MINIMUM DATA SET (MDS)©
ASSISTED LIVING SERVICES (ALS)

FACE SHEET: BACKGROUND INFORMATION ONLY AT ADMISSION

SECTION AA. IDENTIFICATION INFORMATION

1.	**RESIDENT NAME**	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
2.	**GENDER**	☐ **1.** Male ☐ **2.** Female
3.	**BIRTHDATE**	☐☐ — ☐☐ — ☐☐☐☐ Month Day Year
4.	**RACE/ ETHNICITY** *(Check only one.)*	☐ **1.** American Indian/Alaskan Native ☐ **2.** Asian/Pacific Islander ☐ **3.** Black, not of Hispanic origin ☐ **4.** Hispanic ☐ **5.** White, not of Hispanic origin ☐ **6.** Other
5.	**SOCIAL SECURITY and MEDICARE NUMBERS** ***(C in 1st box if no med. no.)***	**a.** Social Security Number ☐☐☐ — ☐☐ — ☐☐☐☐ **b.** Medicare number (or comparable railroad insurance number) ☐☐☐☐☐☐☐☐☐☐☐☐
6.	**FACILITY NAME AND PROVIDER NO.**	**a.** Facility Name _____ **b.** Provider No. ☐☐☐☐☐☐☐☐☐
7.	**MAINECARE NO.**	*[Record a "+" if pending, "N" if not a MaineCare recipient]* ☐☐☐☐☐☐☐☐☐

SECTION AB. DEMOGRAPHIC INFORMATION

1.	**DATE OF ENTRY**	*Date the stay began. (Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date.)* ☐☐ — ☐☐ — ☐☐☐☐ Month Day Year
2.	**ADMITTED FROM (AT ENTRY)** *(Check only one.)*	☐ **1.** Private home/apt. ☐ **2.** Other board and care/assisted living/group home ☐ **3.** Nursing home ☐ **4.** Acute care hospital ☐ **5.** Psychiatric hospital ☐ **6.** MR/DD facility ☐ **7.** Rehabilitation hospital ☐ **8.** Other *(specify)* _____
3.	**LIVED ALONE (PRIOR TO ENTRY)** *(Check only one.)*	☐ **0.** No ☐ **1.** Yes ☐ **2.** In other facility
4.	**PRIOR PRIMARY RESIDENCE**	*Provide town, state, zip code for Resident's primary residence prior to admission* _____ Town _____ State ☐☐☐☐☐ Zip Code
5.	**RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY**	*(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above)* ☐ **a.** Prior stay at this home ☐ **b.** Nursing home ☐ **c.** Other residential facility—board and care home, assisted living, group home ☐ **d.** MH/psychiatric hospital ☐ **e.** MR/DD facility ☐ **f.** *NONE OF ABOVE*
6.	**LIFETIME OCCUPATION**	*Put a "/" between two occupations.* ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

7.	**EDUCATION** ***(Highest Level Completed)*** *(Check only one.)*	☐ **1.** No schooling ☐ **2.** 8th grade or less ☐ **3.** 9–11 grades ☐ **4.** High school ☐ **5.** Technical or trade school ☐ **6.** Some college ☐ **7.** Bachelor's degree ☐ **8.** Graduate degree
8.	**PRIMARY LANGUAGE** *(Check only one.)*	☐ **0.** English ☐ **1.** Spanish ☐ **2.** French ☐ **3.** Other *(specify)* _____
9.	**MENTAL HEALTH HISTORY**	Does resident's RECORD indicate any history of the following? **a.** Mental retardation ☐ **0.** No ☐ **1.** Yes **b.** Mental illness ☐ **0.** No ☐ **1.** Yes **c.** Developmental disability ☐ **0.** No ☐ **1.** Yes
10.	**CONDITIONS RELATED TO MR/DD STATUS**	(***Check all conditions*** *that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely*) ☐ **a.** Not applicable—no MR/DD *(Skip to AB11)* **MR/DD with organic condition** ☐ **b.** Down's syndrome ☐ **c.** Autism ☐ **d.** Epilepsy ☐ **e.** Cerebral palsy ☐ **f.** Other organic condition related to MR/DD ☐ **g.** MR/DD with no organic condition
11.	**ALZHEIMER DEMENTIA HISTORY**	Does resident's RECORD indicate any history of the following? **a.** Alzheimer's disease ☐ **0.** No ☐ **1.** Yes **b.** Dementia other than Alzheimer's disease ☐ **0.** No ☐ **1.** Yes

SECTION AC. CUSTOMARY ROUTINE

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

END

SECTION AD. FACE SHEET SIGNATURES and DATES

1. SIGNATURE(S) OF PERSON(S) COMPLETING FACE SHEET:				
a. Signatures		Title	Sections	Date
b.				Date
2.	**DATE COMPLETED**	Record date background information was completed. ☐☐ — ☐☐ — ☐☐☐☐ Month Day Year		

MDS-ALS ME (Rev 12/03)

Contact Information: Catherine Gunn, USM, Muskie School of Public Service, PO Box 9300, Portland, ME 04104, 207-780-5576

CONFIDENTIAL

MINIMUM DATA SET (MDS)©

ASSISTED LIVING SERVICES (ALS)

(STATUS IN LAST 7 DAYS UNLESS OTHERWISE NOTED)

SECTION A. IDENTIFICATION and BACKGROUND INFORMATION

1.	RESIDENT NAME	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
2.	SOCIAL SECURITY and MEDICARE NUMBERS *(C in 1st box if no med. no.)*	**a.** Social Security Number ☐☐☐ — ☐☐ — ☐☐☐☐ **b.** Medicare number (or comparable railroad insurance number) ☐☐☐☐☐☐☐☐☐☐—☐☐
3.	FACILITY NAME AND PROVIDER NO.	**a.** Facility Name _____ **b.** Provider No. ☐☐☐☐☐☐☐☐☐
4.	MAINECARE NO.	*[Record a "+" if pending, "N" if not a MaineCare recipient]* ☐☐☐☐☐☐☐☐☐
5.	ASSESSMENT DATE	*Last day of observation period* ☐☐ — ☐☐ — ☐☐☐☐ (Month — Day — Year)
6.	REASON FOR ASSESSMENT	*(Check primary reason for assessment)* ☐ **1.** Admission assessment ☐ **4.** Semi-Annual ☐ **2.** Annual assessment ☐ **5.** Other *(specify)* ☐ **3.** Significant change in status assessment _____
7.	MARITAL STATUS *(Check only one.)*	☐ **1.** Never married ☐ **3.** Widowed ☐ **5.** Divorced ☐ **2.** Married ☐ **4.** Separated
8.	CURRENT PAYMENT SOURCES FOR STAY	(*Billing Office to indicate;* **check all that apply in last 30 days or since last admission if less than 30 days**) ☐ **a.** MaineCare ☐ **e.** Private pay ☐ **b.** SSI ☐ **f.** Private insurance (including co-payment) ☐ **c.** VA ☐ **d.** Social Security ☐ **g.** SSDI ☐ **h.** Other *(specify)*_____
9.	RESPONSIBILITY/ LEGAL GUARDIAN	*(Check all that apply.)* ☐ **a.** Legal guardian ☐ **e.** Family member responsible ☐ **b.** Other legal oversight ☐ **f.** Self ☐ **c.** Durable power of attorney/health care ☐ **g.** Legal Conservator ☐ **h.** Representative Payee ☐ **d.** Durable power of attorney/financial ☐ **i.** *NONE OF ABOVE*
10.	ADVANCED DIRECTIVES	*Does resident have any of the following advanced directives in place?* **a.** Living Will ☐ **0.** No ☐ **1.** Yes **b.** Do not resuscitate (DNR) ☐ **0.** No ☐ **1.** Yes **c.** Do not hospitalize ☐ **0.** No ☐ **1.** Yes **d.** Organ donation ☐ **0.** No ☐ **1.** Yes **e.** Other ☐ **0.** No ☐ **1.** Yes (If "yes," specify)_____

SECTION B. COGNITIVE PATTERNS

1.	MEMORY	(*Recall of what was learned or known*) **a.** Short-term memory OK—seems/appears to recall after 5 minutes ☐ **0.** Memory OK ☐ **1.** Memory problem **b.** Long-term memory OK—seems/appears to recall long past ☐ **0.** Memory OK ☐ **1.** Memory problem
2.	MEMORY/ RECALL ABILITY	*(Check all that resident was normally able to recall during* ***last 7 days****)* ☐ **a.** Current season ☐ **d.** That he/she is in a facility/home ☐ **b.** Location of own room ☐ **e.** NONE OF ABOVE are recalled ☐ **c.** Staff names/faces
3.	COGNITIVE SKILLS FOR DAILY DECISION-MAKING *(Check only one.)*	(*Made decisions regarding tasks of daily life*) ☐ **0.** *INDEPENDENT*—decisions consistent/reasonable ☐ **1.** *MODIFIED INDEPENDENCE*—some difficulty in new situations only ☐ **2.** *MODERATELY IMPAIRED*—decisions poor; cues/ supervision required ☐ **3.** *SEVERELY IMPAIRED*—never/rarely made decisions
4.	COGNITIVE STATUS *(Check only one.)*	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 C. COMMUNICATION/HEARING PATTERNS

1.	HEARING *(Check only one.)*	(*With hearing appliance, if used*) ☐ **0.** *HEARS ADEQUATELY*—normal talk, TV, phone ☐ **1.** *MINIMAL DIFFICULTY* when not in quiet setting ☐ **2.** *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly ☐ **3.** *HIGHLY IMPAIRED* –absence of useful hearing
2.	COMMUNICATION DEVICES/ TECHNIQUES	(*Check all that apply during last 7 days.*) ☐ **a.** Hearing aid, present and used ☐ **b.** Hearing aid, present and not used regularly ☐ **c.** Other receptive communication techniques used (e.g., lip reading) ☐ **d.** *NONE OF ABOVE*
3.	MAKING SELF UNDERSTOOD *(Check only one.)*	(*Expressing information content—however able*) ☐ **0.** *UNDERSTOOD* ☐ **1.** *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts ☐ **2.** *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests ☐ **3.** *RARELY/NEVER UNDERSTOOD*
4.	ABILITY TO UNDERSTAND OTHERS *(Check only one.)*	(*Understanding information content—however able*) ☐ **0.** *UNDERSTANDS* ☐ **1.** *USUALLY UNDERSTANDS*—may miss some part / intent of message ☐ **2.** S*OMETIMES UNDERSTANDS*—responds adequately to simple, direct communication ☐ **3.** *RARELY/NEVER UNDERSTANDS*
5.	COMMUNICATION *(Check only one.)*	Resident's current ability to express him/herself or understand others 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. VISION PATTERNS

1.	VISION *(Check only one.)*	(*Ability to see in adequate light and with glasses if used*) ☐ **0.** *ADEQUATE*—sees fine detail, including regular print in newspapers/books ☐ **1.** *IMPAIRED*—sees large print, but not regular print in newspapers/ books ☐ **2.** *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects ☐ **3.** *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects ☐ **4.** *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects
2.	VISUAL APPLIANCES	**a.** Glasses, contact lenses ☐ **0.** No ☐ **1.** Yes **b.** Artificial eye ☐ **0.** No ☐ **1.** Yes

SECTION E. MOOD and BEHAVIOR PATTERNS

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	*(**CODE:** Record the appropriate code for the frequency of the symptom(s) observed* **in last 30 days,** *irrespective of the assumed cause)* **0.** Not exhibited in last 30 days **1.** This type exhibited up to 5 days a week **2.** This type exhibited daily or almost daily (6, 7 days/week) **VERBAL EXPRESSIONS OF DISTRESS** ____ **a.** Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die." ____ **b.** Repetitive questions—e.g., "Where do I go; What do I do?" ____ **c.** Repetitive verbalizations—e.g., calling out for help, ("God help me") ____ **d.** Persistent anger with self or others—e.g., easily annoyed, anger at placement in facility; anger at care received ____ **e.** Self deprecation—e.g.,"I am nothing; I am of no use to anyone" ____ **f.** Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others ____ **g.** Recurrent statements that something terrible is about to happen —e.g., believes he or she is about to die, have a heart attack ____ **h.** Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions ____ **i.** Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues *(continued next page)*

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Resident Name:_____ Date:_____ Soc. Sec. #_____ Facility Provider #_____

SECTION E. MOOD and BEHAVIOR PATTERNS (cont.)

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

*(**CODE:** Record the appropriate code for the frequency of the symptom(s) observed **in last 30 days**, irrespective of the assumed cause)*

0. Not exhibited in last 30 days
1. This type exhibited up to 5 days a week
2. This type exhibited daily or almost daily (6, 7 days/week)

SLEEP-CYCLE ISSUES
____ **j.** Unpleasant mood in morning
____ **k.** Insomnia/change in usual sleep pattern

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

LOSS OF INTEREST
____ **o.** Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends
____ **p.** Reduced social interaction

INDICATORS OF MANIA
____ **q.** Inflated self-worth, exaggerated self-opinion; inflated belief about one's own ability, etc.
____ **r.** Excited behavior, motor excitation (e.g., heightened physical activity; excited, loud or pressured speech; increased reactivity)

2. MOOD PERSISTENCE *(Check only one.)*

*Check if one or more indicators of depressed, sad or anxious mood (above) were not easily altered by attempts to "cheer up", console, or reassure the resident **over last 7 days**.*

☐ **0.** No mood indicators
☐ **1.** Indicators present, easily altered
☐ **2.** Indicators present, not easily altered

3. MOOD *(Check only one.)*

Resident's current mood status compared to resident's status 180 days ago (or since admission if less than 180 days):
☐ **0.** No change ☐ **1.** Improved ☐ **2.** Declined

4. BEHAVIORAL SYMPTOMS

*(**COLUMN A CODES**: Record the appropriate code for the frequency of the symptom **in last 7 days**)*
0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days but less than daily
3. Behavior of this type occurred daily

*(**COLUMN B CODES**: Alterability of behavioral symptoms **in last 7 days**)*
0. Not present or easily altered
1. Behavior not easily altered

*(**COLUMN C CODES**: History of this behavior **in the last 6 months**)*
0. No **1.** Yes

		A FREQUENCY	B ALTERABILITY	C HISTORY
a.	WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)			
b.	VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)			
c.	PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused, gross physical assault)			
d.	SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, sexual behavior, disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings, stealing, self-abusive acts, substance abuse, self-mutilation)			
e.	RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)			
f.	INTIMIDATING BEHAVIOR (made others feel unsafe, at risk, privacy invaded)			
g.	ELOPEMENT			
h.	Dangerous non-violent behavior (e.g., falling asleep while smoking)			
i.	Dangerous violent behavior			
j.	FIRE SETTING			

5. SUICIDAL IDEATION

Resident demonstrated suicidal thoughts or actions in **the last 30 days**:
☐ **0.** No ☐ **1.** Yes

6. SLEEP PROBLEMS

Check all present on 2 or more days during last 7 days
☐ **a.** Inability to awaken when desired
☐ **b.** Difficulty falling asleep
☐ **c.** Restless or non-restful sleep
☐ **d.** Interrupted sleep
☐ **e.** *NONE OF ABOVE*

7. INSIGHT INTO MENTAL HEALTH

Resident has insight about his/her mental problem
☐ **0.** No ☐ **1.** Yes ☐ **2.** No mental health problems

8. BEHAVIORS *(Check only one.)*

Resident's current behavior status compared to resident's status 180 days ago (or since admission if less than 180 days):
☐ **0.** No change ☐ **1.** Improved ☐ **2.** Declined

SECTION F. PSYCHOSOCIAL WELL-BEING

1. SENSE OF INITIATIVE/ INVOLVEMENT *(Check all that apply.)*

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

2. UNSETTLED RELATION-SHIPS *(Check all that apply.)*

☐ **a.** Covert/open conflict with or repeated criticism of staff
☐ **b.** Unhappy with roommate
☐ **c.** Unhappy with residents other than roommate
☐ **d.** Openly expresses conflict/anger with family/friends
☐ **e.** Absence of personal contact with family/friends
☐ **f.** Recent loss of close family member/friend
☐ **g.** Does not adjust easily to change in routines
☐ **h.** *NONE OF ABOVE*

3. LIFE-EVENTS HISTORY *(Check all that apply.)*

Events in past 2 years
☐ **a.** Serious accident or physical illness
☐ **b.** Health concerns for other person
☐ **c.** Death of family member or close friend
☐ **d.** Trouble with the law
☐ **e.** Robbed/physically attacked
☐ **f.** Conflict laden or severed relationship
☐ **g.** Loss of income leading to change in lifestyle
☐ **h.** Sexual assault/abuse
☐ **i.** Child custody issues
☐ **j.** Change in marital/partner status
☐ **k.** Review hearings (e.g., forensic, certification, capacity hearing)
☐ **l.** *NONE OF ABOVE*

SECTION G. PHYSICAL FUNCTIONING

1. (A) ADL SELF-PERFORMANCE

0. INDEPENDENT—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. LIMITED ASSISTANCE—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times —OR— Limited assistance (3 or more times), plus weight-bearing support provided only 1 or 2 times.
3. EXTENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
— Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
4. TOTAL DEPENDENCE—Full staff performance of activity during last 7 days
8. ACTIVITY DID NOT OCCUR DURING LAST 7 DAYS

(B) **ADL SUPPORT CODES** *(*CODE *for MOST SUPPORT PROVIDED OVER EACH 24 HOUR PERIOD)* **during last 7 days; code regardless of person's self-performance classification**.

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

		A SELF-PERFORMANCE	B SUPPORT
a.	**BED MOBILITY**– How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	**TRANSFER** – How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	**LOCOMOTION** – How resident moves to and returns from other locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
d.	**DRESSING** – How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis		
e.	**EATING** – How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
f.	**TOILET USE** – How resident uses the toilet room (or commode, bed- pan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
g.	**PERSONAL HYGIENE** – How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		
h.	**STAIRS** – How resident climbs stairs		

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Resident Name:_____ Date:_____ Soc. Sec. #_____ Facility Provider #_____

SECTION G. PHYSICAL FUNCTIONING (cont.)

2. BATHING SELF-PERFORMANCE

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) ***Check for most dependent*** *in self-performance* during last 7 days.

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

3A. MODES OF LOCOMOTION

*(Check all that apply during **last 7 days**.)*

- ☐ **a.** Cane/walker/crutch
- ☐ **b.** Wheeled self
- ☐ **c.** Other person wheeled
- ☐ **d.** *NONE OF ABOVE*

3B. MAIN MODE OF LOCOMOTION

Was wheelchair the primary mode of locomotion during the last 7 days?

☐ **0.** No ☐ **1.** Yes

3C. BEDFAST/ CHAIRFAST

*(Check if health condition keeps resident in his/her room 22+ hours per day in **last 7 days**)*

- ☐ **a.** Bedfast all or most of time
- ☐ **b.** Chairfast all or most of the time
- ☐ **c.** *NONE OF ABOVE*

4. SELF-PERFORMANCE IN ADLs

(Check only one.)

Resident's current ADL status or abilities compared to resident's status 180 days ago (or since admission if less than 180 days):

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

5A. IADL SELF-PERFORMANCE

Code for level of independence in the **last 30 days** based on resident's involvement in the activity.

SELF-PERFORMANCE CODES:

0. INDEPENDENT: (with/without assistive devices)—No help provided.

1. DONE WITH HELP: Resident involved in activity but help (including supervision, reminders, and/or physical help) is provided.

2. DONE BY OTHERS: Full performance of the activity is done by others. The resident is not involved at all when the activity is performed.

8. Activity did not occur in the last 30 days.

IADL	SELF-PERFORMANCE
a. Resident arranged for shopping for clothing, snacks, other incidentals.	
b. Resident shopped for clothing, snacks, or other incidentals.	
c. Resident arranged for suitable transportation to get to appointments, outings, necessary engagements.	
d. Resident managed finances including banking, handling checkbook, or paying bills.	
e. Resident managed cash, personal needs allowance.	
f. Resident prepared snacks, light meals.	
g. Resident used phone.	
h. Resident did light housework such as making own bed, dusting, or taking care of belongings.	
i. Resident sorted, folded, or washed own laundry.	

5B. TRANSPORTATION

Check all that apply for level of independence in the **last 30 days** based on resident's involvement in the activity.

- ☐ **a.** Resident drove car or used public transportation independently to get to medical, dental appointments, necessary engagements, or other activities.
- ☐ **b.** Resident rode to destination with staff, family, others (in car, van, public transportation) but was **not accompanied** to medical, dental appointments, necessary engagements, or other activities.
- ☐ **c.** Resident rode to destination with staff, family, others (in car, van, public transportation) and **was accompanied** to medical, dental appointments, necessary engagements, or other activities.
- ☐ **d.** Activity did not occur.

6. ADL AND IADL FUNCTIONAL REHABILITATION OR IMPROVEMENT POTENTIAL

(Check all that apply.)

- ☐ **a.** Resident believes he/she is capable of increased independence in at least some ADLs or IADLs.
- ☐ **b.** Direct care staff believes resident is capable of increased independence in at least some ADLs or IADLs.
- ☐ **c.** Resident able to perform tasks/activity but is very slow.
- ☐ **d.** Difference in ADL/IADL Self-Performance comparing mornings to evenings.
- ☐ **e.** Resident requires or only understands a one-step direction.

(continued in next column)

SECTION G. PHYSICAL FUNCTIONING (cont.)

- ☐ **f.** Resident requires or only understands no more than a two-step direction.
- ☐ **g.** Resident could be more independent if he/she had special equipment (e.g., cane, walker, plate guard, velcro closings on clothing or shoes).
- ☐ **h.** Resident could perform more independently if some or all of ADL/IADL activities were broken into subtasks (task segmentation).
- ☐ **i.** Resident could be more independent if he/she received ADL or IADL skills training.
- ☐ **j.** *NONE OF ABOVE*

7. NEW DEVICES NEEDED

(Check all that apply.)

- ☐ **a.** Eyeglasses
- ☐ **b.** Hearing aid
- ☐ **c.** Cane or walker
- ☐ **d.** Wheelchair
- ☐ **e.** Assistive feeding devices (e.g., plate guard, stabilized built-up utensil)
- ☐ **f.** Assistive dressing devices (e.g., button hook, velcro closings)
- ☐ **g.** Dentures
- ☐ **h.** Other *(specify)* _____
- ☐ **i.** *NONE OF ABOVE*

8. SELF-PERFORMANCE IN IADLs

Resident's current IADL status or abilities compared to resident's status 180 days ago (or since admission if less than 180 days):

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

SECTION H. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL CATEGORIES

(Code for resident's PERFORMANCE OVER ALL SHIFTS)

0. *CONTINENT*—Complete control (includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool)
1. *USUALLY CONTINENT*—BLADDER, Incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g. on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a. BOWEL CONTINENCE — Control of bowel movement, with appliance or bowel continence programs, if employed

b. BLADDER CONTINENCE — Control of urinary bladder function with appliances (e.g. foley) or continence programs, if employed

2. BOWEL ELIMINATION PATTERN

Bowel elimination pattern regular—at least one movement every three days

- **a.** Constipation
- **b.** Diarrhea
- **c.** Fecal Impaction
- **d.** Resident is independent
- **e.** *NONE OF ABOVE*

3. APPLIANCES and PROGRAMS

- **a.** Any scheduled toileting plan
- **b.** Bladder retraining program
- **c.** External (condom) catheter
- **d.** Indwelling catheter
- **e.** Intermittent catheter
- **f.** Did not use toilet room/ commode/urinal
- **g.** Pads/briefs used
- **h.** Enemas/irrigation
- **i.** Ostomy present
- **j.** *NONE OF ABOVE*

4. USE OF INCONTINENCE SUPPLIES

(Check only one.)

Resident's management of incontinence supplies (pads, briefs, ostomy, catheter) in **last 14 days**.

- ☐ **0.** Always continent
- ☐ **1.** Resident incontinent and able to manage incontinence supplies independently.
- ☐ **2.** Resident incontinent and receives assistance with managing incontinence supplies.
- ☐ **3.** Resident incontinent and does not use incontinence supplies.

5. CHANGES IN URINARY CONTINENCE

Resident's urinary continence has changed as compared to status of 180 days ago (or since last assessment if less than 180 days):

☐ **0.** No change ☐ **1.** Improved ☐ **2.** Deteriorated

SECTION I. DIAGNOSES

Check only those diagnoses that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nurse monitoring, or risk of death. (Do not list inactive diagnoses.) (If none apply, CHECK item xx. *NONE OF ABOVE*)

1. DIAGNOSES

ENDOCRINE/METABOLIC/ NUTRITIONAL
- ☐ a. Diabetes mellitus
- ☐ b. Hyperthyroidism
- ☐ c. Hypothyroidism

HEART/CIRCULATION
- ☐ d. Arteriosclerotic heart disease (ASHD)
- ☐ e. Cardiac dysrhythmia
- ☐ f. Congestive heart failure
- ☐ g. Deep vein thrombosis
- ☐ h. Hypertension
- ☐ i. Hypotension
- ☐ j. Peripheral vascular disease
- ☐ k. Other cardiovascular disease

(continued on next page)

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Resident Name:_____ Date:_____ Soc. Sec. #_____ Facility Provider #_____

SECTION I. DIAGNOSES (cont.)

MUSCULOSKELETAL
- ☐ l. Arthritis
- ☐ m. Hip fracture
- ☐ n. Missing limb (e.g., amputation)
- ☐ o. Osteoporosis
- ☐ p. Pathological bone fracture

NEUROLOGICAL
- ☐ q. Alzheimer's disease
- ☐ r. Aphasia
- ☐ s. Cerebral palsy
- ☐ t. Cerebrovascular accident (stroke)
- ☐ u. Dementia other than Alzheimer's disease
- ☐ v. Hemiplegia/ hemiparesis
- ☐ w. Multiple sclerosis
- ☐ x. Paraplegia
- ☐ y. Parkinson's disease
- ☐ z. Quadriplegia
- ☐ aa. Seizure disorder
- ☐ bb. Transient ischemic attack (TIA)
- ☐ cc. Traumatic brain injury

PSYCHIATRIC/MOOD
- ☐ dd. Anxiety disorder
- ☐ ee. Depression
- ☐ ff. Manic depressive (Bipolar)
- ☐ gg. Schizophrenia

PULMONARY
- ☐ hh. Asthma
- ☐ ii. Emphysema/COPD

SENSORY
- ☐ jj. Cataracts
- ☐ kk. Diabetic retinopathy
- ☐ ll. Glaucoma
- ☐ mm. Macular degeneration

OTHER
- ☐ nn. Allergies *(specify)*_____
- ☐ oo. Anemia
- ☐ pp. Cancer
- ☐ qq. Renal failure
- ☐ rr. Tuberculosis-TB
- ☐ ss. HIV
- ☐ tt. Mental retardation(e.g., Down's Syndrome, Autism, or other organic condition related to Mental Retardation or Developmental disability (MR/ DD)
- ☐ uu. Substance abuse (alcohol or drug)
- ☐ vv. Other psychiatric diagnosis (e.g., paranoia, phobias, personality disorder)
- ☐ ww. Explicit terminal prognosis
- ☐ xx. *NONE OF ABOVE*

2. OTHER CURRENT DIAGNOSIS AND ICD-9 CODES

a._____ ☐☐☐☐.☐☐

b._____ ☐☐☐☐.☐☐

c._____ ☐☐☐☐.☐☐

SECTION J. HEALTH CONDITIONS and POSSIBLE MEDICATION SIDE EFFECTS

1. PROBLEM CONDITIONS

(Check all problems present in last 7 days unless other time frame is indicated)

- ☐ **a.** Inability to lie flat due to shortness of breath
- ☐ **b.** Shortness of breath
- ☐ **c.** Edema
- ☐ **d.** Dizziness/vertigo
- ☐ **e.** Delusions
- ☐ **f.** Hallucinations
- ☐ **g.** Hostility
- ☐ **h.** Suspiciousness
- ☐ **i.** Headache
- ☐ **j.** Numbness/tingling
- ☐ **k.** Blurred vision
- ☐ **l.** Dry mouth
- ☐ **m.** Excessive salivation or drooling
- ☐ **n.** Change in normal appetite
- ☐ **o.** Other *(specify)*_____
- ☐ **p.** *NONE OF ABOVE*

2. EXTRA-PYRAMIDAL SIGNS AND SYMPTOMS

Check all present at any point during **last 3 days**

INCREASE IN MOTOR ACTIVITY
- ☐ **a.** Akathisia–resident reports subjective feeling of restlessness or need for movement
- ☐ **b.** Dyskinesia–chewing, puckering movements of mouth; abnormal irregular movements of lips; or rocking or writhing of trunk
- ☐ **c.** Tremor–regular rhythmic movements of the fingers, limbs, head, mouth, or tongue

DECREASE IN MOTOR ACTIVITY
- ☐ **d.** Rigidity–resistance to flexion and extension of muscles (e.g., continuous or cogwheeling rigidity)
- ☐ **e.** Slow shuffling gait–reduction in speed and stride length of gait, usually with a decrease in pendular arm movement
- ☐ **f.** Bradykinesis–decrease in spontaneous movements (e.g., reduced body movement or poverty of facial expression, gestures, speech)

MUSCLE CONTRACTIONS
- ☐ **g.** Dystonia–muscle hypertonicity (e.g., muscle spasms or stiffness, protruding tongue, upward deviation of the eyes)
- ☐ **h.** *NONE OF ABOVE*

3. PAIN SYMPTOMS

(Code the highest level of resident's pain present in the last 7 days)

On a scale of 1 to 10, where 1 is the least and 10 is the most, how would you rate your pain? (If no pain, code 0 and skip to J7) ☐

4. PAIN SITE

(If pain is present in the last 7 days)
- ☐ **a.** Back pain
- ☐ **b.** Bone pain
- ☐ **c.** Chest pain while doing usual activities
- ☐ **d.** Headache
- ☐ **e.** Hip pain
- ☐ **f.** Incisional pain
- ☐ **g.** Joint pain (other than hip)
- ☐ **h.** Soft tissue pain (e.g., lesion, muscle)
- ☐ **i.** Stomach pain
- ☐ **j.** Other *(specify)*_____

SECTION J. HEALTH CONDITIONS AND POSSIBLE MEDICATION SIDE EFFECTS (cont.)

5. PAIN INTERFERES

During the last 7 days, how much of the time did pain interfere with resident's normal activities such as visiting with friends, going out, and so on?
- ☐ **1.** All of the time
- ☐ **2.** Some of the time
- ☐ **3.** Little of the time
- ☐ **4.** None of the time

6. PAIN MANAGE-MENT
- ☐ **1.** No pain treatment
- ☐ **2.** Treated, full control
- ☐ **3.** Treated, partial control
- ☐ **4.** Treated, no or minimal control

7. ACCIDENTS *(Check all that apply.)*
- ☐ **a.** Fell in **past 30 days**
- ☐ **b.** Fell in **past 31-180 days**
- ☐ **c.** Hip fracture in **last 180 days**
- ☐ **d.** Other fracture in last **180 days**
- ☐ **e.** *NONE OF ABOVE*

8. DANGER OF FALL *(Check all that apply.)*
- ☐ **a.** Has unsteady gait
- ☐ **b.** Has balance problems when standing
- ☐ **c.** Limits activity because resident or family fearful of resident falling
- ☐ **d.** Unstable transition from seated to standing
- ☐ **e.** Other *(specify)* _____
- ☐ **f.** *NONE OF ABOVE*

SECTION K. ORAL/NUTRITIONAL STATUS

1. ORAL PROBLEMS *(Check all that apply.)*
- ☐ **a.** Mouth is "dry"when eating a meal
- ☐ **b.** Chewing Problem
- ☐ **c.** Swallowing Problem
- ☐ **d.** Mouth Pain
- ☐ **e.** *NONE OF ABOVE*

2. HEIGHT AND WEIGHT

*Record **(a.) height in inches** and **(b.) weight in pounds**. Base weight on most recent measure in **last 30 days**; measure weight consistently in accord with standard facility practice–e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes.*

a. HT (in.) ☐☐ **b.** WT (lb.) ☐☐☐

3. WEIGHT CHANGE

a. Unintended weight loss–5% or more in last 30 days; or 10% or more in last 180 days
☐ **0.** No ☐ **1.** Yes

b. Unintended weight gain–5% or more in last 30 days; or 10% or more in last 180 days
☐ **0.** No ☐ **1.** Yes

4. NUTRI-TIONAL PROBLEMS OR AP-PROACHES *(Check all that apply.)*
- ☐ **a.** Complains about the taste of many foods
- ☐ **b.** Regular or repetitive complaints of hunger
- ☐ **c.** Leaves 25% of food uneaten at most meals
- ☐ **d.** Therapeutic diet
- ☐ **e.** Mechanically altered (or pureed) diet
- ☐ **f.** Noncompliance with diet
- ☐ **g.** Eating disorders
- ☐ **h.** Food allergies *(specify)* _____
- ☐ **i.** Restrictions *(specify)* _____
- ☐ **j.** *NONE OF ABOVE*

SECTION L. ORAL/DENTAL STATUS

1. ORAL STATUS AND DISEASE PREVENTION *(Check all that apply.)*
- ☐ **a.** Has dentures or removable bridge
- ☐ **b.** Some/all natural teeth lost–does not have or does not use dentures (or partial plates)
- ☐ **c.** Broken, loose or carious teeth
- ☐ **d.** Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes
- ☐ **e.** Daily cleaning of teeth/dentures or daily mouth care–by resident or staff
- ☐ **f.** Resident has difficulty brushing teeth or dentures
- ☐ **g.** *NONE OF ABOVE*

SECTION M. SKIN CONDITION

1. SKIN PROBLEMS *(Check all that apply.)*

Any troubling skin conditions or changes in the **last 7 days?**
- ☐ **a.** Abrasions (scrapes) or cuts
- ☐ **b.** Burns (2nd or 3rd degree)
- ☐ **c.** Bruises
- ☐ **d.** Rashes, itchiness, body lice
- ☐ **e.** Open sores or lesions
- ☐ **f.** Other *(specify)* _____
- ☐ **g.** *NONE OF ABOVE*

2. ULCERS *(Due to any cause.)*

(Record the number of ulcers at each ulcer stage–regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during **last 7 days**. Code 9=9 or more.) Requires full body exam.

	Number at Stage
a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues–presents as a deep crater with or without undermining adjacent tissue.	
d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	

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Contact Information: Catherine Gunn, USM, Muskie School of Public Service, PO Box 9300, Portland, ME 04104, 207-780-5576

Resident Name:_____ Date:_____ Soc. Sec. #_____ Facility Provider #_____

SECTION M. SKIN CONDITION (cont.)

3. FOOT PROBLEMS

a. Resident or someone else inspects resident's feet on a regular basis?
☐ **0.** No ☐ **1.** Yes

b. One or more foot problems or infections such as corns, calluses, bunions, hammer toes, overlapping toes, pain, structural problems, gangrene toe, foot fungus, enlarged toe in last 7 days?
☐ **0.** No ☐ **1.** Yes

SECTION N. ACTIVITY PURSUIT PATTERNS

1. TIME AWAKE

(Check appropriate time periods over last 7 days)
Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:
☐ **a.** Morning ☐ **d.** Night (Bedtime to A.M.)
☐ **b.** Afternoon ☐ **e.** *NONE OF ABOVE*
☐ **c.** Evening

2. AVERAGE TIME INVOLVED IN ACTIVITIES
(Check only one.)

(When awake and not receiving treatments or ADL care)
☐ **1.** Most–more than 2/3 of time
☐ **2.** Some–from 1/3 to 2/3 of time
☐ **3.** Little–less than 1/3 of time
☐ **4.** None

3. PREFERRED ACTIVITY SETTINGS

(Check all settings in which activities are preferred)
☐ **a.** Own room ☐ **d.** Away from facility
☐ **b.** Day/activity room ☐ **e.** *NONE OF ABOVE*
☐ **c.** Outside facility (e.g., in yard)

4. GENERAL ACTIVITY PREFERENCES
(Adapted to resident's current abilities.)

(Check all PREFERENCES whether or not activity is currently available to resident)
☐ **a.** Cards/other games ☐ **k.** Gardening or plants
☐ **b.** Crafts/arts ☐ **l.** Talking or conversing
☐ **c.** Exercise/sports ☐ **m.** Helping others
☐ **d.** Dancing ☐ **n.** Doing chores around the house/facility
☐ **e.** Music
☐ **f.** Reading/writing ☐ **o.** Cooking/baking
☐ **g.** Spiritual/religious activity ☐ **p.** Computer activities
☐ **h.** Trips/shopping ☐ **q.** Volunteering
☐ **i.** Walking/wheeling outdoors ☐ **r.** Other *(specify)*_____
☐ **j.** Watching TV ☐ **s.** *NONE OF ABOVE*

5. PREFERRED ACTIVITY SIZE

(Check all that apply)
☐ **a.** Individual ☐ **c.** Larger group
☐ **b.** Small group ☐ **d.** No preference

6. PREFERENCES IN DAILY ROUTINE
(Check all that apply.)

☐ **a.** Resident prefers change in type of activity
☐ **b.** Resident prefers change in extent of involvement in activities (e.g., more or less)
☐ **c.** Resident prefers change in location of activities
☐ **d.** Resident prefers activity at different time of day
☐ **e.** Resident prefers stability in daily routine
☐ **f.** *NONE OF ABOVE*

7. INTERACTION WITH FAMILY AND FRIENDS

a. How often has resident visited or been visited by family and friends in the **last 30 days?** *(check only one)*
☐ **1.** No family or friends outside facility ☐ **4.** Once a week
☐ **2.** None ☐ **5.** 2 or 3 times a week but not daily
☐ **3.** 1-3 times/month ☐ **6.** Daily

b. How often has resident talked by telephone with family and friends in the **last 30 days?** *(check only one)*
☐ **1.** No family or friends outside facility ☐ **4.** Once a week
☐ **2.** None ☐ **5.** 2 or 3 times a week but not daily
☐ **3.** 1-3 times/month ☐ **6.** Daily

8. VOTING

Is resident registered to vote? ☐ **0.** No ☐ **1.** Yes

9. SOCIAL ACTIVITES
(Check only one.)

Resident's current level of participation in social, religious or other personal activities compared to resident's status 180 days ago (since admission if less than 180 days):
☐ **0.** No change ☐ **1.** Improved ☐ **2.** Declined

SECTION O. MEDICATIONS

1. NUMBER OF MEDICATIONS

(Record the number of different medications used in the last 7 days; *enter "0" if none used)* ☐☐

2. NEW MEDICATIONS

*(Resident currently receiving medicatons that were initiated during the **last 90 days**)*
☐ **0.** No ☐ **1.** Yes

3. INJECTIONS

*(Record the number of **DAYS** injections of any type received during the **last 30 days;** enter "0" if none used)* ☐☐

SECTION O. MEDICATIONS (cont.)

4A. DAYS RECEIVED THE FOLLOWING MEDICATION

(Record the number of DAYS during the **last 7 days**; enter "0" if not used. Note–enter "1" for long-acting meds used less than weekly)
_____ **a.** Antipsychotic _____ **d.** Hypnotic _____ **g.** Insulin
_____ **b.** Antianxiety _____ **e.** Diuretic
_____ **c.** Antidepressant _____ **f.** Aricept

4B. PRN MEDICATIONS

Does resident have a prescription for any PRN medication for a mental, emotional or nervous condition, or behavioral problem?
☐ **0.** No ☐ **1.** Yes

5. SELF-ADMINSTERED MEDICATIONS
(Check all that apply.)

Did resident **self-administer** any of the following in the last 7 days:
☐ **a.** Insulin ☐ **e.** Glucosan
☐ **b.** Oxygen ☐ **f.** Over-the-counter Meds
☐ **c.** Nebulizers ☐ **g.** Other (specify) _____
☐ **d.** Nitropatch ☐ **h.** *NONE OF ABOVE*

6. MEDICATION PREPARATION ADMINISTRATION

Did resident prepare and administer his/her own medications in last 7 days? *(Check only one.)*
☐ **0.** No Meds
☐ **1.** Resident prepared and administrated **NONE** of his/her own medications.
☐ **2.** Resident prepared and administrated **SOME** of his/her own medications.
☐ **3.** Resident prepared and administrated **ALL** of his/her own medications.

7. MEDICATION COMPLIANCE
(Check only one.)

Resident's level of compliance with medications prescribed by a physician/psychiatrist **during last 30 days**:
☐ **0.** No Meds
☐ **1.** Always compliant
☐ **2.** Always compliant with reminder, verbal prompts
☐ **3.** Compliant some of the time (80% of time or more often) **or** with some medications
☐ **4.** Rarely or never compliant

8. MISUSE OF MEDICATION

Misuse of prescription or over-the-counter medications in the last 6 months (e.g., resident uses more or less than the directed dose, is using medication for a purpose other than intended) ☐ **0.** No ☐ **1.** Yes

SECTION P. SPECIAL TREATMENTS and PROCEDURES

1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

a. SPECIAL CARE–*Check treatments or programs received during the last 14 days* [Note–count only post admission treatments]

TREATMENTS
☐ **a.** Chemotherapy or radiation
☐ **b.** Oxygen therapy
☐ **c.** Dialysis

PROGRAMS
☐ **d.** Alcohol/drug treatment program
☐ **e.** Alzheimer's/dementia special care unit
☐ **f.** Hospice care
☐ **g.** Home health
☐ **h.** Home care
☐ **i.** Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)
☐ **j.** Case management
☐ **k.** Day treatment program
☐ **l.** Sheltered workshop/employment
☐ **m.** Job training
☐ **n.** Transportation
☐ **o.** Psychological rehabilitation
☐ **p.** Formal education
☐ **q.** *NONE OF ABOVE*

b. THERAPIES–*Record the number of days each of the following therapies was administered (for at least 15 minutes a day) in the **last 7 calendar days** (Enter 0 if none or less than 15 min. a day)*

(Note-count only post admission therapies) **(A) = # of days administered for 15 minutes or more** **Check B if therapy was received at home or in facility** **Check C if therapy was received out-of-home or facility**	Days (A)	ON SITE (B)	OFF SITE (C)
a. Speech-language pathology and auditory services			
b. Occupational therapy			
c. Physical therapy			
d. Respiratory therapy			
e. Psychological therapy (by any licensed mental health professional)			

2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS

(Check all interventions or strategies used in the last 7 days unless other time specified–no matter where received)
☐ **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 bureau in which to rummage
☐ **f.** Reorientation–e.g., cueing
☐ **g.** Validation/Redirection
☐ **h.** Crisis intervention in facility
☐ **i.** Crisis stabilization unit in last 90 days
☐ **j.** Other *(specify)* _____
☐ **k.** *NONE OF ABOVE*

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SECTION P. SPECIAL TREATMENTS AND PROCEDURES (cont.)

3. NEED FOR ON-GOING MONITORING

(Code for person responsible for monitoring)

0. No monitoring required **2.** RCF Other Staff
1. RCF nurse **3.** Home health nurse

_____ **a.** Acute physical or psychiatric condition - not chronic

_____ **b.** New treatment/medication

4. REHABILITATION/ RESTORATIVE CARE

*RECORD THE **number of days** each of the following rehabilitation or restorative techniques or practices was **provided to the resident for more than or equal to 15 minutes per day in the last 7 days** (Enter 0 if none or less than 15 min. daily.)*

_____ **a.** Range of motion (passive)
_____ **b.** Range of motion (active)
_____ **c.** Splint or brace assistance

TRAINING/SKILL PRACTICE IN:

_____ **d.** Bed mobility
_____ **e.** Transfer
_____ **f.** Walking
_____ **g.** Dressing or grooming
_____ **h.** Eating or swallowing
_____ **i.** Amputation/prosthesis care
_____ **j.** Communication
_____ **k.** Time management
_____ **l.** Other (*specify*)_____

5. SKILL TRAINING

*Record the **number of days,** in the **last 30 days** that each of the following IADLs were performed with assistance from staff as a skill training activity identified in the resident's service plan.*

_____ **a.** Meal Preparation (snacks, light meals)
_____ **b.** Telephone Use
_____ **c.** Light Housework (makes own bed, takes care of belongings)
_____ **d.** Laundry (sorts, folds, or washes own laundry)
_____ **e.** Managing Incontinence Supplies (pads, briefs, ostomy, catheter)
_____ **f.** Managing Cash (handles cash, makes purchases)
_____ **g.** Managing Finances (banking, handling checkbook, or paying bills)
_____ **h.** Arranges Shopping (makes list, acquires help)
_____ **i.** Shopping (for groceries, clothes, or other incidentals)
_____ **j.** Transportation (travel by various means to get to medical appointments or other necessary engagements)
_____ **k.** Medications (preparation and administration of medications)
_____ **l.** Other *(specify)* _____

6. ADHERENCE WITH TREATMENTS/ THERAPIES/ PROGRAMS

***In the last 6 months,** compliant all or most of the time with special treatments, therapies and programs:*

☐ **0.** Always compliant ☐ **3.** No treatments or programs
☐ **1.** Compliant 80% of time ☐ **8.** Unknown
☐ **2.** Compliant less than 80% of the time

7. GENERAL HOSPITAL STAY(S)

Record number of times resident was admitted to an acute care hospital with an overnight stay **in last 6 months** (or since last assessment if less than 6 months.) (Enter "0" if no hospital admissions)

8. EMERGENCY ROOM (ER) VISIT(S)

Record number of times resident visited ER without an overnight stay in **last 6 months** (or since last assessment if less than 6 months.) (Enter "0" if no ER visits)

9. PHYSICIAN VISITS

In the **last 6 months** (or since admission to facility if less than 6 months) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter "0" if none)

10. PHYSICIAN ORDERS

In the **last 14 days** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter "0" if none)

11. ABNORMAL LAB VALUES

Has the resident had any abnormal lab values during the **last 90 days** (or since admission if less than 90 days)? ☐ 0. No ☐ 1. Yes

12. PSYCHIATRIC HOSPITAL STAY(S)

Record number of times resident was admitted to a psychiatric hospital with an overnight stay in the **last 6 months** (or since last assessment if less than 6 months.) (Enter "0" if no psychiatric hospital admissions)

13. OUTPATIENT SURGERY

Record number of times resident had outpatient surgery in the **last 6 months** (or since last assessment if less than 6 months.) (Enter "0" if no outpatient surgery)

SECTION Q. SERVICE PLANNING

1. RESIDENT GOALS

(Check all areas in which resident has self-identified goals)

☐ **a.** Health promotion/wellness/exercise
☐ **b.** Social involvement/making friends
☐ **c.** Activities/hobbies/adult learning
☐ **d.** Rehabilitation–skilled
☐ **e.** Maintaining physical or cognitive function
☐ **f.** Participation in the community
☐ **g.** Other *(specify)* _____
☐ **h.** No goals

2. CONFLICT

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

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

SECTION R. DISCHARGE POTENTIAL

1. DISCHARGE POTENTIAL

a. Does resident or family indicate a preference to return to community? ☐ **0**. No ☐ **1**. Yes

b. Does resident have a support person who is positive towards discharge? ☐ **0**. No ☐ **1**. Yes

c. Has resident's self-sufficiency changed compared to 6 months or since admission, if less than 6 months?
☐ **0**. No change ☐ **1**. Improved ☐ **2**. Declined

SECTION S. ASSESSMENT INFORMATION

1. PARTICIPATION IN ASSESSMENT

a. Resident: ☐ **0**. No ☐ **1**. Yes
b. Family: ☐ **0**. No ☐ **1**. Yes ☐ **2**. No Family
c. Other Non-Staff: ☐ **0**. No ☐ **1**. Yes ☐ **2**. None

2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:

_____
a. Signature of Assessment Coordinator (sign on line above)
b. Date Assessment Coordinator signed as complete ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)

c. Other Signatures Title Sections Date

d. Date

e. Date

3. CASE MIX GROUP ☐☐☐☐☐

SECTION T. PREVENTIVE HEALTH/HEALTH BEHAVIORS

1. PREVENTIVE HEALTH

(Check all the procedures the resident received during the past 12 months)

☐ **a.** Blood pressure monitoring
☐ **b.** Hearing assessment
☐ **c.** Vision test
☐ **d.** Dental visit
☐ **e.** Influenza vaccine
☐ **f.** Pneumococcal vaccine (ANY time)
☐ **g.** Breast exam or mammogram
☐ **h.** Pap smear
☐ **i.** PSA or rectal exam
☐ **j.** Other *(specify)* _____

Contact Information: Catherine Gunn, USM, Muskie School of Public Service, PO Box 9300, Portland, ME 04104, 207-780-5576

Resident Name:_____ Date:_____ Soc. Sec. #_____ Facility Provider #_____

SECTION U. MEDICATIONS LIST

List all medications given during the last 7 days. Include medications used regularly less than weekly as part of the resident's treatment regimen.

1. List the medication name and the dosage
2. RA (Route of Administration). Use the appropriate code from the following list:

1 = by mouth (PO)	3 = intramuscular (IM)	5 = subcutaneous (SubQ)	7 = topical	9 = enteral tube
2 = sublingual (SL)	4 = intravenous (IV)	6 = rectally	8 = inhalation	10 = other

3. FREQ (Frequency): Use the appropriate frequency code to show the number of times per day that the medication was given.

PR = (PRN) as necessary	8H = (q8h) every eight hours	5D = five times a day	5W = five times every week
1H = (qh) every hour	1D = (qd or hs) once daily	1W = (QWeek) once every week	6W = six times every week
2H = (q2h) every two hours	2D = (BID) two times daily	2W = twice every week	1M = (QMonth) once every month
3H = (q3h) every three hours	(includes every 12 hours)	3W = three times every week	2M = twice every month
4H = (q4h) every four hours	3D = (TID) three times daily	QO = every other day	C = continuous
6H = (q6h) every six hours	4D = (QID) four times daily	4W = four times every week	O = other

4. PRN-n (prn — number of doses): If the frequency code is "PR", record the number of times during the past 7 days that each PRN medication was given. Do not use this column for scheduled medications.

5. DRUG CODE: Enter the National Drug Code (NDC). The last two digits of the 11-digit NDC define package size and have been omitted from the codes listed in the manual Appendix E. If using this Appendix, the NDC should be entered left-justified (the first digit of the code should be entered in the space farthest to the left of the NDC code column). This should result in the last two spaces being left blank.

1. Medication Name and Dosage	2. RA	3. Freq	4. PRN-n	5. NDC Codes
EXAMPLE: Coumadin 2.5 mg	1	1W		
Digoxin 0.125 mg	1	1D		
Humulin R 25 Units	5	1D		
Robitussin 15cc	1	PR	2	

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Resident Name:_____ Date:_____ Soc. Sec. #_____ Facility Provider #_____

MINIMUM DATA SET (MDS)©
ASSISTED LIVING SERVICES (ALS)

DISCHARGE FORM

SECTION D1. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
2.	GENDER	☐ **1.** Male ☐ **2.** Female
3.	BIRTHDATE	☐☐ — ☐☐ — ☐☐☐☐ Month Day Year
4.	RACE/ ETHNICITY *(Check only one.)*	☐ **1.** American Indian/Alaskan Native ☐ **2.** Asian/Pacific Islander ☐ **3.** Black, not of Hispanic origin ☐ **4.** Hispanic ☐ **5.** White, not of Hispanic origin ☐ **6.** Other
5.	SOCIAL SECURITY AND MEDICARE NUMBERS [C in 1st box if no med. no.]	**a.** Social Security Number ☐☐☐ — ☐☐ — ☐☐☐☐ **b.** Medicare number (or comparable railroad insurance number) ☐☐☐☐☐☐☐☐☐☐—☐☐
6.	FACILITY NAME AND PROVIDER NO.	**a.** Facility Name _____ **b.** Provider No. ☐☐☐☐☐☐☐☐☐
7.	MAINECARE NO.	***[Record a "+" if pending, "N" if not a MaineCare recipient]*** ☐☐☐☐☐☐☐☐☐
8.	REASON FOR ASSESSMENT	***(NOTE: Other codes do not apply to this form)*** **6**. Discharged **7**. Discharged prior to completing initial assessement

SECTION D2. DEMOGRAPHIC INFORMATION

1.	DATE OF ENTRY	*Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date* ☐☐ — ☐☐ — ☐☐☐☐ Month Day Year
2.	ADMITTED FROM (AT ENTRY) *(Check only one.)*	☐ **1.** Private home/apt. ☐ **2.** Other residential care/assisted living/group home ☐ **3.** Nursing home ☐ **4.** Acute care hospital ☐ **5.** Psychiatric hospital ☐ **6.** MR/DD facility ☐ **7.** Rehabilitation hospital ☐ **8.** Other *(specify)* _____

SECTION D3. ASSESSMENT/DISCHARGE INFORMATION

1.	DISCHARGE STATUS	*Code for resident disposition upon discharge* **1.** Private home/apt. with no home health services **2.** Private home/apt. with home health services **3.** Residential care facility *(specify)*_____ **4.** Nursing home *(specify)*_____ **5.** Acute care hospital **6.** Psychiatric hospital, MR/DD facility **7.** Rehabilitation hospital **8.** Deceased **9.** Other *(specify)* _____
2.	DISCHARGE DATE	*Date of death or discharge* ☐☐ — ☐☐ — ☐☐☐☐ Month Day Year
3.	**SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT**:	**a**. Signatures Title Date **b**. Date **c**. Date

MDS-ALS ME (Rev 12/03)
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