerns
☐	☐	e.	**Trouble falling or staying asleep, sleeping too much**
☐	☐	f.	**Crying, tearfulness**
☐	☐	g.	**Withdrawal from activities of interest and/or change in level of social interaction**
☐	☐	h.	**Statements that life is not worth living, statements of wanting to die, attempts to harm self**

Section E: Behavior

E0100. Potential Indicators of Psychosis

Check all that apply:

- ☐ A. **Hallucinations** (*perceptual experiences in the absence of real external sensory stimuli*)
- ☐ B. **Delusions** (*misconceptions or beliefs that are firmly held, contrary to reality*)
- ☐ Z. **None of the above**

E0200. Behavioral Symptoms *(Presence & Frequency)*

Note the presence of symptoms and their frequency:

Enter Code ☐

A. **Physical behavioral symptoms directed toward others** (*e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually*)

1. **Behavior not exhibited** → Skip to E0300, Wandering *(Presence & Frequency)*
2. **Behavior of this type occurred 1 to 3 days**
3. **Behavior of this type occurred 4 to 6 days,** but less than daily
4. **Behavior of this type occurs daily**

Enter Code ☐

B. **Verbal behavioral symptoms directed toward others** (*e.g., threatening others, screaming at others, cursing at others*)

1. **Behavior not exhibited** → Skip to E0300, Wandering *(Presence & Frequency)*
2. **Behavior of this type occurs 1 to 3 days**
3. **Behavior of this type occurs 4 to 6 days,** but less than daily
4. **Behavior of this type occurs daily**

Enter Code ☐

C. **Other behavioral symptoms NOT directed toward others** (*e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily wastes, or verbal/vocal symptoms like screaming or disruptive sounds*)

1. **Behavior not exhibited** → Skip to E0300, Wandering *(Presence & Frequency)*
2. **Behavior of this type occurs 1 to 3 days**
3. **Behavior of this type occurs 4 to 6 days,** but less than daily
4. **Behavior of this type occurs daily**

E0300. Wandering *(Presence & Frequency)*

Has the resident wandered in the last 7 days?

Enter Code ☐

0. **Behavior not exhibited** → Skip to E0600, Socially Inappropriate Behavior *(Presence & Frequency)*
1. **Behavior of this type occurs 1 to 3 days**
2. **Behavior of type occurs 4 to 6 days,** but less than daily
3. **Behavior of this type occurs daily**

E0400. Wandering *(Impact on Resident)*

Check all that apply:

- ☐ A. **Is the behavior alterable?**
- ☐ B. **Did behavior put the resident at significant risk for physical illness or injury?**
- ☐ C. **Did behavior significantly interfere with the resident's care?**
- ☐ D. **Did behavior significantly interfere with the resident's participation in activities or social interactions?**

E0500. Wandering *(Impact on Others)*

Check all that apply:

- ☐ A. **Did behavior put others at significant risk for physical illness or injury?**
- ☐ B. **Did behavior significantly interfere with others' care?**
- ☐ C. **Did behavior significantly interfere with others' participation in activities or social interactions?**

E0600. Socially Inappropriate/Disruptive Behavior *(Presence & Frequency)*

Has the resident exhibited socially inappropriate/disruptive behaviors in the last 7 days?

Enter Code ☐

0. **Behavior not exhibited** → Skip to E0900, Resists, Rejects, or Refuses Care *(Presence & Frequency)*
1. **Behavior of this type occurs 1 to 3 days**
2. **Behavior of type occurs 4 to 6 days, but less than daily**
3. **Behavior of this type occurs daily**

Section E: Behavior

E0700. Socially Inappropriate/Disruptive Behavior *(Impact on Resident)*

Check all that apply:

- ☐ A. **Is the behavior alterable?**
- ☐ B. **Did behavior put the resident at significant risk for physical illness or injury?**
- ☐ C. **Did behavior significantly interfere with the resident's care?**
- ☐ D. **Did behavior significantly interfere with the resident's participation in activities or social interactions?**

E0800. Socially Inappropriate/Disruptive Behavior *(Impact on Others)*

Check all that apply:

- ☐ A. **Did behavior put others at significant risk for physical illness or injury?**
- ☐ B. **Did behavior significantly interfere with others' care?**
- ☐ C. **Did behavior significantly interfere with others' participation in activities or social interactions?**

E0900. Resists, Rejects, or Refuses Care *(Presence & Frequency)*

Has the resident resisted, rejected, or refused care in the last 7 days?

Enter Code ☐

0. **Behavior not exhibited** → Skip to E1200, Intimidating Behavior *(Presence & Frequency)*
1. **Behavior of this type occurs 1 to 3 days**
2. **Behavior of type occurs 4 to 6 days,** but less than daily
3. **Behavior of this type occurs daily**

E1000. Resists, Rejects, or Refuses Care *(Impact on Resident)*

Check all that apply:

- ☐ A. **Is the behavior alterable?**
- ☐ B. **Did behavior put the resident at significant risk for physical illness or injury?**
- ☐ C. **Did behavior significantly interfere with the resident's care?**
- ☐ D. **Did behavior significantly interfere with the resident's participation in activities or social interactions?**

E1100. Resists, Rejects, or Refuses Care *(Impact on Others)*

Check all that apply:

- ☐ A. **Did behavior put others at significant risk for physical illness or injury?**
- ☐ B. **Did behavior significantly interfere with others' care?**
- ☐ C. **Did behavior significantly interfere with others' participation in activities or social interactions?**

E1200. Intimidating Behavior *(Presence & Frequency)*

Has the resident exhibited intimidating behaviors in the last 7 days?

Enter Code ☐

0. **Behavior not exhibited** → Skip to E1500, Elopement *(Presence & Frequency)*
1. **Behavior of this type occurs 1 to 3 days**
2. **Behavior of type occurs 4 to 6 days, but less than daily**
3. **Behavior of this type occurs daily**

E1300. Intimidating Behavior *(Impact on Resident)*

Check all that apply:

- ☐ A. **Is the behavior alterable?**
- ☐ B. **Did behavior put the resident at significant risk for physical illness or injury?**
- ☐ C. **Did behavior significantly interfere with the resident's care?**
- ☐ D. **Did behavior significantly interfere with the resident's participation in activities or social interactions?**

E1400. Intimidating Behavior *(Impact on Others)*

Check all that apply:

- ☐ A. **Did behavior put others at significant risk for physical illness or injury?**
- ☐ B. **Did behavior significantly interfere with others' care?**
- ☐ C. **Did behavior significantly interfere with others' participation in activities or social interactions?**

Section E: Behavior

E1500. Elopement *(Presence & Frequency)*

Has the resident eloped in the last 7 days?

Enter Code ☐

0. **Behavior not exhibited** → Skip to E1800, Dangerous, Non-violent Behaviors *(Presence & Frequency)*
1. **Behavior of this type occurs 1 to 3 days**
2. **Behavior of type occurs 4 to 6 days, but less than daily**
3. **Behavior of this type occurs daily**

E1600. Elopement *(Impact on Resident)*

Check all that apply:

- ☐ A. **Is the behavior alterable?**
- ☐ B. **Did behavior put the resident at significant risk for physical illness or injury?**
- ☐ C. **Did behavior significantly interfere with the resident's care?**
- ☐ D. **Did behavior significantly interfere with the resident's participation in activities or social interactions?**

E1700. Elopement *(Impact on Others)*

Check all that apply:

- ☐ A. **Did behavior put others at significant risk for physical illness or injury?**
- ☐ B. **Did behavior put the resident at significant risk for physical illness or injury?**
- ☐ C. **Did behavior significantly interfere with others' care?**
- ☐ D. **Did behavior significantly interfere with others' participation in activities or social interactions?**

E1800. Dangerous, Non-violent Behaviors *(Presence & Frequency)*

Has the resident exhibited dangerous, non-violent behaviors in the LAST 7 DAYS?

Enter Code ☐

0. **Behavior not exhibited** → Skip to E2100, Dangerous, Violent Behaviors *(Presence & Frequency)*
1. **Behavior of this type occurs 1 to 3 days**
2. **Behavior of type occurs 4 to 6 days, but less than daily**
3. **Behavior of this type occurs daily**

E1900. Dangerous, Non-violent Behaviors *(Impact on Resident)*

Check all that apply:

- ☐ A. **Is the behavior alterable?**
- ☐ B. **Did behavior put the resident at significant risk for physical illness or injury?**
- ☐ C. **Did behavior significantly interfere with the resident's care?**
- ☐ D. **Did behavior significantly interfere with the resident's participation in activities or social interactions?**

E2000. Dangerous, Non-violent Behaviors *(Impact on Others)*

Check all that apply:

- ☐ A. **Did behavior put others at significant risk for physical illness or injury?**
- ☐ B. **Did behavior significantly interfere with others' care?**
- ☐ C. **Did behavior significantly interfere with others' participation in activities or social interactions?**

E2100. Dangerous, Violent Behaviors *(Presence & Frequency)*

Has the resident exhibited dangerous, violent behaviors in the LAST 7 DAYS?

Enter Code ☐

0. **Behavior not exhibited** → Skip to F0100, Resident Preferences
1. **Behavior of this type occurs 1 to 3 days**
2. **Behavior of type occurs 4 to 6 days,** but less than daily
3. **Behavior of this type occurs daily**

E2200. Dangerous, Violent Behaviors *(Impact on Resident)*

Check all that apply:

- ☐ A. **Is the behavior alterable?**
- ☐ B. **Did behavior put the resident at significant risk for physical illness or injury?**
- ☐ C. **Did behavior significantly interfere with the resident's care?**
- ☐ D. **Did behavior significantly interfere with the resident's participation in activities or social interactions?**

Section E: Behavior

E2300. Dangerous, Violent Behaviors *(Impact on Others)*

Check all that apply:

	☐	A. **Did behavior put others at significant risk for physical illness or injury?**
	☐	B. **Did behavior significantly interfere with others' care?**
	☐	C. **Did behavior significantly interfere with others' participation in activities or social interactions?**

Section F: Preferences for Customary Routine and Activities

F0100. Resident Prefers

Check all that apply:

	☐	A. **Staying up past 8:00 p.m.**
	☐	B. **Family or significant other involvement in care discussions**
	☐	C. **Reading books, newspapers, or magazines**
	☐	D. **Listening to music**
	☐	E. **Being around animals such as pets**
	☐	F. **Keeping up with the news**
	☐	G. **Doing things with groups of people**
	☐	H. **Cards/other games**
	☐	I. **Crafts/arts**
	☐	J. **Exercise/sports**
	☐	K. **Spiritual/religious activity**
	☐	L. **Trips/shopping**
	☐	M. **Watching TV**
	☐	N. **Gardening or plants**
	☐	O. **Computer activities**
	☐	Z. **None of the above**

Section G: Functional Abilities and Goals

INSTRUCTIONS FOR G0100 AND G0200

COLUMN 1: Safety and Quality of Performance

If helper assistance is required because the resident's performance is unsafe or of poor quality, score according to the amount of assistance provided.

Activities may be completed with or without assistive devices:

01. **Dependent** - Helper makes all the effort *(the resident makes no effort to complete the activity)*
02. **Substantial/maximal assistance** - Helper makes more than half the effort *(helper lifts or holds trunk or limbs and provides more than half the effort)*
03. **Partial/moderate assistance** - Helper makes less than half the effort *(helper lifts, holds, or supports trunk or limbs but provides less than half the effort)*
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes an activity *(assistance may be provided throughout the activity or intermittently)*
05. **Setup or clean-up assistance** - Helper sets up or cleans up, and resident completes activity *(helper assists only prior to or following the activity)*
06. **Independent** - Resident completes the activity by themselves *(no assistance from a helper)*

If an activity was not attempted, code reason:

07. **Resident refused**
08. **Not applicable** - Not attempted, and the resident did not perform this activity
09. **Not attempted due to environmental limitations** (*e.g., lack of equipment, weather constraints*).
99. **Not attempted due to medical condition(s) or safety concerns.**

COLUMN 2

Two or more helpers are required for the resident to complete the activity.

0. **No**
1. **Yes**

COLUMN 3

The resident required multiple reminders or multiple single-step cues to complete the ADL task due to dementia or cognitive impairment.

0. **No**
1. **Yes**

G0100. Self-Care Activities *(see above instructions)*

1.	2.	3.	
			A. **Eating**
			B. **Oral hygiene**
			C. **Toileting hygiene**
			D. **Shower/bathe self**
			E. **Upper body dressing**
			F. **Lower body dressing**
			G. **Putting on/taking off footwear**
			H. **Personal hygiene**

G0200. Mobility *(see above instructions)*

1.	2.	3.	
			A. **Roll left and right**
			B. **Sit to lying**
			C. **Lying to sitting on the side of the bed**
			D. **Sit to stand**
			E. **Chair/bed-to-chair transfer**
			F. **Toilet transfer**
			G. **Tub/shower transfer**
			H. **Locomotion 10 feet in a room, corridor, or similar space**
			I. **Locomotion 50 feet with two turns** *(shorter distance outside of the room)*
			J. **Locomotion 150 feet** *(longer distance)*

Section G: Functional Abilities and Goals

G0300. Mobility Devices

Check all that apply in the last 7 days:

- ☐ A. **Cane/crutch**
- ☐ B. **Walker**
- ☐ C. **Wheelchair** *(manual or electric)*
- ☐ D. **Limb prosthesis**
- ☐ Z. **None of the above**

G0400. IADL Self-Performance

Code for all that apply in the LAST 30 DAYS:

Enter code ☐

A. **Resident arranged for suitable transportation to get to appointments, outings, and necessary engagements.**
1. **Independent -** No help provided *(with/without assistive devices)*
2. **Done with help -** Resident involved in activity but had assistance *(including supervision, reminders, and/or physical help)*
3. **Done by others -** Others do the full performance of the activity *(resident is not involved at all when the activity is performed)*
9. **None of the above -** Activity did not occur in the last 30 days

Enter code ☐

B. **Resident managed finances, including banking, handling checkbooks, and paying bills.**
1. **Independent -** No help provided *(with/without assistive devices)*
2. **Done with help -** Resident involved in activity but had assistance *(including supervision, reminders, and/or physical help)*
3. **Done by others -** Others do full performance of the activity *(resident is not involved at all when the activity is performed)*
9. **None of the above -** Activity did not occur in the last 30 days

Enter code ☐

C. **Resident managed cash and personal needs allowance**
1. **Independent -** No help provided *(with/without assistive devices)*
2. **Done with help -** Resident involved in activity but had assistance *(including supervision, reminders, and/or physical help)*
3. **Done by others -** Others do full performance of the activity *(resident is not involved at all when the activity is performed)*
9. **None of the above -** Activity did not occur in the last 30 days

Enter code ☐

D. **Resident used phone**
1. **Independent -** No help provided *(with/without assistive devices)*
2. **Done with help -** Resident involved in activity but had assistance *(including supervision, reminders, and/or physical help)*
3. **Done by others -** Others do full performance of the activity *(resident is not involved at all when the activity is performed)*
9. **None of the above -** Activity did not occur in the last 30 days

G0500. Transportation

Code for all that apply in the LAST 30 DAYS:

- ☐ A. **Resident drove a car or used public transportation independently** to get to medical or dental appointments, necessary engagements, or other activities.
- ☐ B. **Resident rode to destination** (*with staff, family, or others*) but did NOT require support to attend medical or dental appointments, necessary engagements, or other activities.
- ☐ C. **Resident rode to destination** (*with staff, family, or others*) *and* required support to attend medical or dental appointments, necessary engagements, or other activities.
- ☐ Z. **None of the above**

Section H: Bladder and Bowel

H0100. Appliances

Check all that apply:

- ☐ A. **Indwelling catheter** *(including suprapubic catheter and nephrostomy tube)*
- ☐ B. **External catheter**
- ☐ C. **Ostomy** *(including urostomy, ileostomy, and colostomy)*
- ☐ D. **Intermittent catheterization**
- ☐ Z. **None of the above**

H0200. Urinary Continence

Enter code ☐

Select the one category that best describes the resident:

0. **Always continent**
1. **Occasionally incontinent** *(less than 7 episodes of incontinence)*
2. **Frequently incontinent** *(7 or more episodes of urinary incontinence, but at least one episode of continent voiding)*
3. **Always incontinent** *(no episodes of continent voiding)*
9. **None of the above** - resident had a catheter *(indwelling, condom, urinary ostomy)* or no urine output for the entire 7 days

H0300. Urinary Toileting Program

Enter code ☐

Is a toileting program currently being used to manage the resident's urinary continence? *(e.g., scheduled toileting, prompted voiding, or bladder training)*

0. **No**
1. **Yes**

H0400. Use and Management of Incontinence Supplies

Enter code ☐

Resident's use and management of incontinence supplies in the LAST 14 DAYS *(pads, briefs, ostomy, catheter)*

0. **Incontinence supplies not used**
1. **Resident is incontinent** and able to manage incontinence supplies independently
2. **Resident is incontinent** and requires assistance to manage incontinence supplies
3. **Resident is incontinent** and unable to manage incontinence supplies

H0500. Bowel Continence

Enter code ☐

Select one category that best describes the resident:

0. **Always continent**
1. **Occasionally incontinent** *(one episode of bowel incontinence)*
2. **Frequently incontinent** *(2 or more episodes of bowel incontinence, but at least one continent bowel movement)*
3. **Always incontinent** *(no episodes of continent bowel movements)*
9. **None of the above -** resident had an ostomy or did not have a bowel movement for the entire 7 days

H0600. Bowel Toileting Program

Enter code ☐

Is a toileting program currently being used to manage the resident's bowel continence? *(e.g., scheduled toileting)*

0. **No**
1. **Yes**

H0700. Bowel Elimination Pattern

Check all that apply:

- ☐ A. **Bowel elimination pattern regular** *(at least one movement every three days)*
- ☐ B. **Constipation**
- ☐ C. **Diarrhea**
- ☐ D. **Fecal impaction**
- ☐ E. **Resident is independent**
- ☐ Z. **None of the above**

Section I: Active Diagnoses

Active Diagnoses in the LAST 7 DAYS. Check all that apply:
(Diagnoses listed in parentheses are provided as examples and should not be considered all-inclusive lists)

CANCER

- ☐ **I0100. Cancer** *(with or without metastasis)*

HEART/CIRCULATION

- ☐ **I0200. Anemia** *(e.g., aplastic, iron deficiency, pernicious, and sickle cell)*
- ☐ **I0300. Atrial Fibrillation or Other Dysrhythmias** *(e.g., bradycardias and tachycardias)*
- ☐ **I0400. Coronary Artery Disease (CAD)** *(e.g., angina, myocardial infarction, and atherosclerotic heart disease)*
- ☐ **I0500. Deep Venous Thrombosis (DVT), Pulmonary Embolus (PE), or Pulmonary Thrombo-Embolism (PTE)**
- ☐ **I0600. Heart Failure** *(e.g., congestive heart failure [CHF] and pulmonary edema)*
- ☐ **I0700. Hypertension**
- ☐ **I0800. Orthostatic Hypotension**
- ☐ **I0900. Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)**

GASTROINTESTINAL

- ☐ **I1000. Cirrhosis**
- ☐ **I1100. Gastroesophageal Reflux Disease (GERD) or Ulcer** *(e.g., esophageal, gastric, and peptic ulcers)*
- ☐ **I1200. Ulcerative Colitis, Crohn's Disease, or Inflammatory Bowel Disease**

GENITOURINARY

- ☐ **I1300. Benign Prostatic Hyperplasia (BPH)**
- ☐ **I1400. Neurogenic Bladder**
- ☐ **I1500. Obstructive Uropathy**
- ☐ **I1600. Renal Insufficiency, Renal Failure, or End-Stage Renal Disease (ESRD)**

INFECTIONS

- ☐ **I1700. Multidrug-Resistant Organism (MDRO)**
- ☐ **I1800. Pneumonia**
- ☐ **I1900. Septicemia**
- ☐ **I2000. Tuberculosis**
- ☐ **I2100. Urinary Tract Infection (UTI) - LAST 30 DAYS**
- ☐ **I2200. Viral Hepatitis** *(e.g., Hepatitis A, B, C, D, and E)*
- ☐ **I2300. Wound Infection** *(other than foot)*

METABOLIC

- ☐ **I2400. Diabetes Mellitus (DM)** *(e.g., diabetic retinopathy, nephropathy, and neuropathy)*
- ☐ **I2500. Hyperkalemia**
- ☐ **I2600. Hyperlipidemia** *(e.g., hypercholesterolemia)*
- ☐ **I2700. Hyponatremia**
- ☐ **I2800. Thyroid Disorder** *(e.g., hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)*

MUSCULOSKELETAL

- ☐ **I2900. Arthritis** *(e.g., degenerative joint disease [DJD], osteoarthritis, and rheumatoid arthritis [RA])*
- ☐ **I3000. Hip Fracture - any hip fracture that has a relationship to current status, treatments, or monitoring** *(e.g., sub-capital fractures and fractures of the trochanter and femoral neck)*
- ☐ **I3100. Osteoporosis**
- ☐ **I3200. Other Fracture**

Section I: Active Diagnoses

Active Diagnoses in the LAST 7 DAYS. Check all that apply:
(Diagnoses listed in parentheses are provided as examples and should not be considered all-inclusive lists)

NEUROLOGICAL

- ☐ **I3300. Acquired Brain Injury**
- ☐ **I3400. Alzheimer's Disease**
- ☐ **I3500. Aphasia**
- ☐ **I3600. Cerebral Palsy**
- ☐ **I3700. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
- ☐ **I3800. Hemiplegia or Hemiparesis**
- ☐ **I3900. Huntington's Disease**
- ☐ **I4000. Multiple Sclerosis (MS)**
- ☐ **I4100. Non-Alzheimer's Dementia** *(e.g., Lewy body dementia, vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)*
- ☐ **I4200. Paraplegia**
- ☐ **I4300. Parkinson's Disease**
- ☐ **I4400. Quadriplegia**
- ☐ **I4500. Seizure Disorder or Epilepsy**
- ☐ **I4600. Tourette's Syndrome**
- ☐ **I4700. Traumatic Brain Injury (TBI)**

NUTRITIONAL

- ☐ **I4800. Malnutrition** *(protein or calorie)* **or at risk for malnutrition**

PSYCHIATRIC/MOOD DISORDER

- ☐ **I4900. Anxiety Disorder**
- ☐ **I5000. Bipolar Disorder**
- ☐ **I5100. Depression** *(other than bipolar)*
- ☐ **I5200. Post Traumatic Stress Disorder (PTSD)**
- ☐ **I5300. Schizophrenia** *(e.g., schizoaffective and schizophreniform disorders)*
- ☐ **I5400. Substance Abuse Disorder**

PULMONARY

- ☐ **I5500. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** *(e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)*
- ☐ **I5600. Respiratory Failure**

VISION

- ☐ **I5700. Cataracts, Glaucoma, or Macular Degeneration**

NONE OF ABOVE

- ☐ **I5800. None of the above active diagnoses within the last 7 days**

Section I: Active Diagnoses

Active Diagnoses in the LAST 7 DAYS. Check all that apply:
(Diagnoses listed in parentheses are provided as examples and should not be considered all-inclusive lists)

OTHER

I5900. Additional active diagnoses *(enter the diagnosis online and the ICD code in boxes. Include the decimal for the code in the appropriate box)*

A. ICD code:		
B. ICD code:		
C. ICD code:		
D. ICD code:		
E. ICD code:		
F. ICD code:		
G. ICD code:		
H. ICD code:		
I. ICD code:		
J. ICD code:		

Section J: Health Conditions

J0100. Problem Conditions

Check all that apply

- ☐ A. **Fever**
- ☐ B. **Vomiting**
- ☐ C. **Dehydrated**
- ☐ D. **Internal bleeding**
- ☐ E. **Dizziness/vertigo**
- ☐ F. **Edema**
- ☐ Z. **None of the above**

J0200. Shortness of Breath *(dyspnea)*

Check all that apply:

- ☐ A. **Shortness of breath or trouble breathing with exertion** *(e.g., walking, bathing, transferring)*
- ☐ B. **Shortness of breath or trouble breathing when sitting at rest**
- ☐ C. **Shortness of breath or trouble breathing when lying flat**
- ☐ Z. **None of the above**

J0300. Current Tobacco Use

Enter code ☐

Does the resident use tobacco products?

0. **No**
1. **Yes**

J0400. Prognosis

Enter code ☐

Does the resident have a condition or chronic disease that may result in a life expectancy of LESS THAN 6 MONTHS? (*Requires physician documentation*)

0. **No**
1. **Yes**

J0500. Indicators of Pain or Possible Pain in the LAST 5 DAYS

Check all that apply:

- ☐ A. **Non-verbal sounds** *(e.g., crying, whining, gasping, moaning, or groaning)*
- ☐ B. **Vocal complaints of pain** *(e.g., that hurts, ouch, stop)*
- ☐ C. **Facial expressions** *(e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)*
- ☐ D. **Protective body movements or postures** *(e.g., bracing, guarding, rubbing or massaging a body part/ area, clutching or holding a body part during movement)*
- ☐ Z. **None of the above**

J0600. Frequency of Indicator of Pain or Possible Pain in the LAST 5 DAYS

Enter code ☐

Frequency with which resident complains or shows evidence of pain or possible pain

1. **Indicators of pain or possible pain observed 1 to 2 days**
2. **Indicators of pain or possible pain observed 3 to 4 days**
3. **Indicators of pain or possible pain observed daily**

Section K: Swallowing/Nutritional Status

K0100. Height and Weight *(while measuring, if the number is X.1-X.4, round down; X.5 or greater, round up)*

Enter number

A. Height *(in inches)* Record the most recent height measure since the most recent admission/entry or reentry

Enter number

B. Weight *(in pounds)* Base weight on the most recent measure in the last 30 days; measure weight consistently, according to standard facility practice *(e.g., in a.m. after voiding, before a meal, with shoes off, etc.)*

K0200. Weight Loss

Enter number

Loss of 5% or more in the last month or loss of 10% or more in the last 6 months

0. **No or unknown**
1. **Yes, on a physician-prescribed weight-loss regimen**
2. **Yes, not on a physician-prescribed weight-loss regimen**

K0300. Weight Gain

Enter number

Gain of 5% or more in the last month or gain of 10% or more in the last 6 months

0. **No or unknown**
1. **Yes - on a physician-prescribed weight-gain regimen**
2. **Yes - not on a physician-prescribed weight-gain regimen**

K0400. Nutritional Problems or Approaches

Check all that apply:

- A. **Leaves 50% of food uneaten at most meals**
- B. **Noncompliance with diet**
- C. **Feeding tube** *(e.g., nasogastric or abdominal (PEG))*
- D. **Mechanically altered diet – requires a change in the texture of food or liquids** *(e.g., pureed food, thickened liquids)*
- E. **Therapeutic diet** *(e.g., low salt, diabetic, low cholesterol)*
- Z. **None of the above**

K0500. Swallowing Disorder

Signs and symptoms of possible swallowing disorder. Check all that apply:

- A. **Loss of liquids/solids from mouth when eating or drinking**
- B. **Holding food in mouth/cheeks or residual food in mouth after meals**
- C. **Coughing or choking during meals or when swallowing medications**
- D. **Complaints of difficulty or pain with swallowing**
- Z. **None of the above**

Section L: Oral/Dental Status

L0100. Dental

Check all that apply:

- ☐ A. **Has well-fitting dentures or removable bridge**
- ☐ B. **Broken or loosely fitting full or partial denture** *(chipped, cracked, uncleanable, or loose)*
- ☐ C. **No natural teeth or tooth fragment(s)** *(edentulous)*
- ☐ D. **Abnormal mouth tissue** *(ulcers, masses, oral lesions, including under denture or partial if one is worn)*
- ☐ E. **Obvious or likely cavity or broken natural teeth**
- ☐ F. **Inflamed or bleeding gums or loose natural teeth**
- ☐ G. **Mouth or facial pain, discomfort, or difficulty chewing**
- ☐ H. **Unable to examine**
- ☐ Z. **None of the above**

Section M: Skin Conditions

M0100. Risk of Pressure Ulcers/Injuries

Enter code ☐

Is this resident at risk of developing pressure ulcers/injuries?

0. **No**
1. **Yes**

M0200. Unhealed Pressure Ulcers/Injuries

Enter code ☐

Does this resident have one or more unhealed pressure ulcers/injuries?

0. **No** → Skip to M0500, Number of Venous and Arterial Ulcers
1. **Yes**

M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

Record the number of pressure ulcers:

Enter number ☐	A. **Stage 1 -** Intact skin with non-blanchable redness of a localized area, usually over a bony prominence. Darkly pigmented skin may not have visible blanching; in dark skin tones only, it may appear with blue or purple hues.
Enter number ☐	B. **Stage 2 -** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. It may also present as an intact or open/ruptured blister.
Enter number ☐	C. **Stage 3 -** Full-thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. This may include undermining and tunneling.
Enter number ☐	D. **Stage 4 -** Full-thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.
Enter number ☐	E. **Unstageable -** Non-removable dressing/device: Known but not stageable due to non-removable dressing/device.
Enter number ☐	F. **Unstageable -** Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar
Enter number ☐	G. **Unstageable -** Deep tissue injury

M0400. Number of Venous and Arterial Ulcers

Enter number ☐

Enter the total number of circulatory *(venous or arterial)* **ulcers present** (e*nter "0" if none are present*)

M0500. Other Ulcers, Wounds and Skin Problems

Foot Problems - Check all that apply:

- ☐ A. **Infection of the foot** *(e.g., cellulitis, purulent drainage)*
- ☐ B. **Diabetic foot ulcer(s)**
- ☐ C. **Other open lesion(s) on the foot**

Other Skin Problems - Check all that apply:

- ☐ D. **Open lesion(*s*) other than ulcers, rashes, or cuts** (*e.g., cancer lesion*)
- ☐ E. **Rashes, itchiness, or body lice**
- ☐ F. **Surgical wound(s)**
- ☐ G. **Burn(s)** *(second or third degree)*
- ☐ H. **Skin tear(s)**
- ☐ I. **Moisture Associated Skin Damage** (*MASD*) (*e.g., incontinence-associated dermatitis [IAD], perspiration, drainage*)
- ☐ J. **Other skin problems** Specify:

None of the Above

- ☐ Z. **None of the above**

Section M: Skin Conditions

M0600. Skin and Ulcer/Injury Treatments

Check all that apply:

☐	A. **Pressure-reducing device for chair**
☐	B. **Pressure-reducing device for bed**
☐	C. **Turning/repositioning program**
☐	D. **Nutrition or hydration intervention to manage skin problems**
☐	E. **Pressure ulcer/injury care**
☐	F. **Surgical wound care**
☐	G. **Application of nonsurgical dressings other than to feet** *(with or without topical medications)*
☐	H. **Applications of ointments/medications other than to feet**
☐	I. **Application of dressings to feet** *(with or without topical medications)*
☐	Z. **None of the above**

Section N: Medications

N0100. New or Changed Medications

Enter code ☐

A. **The resident is currently receiving *new* medications that were started within the LAST 90 DAYS**.
0. **No**
1. **Yes**

Enter code ☐

B. **The resident received *changes* to existing medications within the LAST 90 DAYS**.
0. **No**
1. **Yes**

N0200. Injections

Enter number ☐

Record the number of days that injection of any type was received within the last 7 days or since admission/entry or reentry if less than 7 days.

N0300. Insulin

Enter number ☐

A. **Insulin injections** - Record the number of days that insulin injections were received within the last 7 days or since admission/entry or reentry if less than 7 days.

Enter number ☐

B. **Orders for insulin** - Record the number of days the physician *(or authorized assistant or practitioner)* changed the resident's insulin orders within the last 7 days or since admission/entry or reentry if less than 7 days.

N0400. High-Risk Drug Classes: Use

Check all that apply:

☐ A. **Antipsychotic**
☐ B. **Antianxiety**
☐ C. **Antidepressant**
☐ D. **Hypnotic**
☐ E. **Antibiotic**
☐ F. **Diuretic**
☐ G. **Opioid**
☐ H. **Anticoagulant or antiplatelet**
☐ I. **Medications used to treat Diabetes** *(including insulin)*
☐ J. **Dementia medications**
☐ K. **Anticonvulsant**
☐ Z. **None of the above**

N0500. Self-Administered Medications

Did the resident self-administer any of the following in the last 7 days? Check all that apply:

☐ A. **Oxygen**
☐ B. **Inhaler**
☐ C. **Over-the-counter**
☐ D. **Other** *(specify)* _____
☐ Z. **None of the above**

N0600. Medication Preparation Administration

Enter code ☐

Did the resident prepare and administer their own medication in the last 7 days?
0. **No**
1. **Yes**

Section N: Medications

N0700. Antipsychotic Medication Review

Enter code ☐

A. **Did the resident receive antipsychotic medications since admission/entry or reentry or the prior assessment, whichever is more recent?**
0. **No** → Skip to N0800, Influenza vaccine
1. **Yes** - Antipsychotics were received on a routine basis only
2. **Yes** - Antipsychotics were received on a PRN basis only
3. **Yes** - Antipsychotics were received on a routine and PRN basis

Enter code ☐

B. **Has a gradual dose reduction (GDR) been attempted?**
0. **No** → Skip to N0800, Influenza vaccine
1. **Yes**

C. **Date of last attempted GDR:**

☐☐ - ☐☐ - ☐☐☐☐
M M D D Y Y Y Y

Enter code ☐

D. **Physician documented GDR as clinically contraindicated.**
0. **No**
1. **Yes**

E. **Date physician documented GDR as clinically contraindicated:**

☐☐ - ☐☐ - ☐☐☐☐
M M D D Y Y Y Y

N0800. Influenza Vaccine

Enter code ☐

A. **Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season?**
0. **No** → Skip to N0800C, Reason influenza vaccine not received
1. **Yes**

B. **Date of influenza vaccine** → Skip to N0900, Pneumococcal vaccination

☐☐ - ☐☐ - ☐☐☐☐
M M D D Y Y Y Y

Enter code ☐

C. **If the influenza vaccine was not received, state the reason:**
1. **Resident not in this facility during this year's influenza vaccination season**
2. **Received outside of this facility**
3. **Not eligible - medical contraindication**
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain influenza vaccine due to a declared shortage**
9. **None of the above**

N0900. Pneumococcal Vaccine

Enter code ☐

A. **Is the resident's pneumococcal vaccination up to date?**
0. **No**
1. **Yes**

Enter code ☐

B. **If the pneumococcal vaccine was not received, state the reason:**
1. **Not eligible** (*medical contraindication)*
2. **Offered and declined**
3. **Not offered**

N1000. COVID-19 Vaccine

Enter code ☐

A. **Is the resident's COVID-19 vaccination up to date?**
0. **No**
1. **Yes**

Enter code ☐

B. **If the COVID-19 vaccine was not received, state the reason:**
1. **Not eligible** (*medical contraindication)*
2. **Offered and declined**
3. **Not offered**

Section O: Special Treatments, Procedures, and Programs

O0100. Special Care

Has the resident received any of the following in the **LAST 14 DAYS**? Check all that apply:

- ☐ A. **Alcohol/drug treatment**
- ☐ B. **Chemotherapy**
- ☐ C. **Radiation**
- ☐ D. **Oxygen therapy**
- ☐ E. **BiPAP or CPAP**
- ☐ F. **IV access**
- ☐ G. **IV medications**
- ☐ H. **Transfusions**
- ☐ I. **Dialysis**
- ☐ J. **Hospice Care**
- ☐ K. **Isolation or quarantine for active infectious disease** *(does not include standard body/fluid precautions)*
- ☐ Z. **None of the above**

O0200. Therapies

Record the number of days each of the following therapies were administered in the last 7 calendar days *(for at least 15 minutes a day)*

		1. On-site	2. Off-site
Enter number ☐	A. **Respiratory therapy**	☐	☐
Enter number ☐	B. **Psychological therapy** *(by any licensed mental health professional)*	☐	☐
Enter number ☐	C. **Speech-Language Pathology**	☐	☐
Enter number ☐	D. **Occupational Therapy**	☐	☐
Enter number ☐	E. **Physical Therapy**	☐	☐

O0300. Need for On-going Monitoring

A. **Acute physical or psychiatric condition** *(not chronic)*

Enter code ☐

0. **No monitoring is required**
1. **Facility nurse**
2. **Facility other staff**
3. **Home health nurse**

B. **New treatment or medication**

Enter code ☐

0. **No monitoring is required**
1. **Facility nurse**
2. **Facility other staff**
3. **Home health nurse**

Section O: Special Treatments, Procedures, and Programs

O0400. Rehabilitation/Restorative Care

Record the number of days each of the following restorative programs was performed in the last 7 calendar days for at least 15 minutes a day *(enter 0 if none or less than 15 minutes daily)*

Enter number	
	A. **Range of motion** *(passive)*
	B. **Range of motion** *(active)*
	C. **Splint or brace assistance**
	D. **Bed mobility**
	E. **Transfer**
	F. **Walking**
	G. **Dressing and/or grooming**
	H. **Eating and/or swallowing**
	I. **Amputation/prostheses care**
	J. **Communication**

O0500. General Hospital Stay(s)

Enter number

How many times was the resident admitted to an acute care hospital with an overnight stay in the **LAST 6 MONTHS**?

O0600. Emergency Room Visit(s)

Enter number

How many times did the resident visit an ER without an overnight stay in the **LAST 6 MONTHS**?

O0700. Physician Visits

Enter number

On how many days has a physician examined the resident in the **LAST 6 MONTHS**?

O0800. Physician Orders

Enter number

How many days has a physician changed the resident's orders in the last 14 days?

O0900. Psychiatric Hospital Stay(s)

Enter number

How many times was the resident admitted to a psychiatric hospital with an overnight stay in the **LAST 6 MONTHS**?

O1000. Outpatient Procedures

Enter number

How many times has the resident had outpatient procedures in the **LAST 6 MONTHS**?

Section P: Restraints and Alarms

P0100. Physical Restraints

Physical restraints are any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body.

Coding:

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

Used in Bed

Enter Code ☐ A. **Bedrail**

Enter Code ☐ B. **Trunk restraint**

Enter Code ☐ C. **Limb restraint**

Enter Code ☐ D. **Other** *(specify)* _____

Used in Chair or Out of Bed

Enter Code ☐ E. **Trunk restraint**

Enter Code ☐ F. **Limb restraint**

Enter Code ☐ G. **Chair prevents rising**

Enter Code ☐ H. **Other** *(specify)* _____

P0200. Alarms

An alarm is any physical or electronic device that monitors resident movement and alerts the staff when movement is detected.

Coding:

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

Enter Code ☐ A. **Bed alarm**

Enter Code ☐ B. **Chair alarm**

Enter Code ☐ C. **Floor mat alarm**

Enter Code ☐ D. **Motion sensor alarm**

Enter Code ☐ E. **Wander/elopement alarm**

Enter Code ☐ F. **Other** *(specify)* _____

Section Q: Participation in Discharge Planning and Goal Setting

Q0100. Conflict

Enter code

A. **Any disagreement between resident and family about goals or the service plan?**
0. **No**
1. **Yes**

Enter code

B. **Any disagreement between resident/family and staff about goals or the service plan?**
0. **No**
1. **Yes**

Q0200. Participation in Discharge Planning and Goal Setting

Identify all active participants in the assessment process. Check all that apply:

- ☐ A. **Resident**
- ☐ B. **Family**
- ☐ C. **Significant other**
- ☐ D. **Legal guardian**
- ☐ E. **Other legally authorized representative**
- ☐ Z. **None of the above**

Q0300. Resident's Overall Goal

Enter code

A. **The resident's overall goal for discharge was established during the assessment process.**
1. **Discharge to the community**
2. **Remain in the facility**
3. **Discharge to another facility/institution**
9. **Unknown or uncertain**

Enter code

B. **Indicate information source for Q0300A:**
1. **Resident**
2. **Family**
3. **Significant other**
4. **Legal guardian**
5. **Other legally authorized representative**
9. **None of the above**

Q0400. Return to Community

Enter code

A. **Does the resident wish to talk to someone about leaving this facility to live and receive services in the community?**
0. **No**
1. **Yes**

Enter code

B. **Indicate information source for Q0400A:**
1. **Resident**
2. **Family**
3. **Significant other**
4. **Facility staff**
5. **Legal guardian**
6. **Other legally authorized representative**
9. **None of the above**

Q0500. Referral

Enter code

Has a referral been made to the Local Contact Agency (LCA) within the last calendar year?
0. **No**
1. **Yes**

Section X: Correction/Inactivation Request

X0100. Type of Provider *(A0300 on existing record to be modified/inactivated)*

Enter code

Type of provider

1. **Residential Care Level IV PNMI** (*RCF*)
2. **Adult Family Care Home** (*AFCH*)

X0200. Type of Assessment

Enter Code

A. **Reason for assessment** *(A0400A on existing record to be modified/inactivated)*

01. **Admission assessment** (*REQUIRED BY DAY 14*)
02. **Annual assessment**
03. **Semi-annual assessment**
04. **Significant change in status assessment**
05. **Significant correction to prior comprehensive assessment**
06. **Significant correction to prior quarterly assessment**
99. **None of the above**

Enter Code

B. **Entry/discharge reporting** *(A0400B on existing record to be modified/inactivated)*

01. **Entry tracking record**
02. **Discharge assessment -** return not anticipated
03. **Discharge assessment -** return anticipated
04. **Death in facility -** tracking record
05. **Discharge prior to completion of assessment**
99. **None of the above**

X0300. Legal Name of Resident *(A0500 on existing record to be modified/inactivated)*

A. **First Name:**

B. **Middle Initial**

C. **Last Name:**

D. **Suffix:**

X0400. Social Security Number *(A0600 on existing record to be modified/inactivated)*

___ - __ - ____

X0500. Gender *(A0700 on existing record to be modified/inactivated)*

Enter code

1. **Male**
2. **Female**
3. **X**

X0600. Birth Date *(A0800 on existing record to be modified/inactivated)*

M M - D D - Y Y Y Y

X0700. Assessment Reference Date *(A0900 on existing record to be modified/inactivated)*

M M - D D - Y Y Y Y

X0800. Date of Death or Discharge *(A1800 on existing record to be modified/inactivated)*

M M - D D - Y Y Y Y

X0900. Date of Entry/Reentry *(A1200 on existing record to be modified/inactivated)*

M M - D D - Y Y Y Y

X1000. Correction Number

Enter number

Enter the number of correction requests to modify/inactivate the existing record, including the present one.

Section X: Correction/Inactivation Request

X1100. Reasons for Modification

Check all that apply:

- ☐ A. **Transcription error**
- ☐ B. **Data entry error**
- ☐ C. **Software product error**
- ☐ D. **Item coding error**
- ☐ E. **Other errors requiring modification**

X1200. Reasons for Inactivation

Check all that apply:

- ☐ A. **The event did not occur**
- ☐ B. **Test record submitted as production record**
- ☐ C. **Inadvertent submission of non-required record**
- ☐ D. **Other errors requiring inactivation**

X1300. Attesting Individual's First Name

X1400. Attesting Individual's Last Name

X1500. Signature

_____

X1600. Attestation Date

		-			-				
M	M		D	D		Y	Y	Y	Y

Section Z: Assessment Administration

Z0100. Assessment Information

MaineCare Billing Group *(calculated by software)*

Z0200. Attestation

Attestation Statement: I certify that the accompanying information accurately reflects assessment information for this resident and that I collected or coordinated the collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable MaineCare requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care and as a basis for payment from state and federal funds. I further understand that payment of such state and federal funds and continued participation in government-funded health care programs is conditioned on the accuracy and truthfulness of this information. I may be held personally accountable for or may subject my organization to criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information for this facility and on its behalf.

A. **Signature(s) of the person(s) completing this form:**
(write "ALL" for sections completed if the person signing completed sections A - Z)

1. _____
Signature | Title | Section(s) Completed | Date

2. _____
Signature | Title | Section(s) Completed | Date

3. _____
Signature | Title | Section(s) Completed | Date

4. _____
Signature | Title | Section(s) Completed | Date

B. **Coordinator signature:**

1. _____
Signature | Title | Date

Discharge Assessment

A0100. Type of Record

Enter code ☐

1. **Add a new record**
2. **Modify an existing record**
3. **Inactivate an existing record** → Skip to X0100, Type of Provider

A0200. Type of Assessment

A. **Facility Name:** _____

B. **National Provider Identifier** (*NPI*): ☐☐☐☐☐☐☐☐☐☐

C. **State Provider Number** (*NPI+3*): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0300. Type of Provider

Enter code ☐

Type of provider

1. **Residential Care Level IV PNMI (RCF)**
2. **Adult Family Care Home (AFCH)**

A0400. Type of Assessment

Enter Code ☐☐

B. **Entry/discharge reporting**

01. **Entry tracking record**
02. **Discharge assessment** – *return not anticipated*
03. **Discharge assessment** – *return anticipated*
04. **Death in facility** – *tracking record*
05. **Discharge prior to completion of assessment**
99. **None of the above**

A0500. Legal Name of Resident

A. **First Name:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

B. **Middle Initial:** ☐

C. **Last Name:** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. **Suffix:** ☐☐☐

A0600. Social Security Number

☐☐☐ - ☐☐ - ☐☐☐☐

A0700. Gender

Enter code ☐

1. **Male**
2. **Female**
3. **X**

A0800. Birth Date

☐☐ - ☐☐ - ☐☐☐☐

M M D D Y Y Y Y

A1000. MaineCare Number

Record a "+" if pending "N" if not a MaineCare recipient.

☐☐☐☐☐☐☐☐☐

A1400. Date of Admission

On what date did the resident's stay begin? *(Note – Does not include readmission if the record was closed at the time of temporary discharge to hospital, etc. In such cases, use the prior admission date.)*

☐☐ - ☐☐ - ☐☐☐☐

M M D D Y Y Y Y

Discharge Assessment

A1800. Date of Death or Discharge

M M - D D - Y Y Y Y

A1900. Discharge Status

Enter Code

Where was the resident discharged to?

01. **Home/Community** *(e.g., private home/apt., board/care, assisted living, group home, transitional living, other residential care)*
02. **Nursing home** *(long-term care facility)*
03. **Skilled Nursing Facility** *(SNF, swing beds)*
04. **Short-Term General Hospital** *(acute hospital, IPPS)*
05. **Long-Term Care Hospital** *(LTCH)*
06. **Inpatient Rehabilitation Facility** *(IRF, free-standing facility or unit)*
07. **Inpatient Psychiatric Facility** *(psychiatric hospital or unit)*
08. **ID/DD facility**
09. **Hospice** *(home/non-institutional)*
10. **Hospice** *(institutional facility)*
11. **Critical Access Hospital** *(CAH)*
12. **Home under the care of an organized home health service organization**
13. **Home with no home health service care**
14. **Deceased**
99. **Not listed**

A2000. Provision of Current Reconciled Medication List to Subsequent Provider at Discharge

Enter Code

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the subsequent provider?

0. **No**
1. **Yes**

A2100. Provision of Current Reconciled Medication List to Resident at Discharge

Enter Code

At the time of discharge to another provider, did your facility provide the resident's current reconciled medication list to the resident?

0. **No**
1. **Yes**

X0100. Type of Provider *(A0300 on existing record to be modified/inactivated)*

Enter Code

Type of provider

A. **Residential Care Level IV PNMI** (*RCF*)
B. **Adult Family Care Home** (*AFCH*)

X0200. Type of Assessment

Enter Code

B. **Entry/discharge reporting** *(A0400B on existing record to be modified/inactivated)*

01. **Entry tracking record**
02. **Discharge assessment - return not anticipated**
03. **Discharge assessment - return anticipated**
04. **Death in facility - tracking record**
05. **Discharge prior to completion of assessment**
99. **None of the above**

X0300. Legal Name of Resident *(A0500 on existing record to be modified/inactivated)*

B. **First Name:**

B**. Middle Initial:**

C**. Last Name:**

D**. Suffix:**

X0400. Social Security Number *(A0600 on existing record to be modified/inactivated)*

- -

Discharge Assessment

X0500. Gender *(A0700 on existing record to be modified/inactivated)*

Enter Code

1. **Male**
2. **Female**
3. **X**

X0600. Birth Date *(A0800 on existing record to be modified/inactivated)*

M M - D D - Y Y Y Y

X0800. Date of Death or Discharge *(A1800 on existing record to be modified/inactivated)*

M M - D D - Y Y Y Y

X0900. Date of Entry/Reentry *(A1200 on existing record to be modified/inactivated)*

M M - D D - Y Y Y Y

X1000. Correction Number

Enter Code

Enter the number of correction requests to modify/inactivate the existing record, including the present one.

X1100. Reasons for Modification

Check all that apply:

- A. **Transcription error**
- B. **Data entry error**
- C. **Software product error**
- D. **Item coding error**
- E. **Other errors requiring modification**

X1200. Reasons for Inactivation

Check all that apply:

- A. **The event did not occur**
- B. **Test record submitted as production record**
- C. **Inadvertent submission of non-required record**
- D. **Other errors requiring inactivation**
- E. **The event did not occur**

X1300. Attesting Individual's First Name

X1400. Attesting Individual's Last Name

X1500. Signature

X1600. Attestation Date

M M - D D - Y Y Y Y

Discharge Assessment

Z0200. Attestation

Attestation Statement: I certify that the accompanying information accurately reflects assessment information for this resident and that I collected or coordinated the collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable MaineCare requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care and as a basis for payment from state and federal funds. I further understand that payment of such state and federal funds and continued participation in government-funded health care programs is conditioned on the accuracy and truthfulness of this information. I may be held personally accountable for or may subject my organization to criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information for this facility and on its behalf.

A. **Signature(s) of the person(s) completing this form:**

(write "ALL" for sections completed if the person signing completed sections A - Z)

1.

Signature	Title	Sections Complete	Date

2.

Signature	Title	Sections Complete	Date

3.

Signature	Title	Sections Complete	Date

4.

Signature	Title	Sections Complete	Date

B. **Coordinator signature:**

1.

Signature	Title	Sections Complete	Date