Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

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

Enter code ☐☐

A. **Reason for assessment:**

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

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. **Non-binary**

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section A: Identification and Background Information

A0800. Birth Date

		-			-				
M	M		D	D		Y	Y	Y	Y

A0900. Assessment Reference Date *(ARD)*

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 Source for Stay

Check the payer source at the time of the ARD:
(Billing Office to indicate)

- ☐ 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

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section A: Identification and Background Information

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 admission)*

Did the resident live alone prior to admission?

Enter code ☐

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

A1700. Primary Zip Code *(prior to admission)*

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

☐☐☐☐☐☐☐☐☐☐

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**

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section A: Identification and Background Information

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

Enter code ☐

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

0. **No**
1. **Yes**
2. **Not applicable**

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

Enter code ☐

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

0. **No**
1. **Yes**
2. **Not applicable**

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

Enter code ☐

Has the resident received a level I PASRR assessment?

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 assessment?**

0. **No** → Skip to A2400A, Conditions related to ID/DD
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**

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**

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section A: Identification and Background Information

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 living will?**
- ☐ B. **Does the resident have a DNR directive?**
- ☐ C. **Does the resident have a directive to not hospitalize?**
- ☐ D. **Does the resident have a directive not to intubate?**
- ☐ E. **Does the resident have feeding restrictions?**
- ☐ F. **Does the resident have a directive to donate organs?**
- ☐ G. **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**

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

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?** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
Enter code ☐	B. **Does the resident need or want an interpreter to communicate with a doctor or healthcare staff?** 0. **No** 1. **Yes**

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

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 ☐

Were corrective lenses used in completing B0600, Vision?

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

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

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)*

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section D: Mood

D0100. Indicators of Depression, Anxiety, Sad Mood	
A. **Exhibited -** Indicate the frequency of the symptom(s) observed in the **LAST 14 DAYS**, regardless of the 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 -** Indicate how easily altered the mood indicator 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**

D0200. Verbal Expressions of Distress	
A. **Exhibited -** Indicate the frequency of the symptom(s) observed in the **LAST 14 DAYS**, regardless of the 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 -** Indicate how easily altered the mood indicator 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. **Repetitive verbalizations** *(e.g., calling out for help, "God help me")*
☐	☐	b. **Self-deprecation** *(e.g., "I am nothing; I am no use to anyone.")*
☐	☐	c. **Expressions of what appear to be unrealistic fears** *(e.g., fear of being abandoned, left alone, being with others)*
☐	☐	d. **Recurrent statements that something terrible is about to happen** *(e.g. believes he or she is about to die, have a heart attack)*
☐	☐	e. **Repetitive anxious complaints/concerns** - Non-health related *(e.g., persistently seeks attention/reassurance on schedules, meals, laundry, relationship issues, etc.)*
☐	☐	f. **Unpleasant mood in the morning**
☐	☐	g. **Insomnia/change in usual sleep pattern**
☐	☐	h. **Sad, pained, worried facial expressions** *(e.g., furrowed brows)*
☐	☐	i. **Repetitive physical movements** *(e.g., restlessness, fidgeting, picking)*
☐	☐	j. **Reduced social interaction**
☐	☐	k. **Inflated self-worth, exaggerated self-opinion, belief in one's own ability, etc.**
☐	☐	l. **Excited behavior, motor excitation** *(e.g., heightened physical activity, pressured speech; increased reactivity)*

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section E: Behavior

E0100. Potential Indicators of Psychosis

Check all that apply within the LAST 7 DAYS:

- ☐ 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 within the LAST 7 DAYS:

Enter code ☐

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

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days, but less than daily**
3. **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)*

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days, but less than daily**
3. **Behavior of this type occurred 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)*

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days, but less than daily**
3. **Behavior of this type occurred 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 occurred 1 to 3 days**
2. **Behavior of type occurred 4 to 6 days, but less than daily**
3. **Behavior of this type occurred daily**

E0400. Wandering *(Impact on Resident)*

Check all that apply:

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

E0500. Wandering *(Impact on Others)*

Check all that apply:

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

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section E: Behavior

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 occurred 1 to 3 days**
2. **Behavior of type occurred 4 to 6 days, but less than daily**
3. **Behavior of this type occurred daily**

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

Check all that apply:

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

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

Check all that apply:

- ☐ A. **The behavior put others at significant risk for physical illness or injury**
- ☐ B. **The behavior significantly interfered with others' care**
- ☐ C. **The behavior significantly interfered 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 occurred 1 to 3 days**
2. **Behavior of type occurred 4 to 6 days, but less than daily**
3. **Behavior of this type occurred daily**

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

Check all that apply:

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

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

Check all that apply:

- ☐ A. **The behavior put others at significant risk for physical illness or injury**
- ☐ B. **The behavior significantly interfered with others' care**
- ☐ C. **The behavior significantly interfered 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 occurred 1 to 3 days**
2. **Behavior of type occurred 4 to 6 days, but less than daily**
3. **Behavior of this type occurred daily**

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section E: Behavior

E1300. Intimidating Behavior *(Impact on Resident)*

Check all that apply:

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

E1400. Intimidating Behavior *(Impact on Others)*

Check all that apply:

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

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 occurred 1 to 3 days**
2. **Behavior of type occurred 4 to 6 days, but less than daily**
3. **Behavior of this type occurred daily**

E1600. Elopement *(Impact on Resident)*

Check all that apply:

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

E1700. Elopement *(Impact on Others)*

Check all that apply:

- ☐ A. **The behavior put others at significant risk for physical illness or injury**
- ☐ B. **The behavior significantly interfered with others' care**
- ☐ C. **The behavior significantly interfered 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 occurred 1 to 3 days**
2. **Behavior of type occurred 4 to 6 days, but less than daily**
3. **Behavior of this type occurred daily**

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section E: Behavior

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

Check all that apply:

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

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

Check all that apply:

- ☐ A. **The behavior put others at significant risk for physical illness or injury**
- ☐ B. **The behavior significantly interfered with others' care**
- ☐ C. **The behavior significantly interfered 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 occurred 1 to 3 days**
2. **Behavior of type occurred 4 to 6 days, but less than daily**
3. **Behavior of this type occurred daily**

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

Check all that apply:

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

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

Check all that apply:

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

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section E: Behavior

E2400. Intervention Programs for Mood, Behavior, Cognitive Loss	
Check all that apply in the 7-day lookback period unless otherwise specified:	
☐	A. **Special behavior symptom evaluation program**
☐	B. **Special behavior management program**
☐	C. **Evaluation by a licensed mental health specialist in LAST 90 DAYS**
☐	D. **Group therapy**
☐	E. **Resident-specific deliberate changes in the environment to address mood/behavior patterns** *(e.g., providing a bureau in which to rummage)*
☐	F. **Reorientation** *(e.g., cueing)*
☐	G. **Validation/Redirection**
☐	H. **Crisis intervention in the facility**
☐	I. **Crisis stabilization unit in LAST 90 DAYS**
☐	J. **Other** *(specify)* _____
☐	Z. **None of the above**

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

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**

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section G: Functional Abilities

INSTRUCTIONS FOR G0100

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 -** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident.
☐☐	☐	☐	B. **Oral hygiene -** The ability to use suitable items to clean teeth or dentures
☐☐	☐	☐	C. **Toileting hygiene -** The ability to maintain perineal hygiene and adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
☐☐	☐	☐	D. **Shower/bathe self** - The ability to bathe self, including washing, rinsing, and drying self *(excludes washing of back and hair)*
☐☐	☐	☐	E. **Upper body dressing -** The ability to dress and undress above the waist, including fasteners, if applicable.
☐☐	☐	☐	F. **Lower body dressing -** The ability to dress and undress below the waist, including fasteners; does not include footwear.
☐☐	☐	☐	G. **Putting on/taking off footwear -** The ability to put on and take off socks and shoes or other footwear appropriate for safe mobility, including fasteners.
☐☐	☐	☐	H. **Personal hygiene -** The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands *(excludes baths, showers, and oral hygiene)*.

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section G: Functional Abilities

INSTRUCTIONS FOR 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**

G0200. Mobility *(see above instructions)*

1.	2.	3.	
☐☐	☐	☐	A. **Roll left and right -** Resident can roll left and roll right, move from lying on their back to the left and right side, and return to lying on their back on the bed.
☐☐	☐	☐	B. **Sit to lying -** Move from sitting on the side of the bed to lying flat on the bed.
☐☐	☐	☐	C. **Lying to sitting on the side of the bed -** Move from lying on the back to sitting on the side of the bed with no back support.
☐☐	☐	☐	D. **Sit to stand -** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
☐☐	☐	☐	E. **Chair/bed-to-chair transfer -** The ability to transfer to and from a bed to a chair *(or wheelchair)*.
☐☐	☐	☐	F. **Toilet transfer -** The ability to get on and off a toilet or commode.
☐☐	☐	☐	G. **Tub/shower transfer -** The ability to get in and out of a tub/shower.
☐☐	☐	☐	H. **Locomotion 10 feet in a room, corridor, or similar space while standing**
☐☐	☐	☐	I. **Locomotion 50 feet with two turns** *(shorter distance outside of the room)*
☐☐	☐	☐	J. **Locomotion 150 feet in a room, corridor, or similar space while standing**
☐☐	☐	☐	K. **Car transfer -** The ability to transfer in and out of a vehicle on the passenger side *(does not include the ability to open/close the door or fasten the seat belt)*

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section G: Functional Abilities

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

A. **Resident arranged for suitable transportation to get to appointments, outings, and necessary engagements in the LAST 30 DAYS:**

Enter code ☐

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

B. **Resident managed finances, including banking, handling checkbooks, and paying bills in the LAST 30 DAYS:**

Enter code ☐

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

C. **Resident managed cash and personal needs allowance in the LAST 30 DAYS:**

Enter code ☐

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

D. **Resident used phone in the LAST 30 DAYS:**

Enter code ☐

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

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section G: Functional Abilities

G0410 IADL Self-Performance – Part 2

Check all that apply in the LAST 30 DAYS:

Enter code ☐

A. **Resident arranged for shopping for clothing, snacks, and other incidentals.**
0. **Independent -** No help provided *(with/without assistive devices)*
1. **Done with help -** Resident involved in activity but had assistance *(including supervision, reminders, and/or physical help)*
2. **Done by others -** Others do the full performance of the activity *(resident is not involved at all)*
9. **None of the above -** Activity did not occur in the last 30 days

Enter code ☐

B. **Resident shopped for clothing, snacks, or other incidentals**
0. **Independent -** No help provided *(with/without assistive devices)*
1. **Done with help -** Resident involved in activity but had assistance *(including supervision, reminders, and/or physical help)*
2. **Done by others -** Others do the full performance of the activity *(resident is not involved at all)*
9. **None of the above -** Activity did not occur in the last 30 days

Enter code ☐

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

Enter code ☐

D. **Resident did light housework such as making their own bed, dusting, or taking care of belongings.**
0. **Independent -** No help provided *(with/without assistive devices)*
1. **Done with help -** Resident involved in activity but had assistance *(including supervision, reminders, and/or physical help)*
2. **Done by others -** Others do the full performance of the activity *(resident is not involved at all)*
9. **None of the above -** Activity did not occur in the last 30 days

Enter code ☐

E. **Resident sorted, folded, or washed their own laundry.**
0. **Independent -** No help provided *(with/without assistive devices)*
1. **Done with help -** Resident involved in activity but had assistance *(including supervision, reminders, and/or physical help)*
2. **Done by others -** Others do the full performance of the activity *(resident is not involved at all)*
9. **None of the above -** Activity did not occur in the last 30 days

G0500. Transportation

Check 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**

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

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 -** No episodes of incontinence
1. **Bladder incontinence episodes once a week or less**
2. **Incontinent episodes two or more times a week but not daily**
3. **Incontinent daily -** Some control present
4. **Bladder incontinence episodes occur multiple times daily**
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 7 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 in the LAST 7 DAYS:

0. **Continent of bowel on all occasions** of bowel movements, without any episodes of incontinence.
1. **Incontinent of bowel once -** Includes incontinence of any amount of stool day or night.
2. **Incontinent of the bowel more than once** but had at least one continent bowel movement.
3. **Incontinent of bowel for all bowel movements** and had no 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**

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section H: Bladder and Bowel

H0700. Bowel Elimination Pattern	
Check all that apply:	
☐	A. **Constipation**
☐	B. **Diarrhea**
☐	C. **Fecal impaction**
☐	Z. **None of the above**

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section I: Active Diagnoses

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

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section I: Active Diagnoses

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

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section I: Active Diagnoses

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

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

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

Check all that apply over the LAST 5 DAYS:

- ☐ 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

Enter code ☐

Frequency with which resident complains or shows evidence of pain or possible pain in the LAST 5 DAYS:

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**

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section J: Health Conditions

J0700. Pain Management

Check all that apply over the **PAST 5 DAYS:**

- ☐ A. **Received scheduled pain medication regimen**
- ☐ B. **Received PRN or unscheduled pain medication**
- ☐ C. **Was offered and declined pain medication**
- ☐ D. **Received non-medication intervention for pain**
- ☐ Z. **None of the above**

J0800. Number of Falls Since Admission/Entry, Reentry or Prior Assessment

1. Number of falls within **PAST 30 DAYS:**	2. Number of falls within **DAYS 31-180:**	
Enter code ☐	Enter code ☐	A. **No injury:** 0. If the resident had no falls 1. If the resident had one fall 2. If the resident had two or more falls
Enter code ☐	Enter code ☐	B. **Minor injury:** 0. If the resident had no falls 1. If the resident had one fall 2. If the resident had two or more falls
Enter code ☐	Enter code ☐	C. **Major injury:** 0. If the resident had no falls 1. If the resident had one fall 2. If the resident had two or more falls

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

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**

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

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**

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section M: Skin Conditions

M0100. Unhealed Pressure Ulcers/Injuries

Enter code ☐

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

0. **No** → Skip to M0300, Number of Venous and Arterial Ulcers
1. **Yes**

M0200. 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)*
☐	B. **Stage 2 -** Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough *(may also present as an intact or open/ruptured blister)*
☐	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)*
☐	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)*
☐	E. **Unstageable – Due to non-removable dressing/device**: Not stageable due to non-removable dressing/device.
☐	F. **Unstageable – Due to slough and/or eschar**: Not stageable due to coverage of wound bed by slough and/or eschar
☐	G. **Unstageable -** Deep tissue injury

M0300. Number of Venous and Arterial Ulcers

Enter number ☐

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

M0400. 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. **Surgical wound(s)**
- ☐ F. **Burn(s)** *(second or third degree)*
- ☐ G. **Skin tear(s)**
- ☐ H. **Moisture Associated Skin Damage** *(MASD)* (*e.g., incontinence-associated dermatitis [IAD], perspiration, drainage*)

None of the Above:

- ☐ Z. **None of the above**

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section M: Skin Conditions

M0500. 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**

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

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 medications of any type**

☐ D. **Other** *(specify)* _____

☐ Z. **None of the above**

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section N: Medications

N0600. Medication Preparation Administration

Enter code ☐

Did the resident prepare and administer their own medication in the LAST 7 DAYS?

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

N0610. Medication Preparation and Administration – *as Performed by the Resident*

Code one response that applies to the LAST 7 DAYS:

Enter code ☐

0. Resident had no prescribed medications**.**
1. Resident prepared and administrated NONE of their own medications
2. Resident prepared and administrated SOME of their own medications.
3. Resident prepared and administrated ALL of their own 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

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section N: Medications

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 N0900A, 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** → Skip to N1000A, COVID-19 Vaccine
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** → Skip to O0100A, Special care: Alcohol/drug treatment

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**

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

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**	☐	☐

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section O: Special Treatments, Procedures, and Programs

O0300. Rehabilitation/Restorative Care

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

O0400. 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?**

O0500. Emergency Department Visit(s)

Enter number ☐☐ **How many times did the resident visit an ED without an overnight stay in the LAST 6 MONTHS?**

O0600. Physician Visits

Enter number ☐☐ **On how many days has a physician examined the resident in the LAST 14 DAYS?**

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section O: Special Treatments, Procedures, and Programs

O0700. Physician Orders

Enter number ☐☐

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

O0800. 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?

O0900. Outpatient Procedures

Enter number ☐☐

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

O1000. Need for Ongoing Monitoring

Enter code ☐

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

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

Enter code ☐

B. **New treatment or medication**

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

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

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)* _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section P: Restraints and Alarms

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)* _____

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section Q: Participation in Discharge Planning and Goal Setting

Q0100. 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**

Q0200. 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 Q0200A:**
1. **Resident**
2. **Family**
3. **Significant other**
4. **Legal guardian**
5. **Other legally authorized representative**
9. **None of the above**

Q0300. Discharge Potential

Enter code ☐

Does the resident have a support person who expresses a positive and supportive attitude towards discharge?
0. **No**
1. **Yes**

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**

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

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 *(A0400 on existing record to be modified/inactivated)*

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

Enter code ☐☐

01. **Admission assessment** *(REQUIRED BY DAY 14)*
02. **Semi-annual assessment**
03. **Significant change in status assessment**
04. **Significant correction to prior comprehensive 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 ☐

1. **Male**
2. **Female**
3. **Non-binary**

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

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section X: Correction/Inactivation Request

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 requests to modify/inactivate the existing record, including the present one.

X1100. Reasons for Modification - Complete only if the Type of Record is to modify in error *(A0100 = 2)*

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 Name

A. **First Name:**

B. **Last Name:**

C. **Signature:**

_____

D. **Attestation Date:**

		-			-				
M	M		D	D		Y	Y	Y	Y

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Section Z: Assessment Administration

Z0100. Assessment Information

MaineCare Billing Group: *(calculated by software)*

Z0200. Signatures

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

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

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)*

A0400. Type of Assessment

Enter code ☐☐

B. **Entry/discharge reporting:**

01. **Entry tracking record**

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. **Non-binary**

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:

☐☐☐☐☐☐☐☐☐

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Entry Tracking Form

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

		-			-				
M	M		D	D		Y	Y	Y	Y

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 ☐☐

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

01. **Entry tracking record**

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. **Non-binary**

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. Most Recent Admission/Entry or Reentry into this Facility *(A1200 on existing record to be modified/inactivated)*

		-			-				
M	M		D	D		Y	Y	Y	Y

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Entry Tracking Form

Z0200. Signature
B. **Coordinator signature:** 1. _____ Signature Title Date

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

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. 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

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. **Non-binary**

A0800. Birth Date

☐☐ - ☐☐ - ☐☐☐☐

M M D D Y Y Y Y

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Discharge Assessment

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**: 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

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**
2. **Not applicable**

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**
2. **Not applicable**

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Discharge Assessment

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 ☐☐

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. **Non-binary**

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 number ☐☐

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

Resident _____ Identifier _____ Date _____

MINIMUM DATA SET (MDS)

ASSISTED HOUSING

Discharge Assessment

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 Name

A. **First Name:**

B. **Last Name:**

C. **Signature:**

_____

D. **Attestation Date:**

		-			-				
M	M		D	D		Y	Y	Y	Y

MINIMUM DATA SET (MDS)
ASSISTED HOUSING
Discharge Assessment

Z0200. Signature

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