

Resident Name: SAMANTHA GREEN Date: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Facility Provider # \_\_\_\_\_

**MINIMUM DATA SET (MDS)<sup>®</sup>**  
**ASSISTED LIVING SERVICES (ALS)**

**DISCHARGE FORM**

**SECTION D1. IDENTIFICATION INFORMATION**

1.	<b>RESIDENT NAME</b>	<b>SAMANTHA GREEN</b>
	a. (First)      b. (Middle Initial)      c. (Last)      d. (Jr/Sr)	
2.	<b>GENDER</b>	<input type="checkbox"/> 1. Male      X 2. Female
3.	<b>BIRTHDATE</b>	0 2 — 2 5 — 1 9 2 4 Month      Day      Year
4.	<b>RACE/ETHNICITY</b> <i>(Check only one.)</i>	<input type="checkbox"/> 1. American Indian/Alaskan Native <input type="checkbox"/> 5. White, not of Hispanic origin <input type="checkbox"/> 2. Asian/Pacific Islander <input checked="" type="checkbox"/> 3. Black, not of Hispanic origin <input type="checkbox"/> 6. Other <input type="checkbox"/> 4. Hispanic
5.	<b>SOCIAL SECURITY AND MEDICARE NUMBERS</b> <i>[C in 1<sup>st</sup> box if no med. no.]</i>	a. Social Security Number 0 0 5 — 2 2 — 9 4 4 4 b. Medicare number (or comparable railroad insurance number) 0 0 5 2 2 9 4 4 4 — A
6.	<b>FACILITY NAME AND PROVIDER NO.</b>	a. Facility Name <b>MCBVI</b> b. Provider No. 9 9 9 9 9 9 9 9
7.	<b>MAINECARE NO.</b>	<i>[Record a "+" if pending, "N" if not a MaineCare recipient]</i> 2 4 6 0 3 7 7 0 A
8.	<b>REASON FOR ASSESSMENT</b>	<i>(NOTE: Other codes do not apply to this form)</i> 6. Discharged 7. Discharged prior to completing initial assessment

**SECTION D3. ASSESSMENT/DISCHARGE INFORMATION**

1.	<b>DISCHARGE STATUS</b>	<i>Code for resident disposition upon discharge</i> 1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Another residential care facility ( <i>specify</i> ) _____ 4. Nursing home ( <i>specify</i> ) _____ 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Deceased 9. Other ( <i>specify</i> ) _____	6
2.	<b>DISCHARGE DATE</b>	<i>Date of death or discharge</i> 0 7 — 2 5 — 2 0 0 4 Month      Day      Year	
3.	<b>SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:</b>		
	<b>NANCY SMITH</b>	<b>RCA DIRECTOR</b>	<b>07/26/2004</b>
	a. Signatures	Title	Date
	b.		Date
	c.		Date

**SECTION D2. DEMOGRAPHIC INFORMATION**

1.	<b>DATE OF ENTRY</b>	<i>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</i> 0 8 — 0 9 — 1 9 7 1 Month      Day      Year
2.	<b>ADMITTED FROM (AT ENTRY)</b> <i>(Check only one.)</i>	X1. Private home/apt. <input type="checkbox"/> 2. Other residential care/assisted living/group home <input type="checkbox"/> 3. Nursing home <input type="checkbox"/> 4. Acute care hospital <input type="checkbox"/> 5. Psychiatric hospital <input type="checkbox"/> 6. MR/DD facility <input type="checkbox"/> 7. Rehabilitation hospital <input type="checkbox"/> 8. Other ( <i>specify</i> ) _____

**MINIMUM DATA SET (MDS)<sup>®</sup>**  
**ASSISTED LIVING SERVICES (ALS)**

**DISCHARGE FORM**

**SECTION D1. IDENTIFICATION INFORMATION**

1.	<b>RESIDENT NAME</b>	<b>WHITEHORSE CARTWRIGHT</b>																					
	a. (First)      b. (Middle Initial)      c. (Last)      d. (Jr/Sr)																						
2.	<b>GENDER</b>	<input checked="" type="checkbox"/> 1. Male <input type="checkbox"/> 2. Female																					
3.	<b>BIRTHDATE</b>	<table border="1"> <tr> <td>0</td><td>9</td> <td>1</td><td>1</td> <td>1</td><td>9</td><td>0</td><td>9</td> </tr> <tr> <td colspan="2">Month</td> <td colspan="2">Day</td> <td colspan="4">Year</td> </tr> </table>	0	9	1	1	1	9	0	9	Month		Day		Year								
0	9	1	1	1	9	0	9																
Month		Day		Year																			
4.	<b>RACE/ETHNICITY</b> <i>(Check only one.)</i>	<input checked="" type="checkbox"/> 1. American Indian/Alaskan Native <input type="checkbox"/> 5. White, not of Hispanic origin <input type="checkbox"/> 2. Asian/Pacific Islander <input type="checkbox"/> 3. Black, not of Hispanic origin <input type="checkbox"/> 6. Other <input type="checkbox"/> 4. Hispanic																					
5.	<b>SOCIAL SECURITY AND MEDICARE NUMBERS</b> <i>[C in 1<sup>st</sup> box if no med. no.]</i>	a. Social Security Number <table border="1"> <tr> <td>0</td><td>8</td><td>8</td> <td>9</td><td>5</td> <td>8</td><td>9</td><td>8</td><td>9</td> </tr> </table> b. Medicare number (or comparable railroad insurance number) <table border="1"> <tr> <td>0</td><td>8</td><td>8</td><td>9</td><td>5</td><td>8</td><td>9</td><td>8</td><td>9</td><td>—</td><td>C</td><td>1</td> </tr> </table>	0	8	8	9	5	8	9	8	9	0	8	8	9	5	8	9	8	9	—	C	1
0	8	8	9	5	8	9	8	9															
0	8	8	9	5	8	9	8	9	—	C	1												
6.	<b>FACILITY NAME AND PROVIDER NO.</b>	a. Facility Name <p style="text-align: center;"><b>MCBVI</b></p> b. Provider No. <table border="1"> <tr> <td>9</td><td>9</td><td>9</td><td>9</td><td>9</td><td>9</td><td>9</td><td>9</td><td>9</td> </tr> </table>	9	9	9	9	9	9	9	9	9												
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7.	<b>MAINECARE NO.</b>	<i>[Record a "+" if pending, "N" if not a MaineCare recipient]</i> <table border="1"> <tr> <td>9</td><td>8</td><td>3</td><td>5</td><td>4</td><td>5</td><td>6</td><td>7</td><td>A</td> </tr> </table>	9	8	3	5	4	5	6	7	A												
9	8	3	5	4	5	6	7	A															
8.	<b>REASON FOR ASSESSMENT</b>	(NOTE: Other codes do not apply to this form) <input type="checkbox"/> 6. Discharged <input type="checkbox"/> 7. Discharged prior to completing initial assessment																					

**SECTION D3. ASSESSMENT/DISCHARGE INFORMATION**

1.	<b>DISCHARGE STATUS</b>	<i>Code for resident disposition upon discharge</i> 1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Another 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) _____	<b>5</b>																
2.	<b>DISCHARGE DATE</b>	<i>Date of death or discharge</i> <table border="1"> <tr> <td>0</td><td>6</td> <td>2</td><td>4</td> <td>2</td><td>0</td><td>0</td><td>4</td> </tr> <tr> <td colspan="2">Month</td> <td colspan="2">Day</td> <td colspan="4">Year</td> </tr> </table>	0	6	2	4	2	0	0	4	Month		Day		Year				
0	6	2	4	2	0	0	4												
Month		Day		Year															
3.	<b>SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:</b> <table border="1"> <tr> <td><b>NANCY SMITH</b></td> <td><b>RCA DIRECTOR</b></td> <td><b>08/24/2004</b></td> </tr> <tr> <td>a. Signatures</td> <td>Title</td> <td>Date</td> </tr> <tr> <td>b. _____</td> <td>_____</td> <td>Date</td> </tr> <tr> <td>c. _____</td> <td>_____</td> <td>Date</td> </tr> </table>			<b>NANCY SMITH</b>	<b>RCA DIRECTOR</b>	<b>08/24/2004</b>	a. Signatures	Title	Date	b. _____	_____	Date	c. _____	_____	Date				
<b>NANCY SMITH</b>	<b>RCA DIRECTOR</b>	<b>08/24/2004</b>																	
a. Signatures	Title	Date																	
b. _____	_____	Date																	
c. _____	_____	Date																	

**SECTION D2. DEMOGRAPHIC INFORMATION**

1.	<b>DATE OF ENTRY</b>	<i>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</i> <table border="1"> <tr> <td>0</td><td>6</td> <td>2</td><td>2</td> <td>2</td><td>0</td><td>0</td><td>4</td> </tr> <tr> <td colspan="2">Month</td> <td colspan="2">Day</td> <td colspan="4">Year</td> </tr> </table>	0	6	2	2	2	0	0	4	Month		Day		Year			
0	6	2	2	2	0	0	4											
Month		Day		Year														
2.	<b>ADMITTED FROM (AT ENTRY)</b> <i>(Check only one.)</i>	<input type="checkbox"/> 1. Private home/apt. <input type="checkbox"/> 2. Other residential care/assisted living/group home <input type="checkbox"/> 3. Nursing home <input checked="" type="checkbox"/> 4. Acute care hospital <input type="checkbox"/> 5. Psychiatric hospital <input type="checkbox"/> 6. MR/DD facility <input type="checkbox"/> 7. Rehabilitation hospital <input type="checkbox"/> 8. Other (specify) _____																

**MINIMUM DATA SET (MDS)®**  
ASSISTED LIVING SERVICES (ALS)

FACE SHEET: BACKGROUND INFORMATION ONLY AT ADMISSION

**SECTION AA. IDENTIFICATION INFORMATION**

1. RESIDENT NAME	JOHN D CONWAY a. (First)      b. (Middle Initial)      c. (Last)      d. (Jr/Sr)
2. GENDER	X 1. Male <input type="checkbox"/> 2. Female
3. BIRTHDATE	0 6 — 1 0 — 1 9 2 0 Month      Day      Year
4. RACE/ETHNICITY <i>(Check only one.)</i>	<input type="checkbox"/> 1. American Indian/Alaskan Native <input type="checkbox"/> 4. Hispanic <input type="checkbox"/> 2. Asian/Pacific Islander      X 5. White, not of Hispanic origin <input type="checkbox"/> 3. Black, not of Hispanic origin <input type="checkbox"/> 6. Other
5. SOCIAL SECURITY and MEDICARE NUMBERS <i>(C in 1st box if no med. no.)</i>	a. Social Security Number 0 0 4 — 2 8 — 3 2 2 0 b. Medicare number (or comparable railroad insurance number) 0 0 4 0 7 4 6 8 9 — C 1
6. FACILITY NAME AND PROVIDER NO.	a. Facility Name MCBVI b. Provider No. 9 9 9 9 9 9 9 9 9
7. MAINECARE NO.	<i>[Record a "+" if pending, "N" if not a MaineCare recipient]</i> 3 1 9 9 2 0 1 0 A

**SECTION AB. DEMOGRAPHIC INFORMATION**

1. DATE OF ENTRY	Date the stay began. <i>(Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date.)</i> 0 2 — 0 3 — 1 9 6 8 Month      Day      Year
2. ADMITTED FROM (AT ENTRY) <i>(Check only one.)</i>	X 1. Private home/apt. <input type="checkbox"/> 2. Other board and care/assisted living/group home <input type="checkbox"/> 3. Nursing home <input type="checkbox"/> 4. Acute care hospital <input type="checkbox"/> 5. Psychiatric hospital <input type="checkbox"/> 6. MR/DD facility <input type="checkbox"/> 7. Rehabilitation hospital <input type="checkbox"/> 8. Other <i>(specify)</i> _____
3. LIVED ALONE (PRIOR TO ENTRY) <i>(Check only one.)</i>	X 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. In other facility
4. PRIOR PRIMARY RESIDENCE	Provide town, state, zip code for Resident's primary residence prior to admission SOUTH PORTLAND      MAINE      0 4 1 0 6 Town      State      Zip Code
5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	<i>(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above)</i> <input type="checkbox"/> a. Prior stay at this home <input type="checkbox"/> b. Nursing home <input type="checkbox"/> c. Other residential facility—board and care home, assisted living, group home <input type="checkbox"/> d. MH/psychiatric hospital <input type="checkbox"/> e. MR/DD facility X f. NONE OF ABOVE
6. LIFETIME OCCUPATION	Put a "/" between two occupations. P R O D U C T I O N      W O R K E R

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

**SECTION AC. CUSTOMARY ROUTINE**

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

**SECTION AD. FACE SHEET SIGNATURES and DATES**

1. SIGNATURE(S) OF PERSON(S) COMPLETING FACE SHEET:			
a. Signatures	Title	Sections	Date
NANCY SMITH	RCA COORDINATOR	ALL	12/12/1968
b.			Date
2. DATE COMPLETED	Record date background information was completed.		
	1 2 — 1 2 — 1 9 6 8 Month      Day      Year		

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

**SECTION B. COGNITIVE PATTERNS**

1. MEMORY	<i>(Recall of what was learned or known)</i> a. Short-term memory OK—seems/appears to recall after 5 minutes <input checked="" type="checkbox"/> 0. Memory OK <input type="checkbox"/> 1. Memory problem b. Long-term memory OK—seems/appears to recall long past <input checked="" type="checkbox"/> 0. Memory OK <input type="checkbox"/> 1. Memory problem
2. MEMORY/RECALL ABILITY	<i>(Check all that resident was normally able to recall during last 7 days)</i> <input checked="" type="checkbox"/> a. Current season <input checked="" type="checkbox"/> d. That he/she is in a facility/home <input checked="" type="checkbox"/> b. Location of own room <input type="checkbox"/> e. NONE OF ABOVE are recalled <input checked="" type="checkbox"/> c. Staff names/faces
3. COGNITIVE SKILLS FOR DAILY DECISION-MAKING <i>(Check only one.)</i>	<i>(Made decisions regarding tasks of daily life)</i> <input checked="" type="checkbox"/> 0. INDEPENDENT—decisions consistent/reasonable <input type="checkbox"/> 1. MODIFIED INDEPENDENCE—some difficulty in new situations only <input type="checkbox"/> 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required <input type="checkbox"/> 3. SEVERELY IMPAIRED—never/rarely made decisions
4. COGNITIVE STATUS <i>(Check only one.)</i>	Resident's cognitive status or abilities now compared to resident's status 180 days ago (or since admission if less than 180 days). <input checked="" type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined

**SECTION C. COMMUNICATION/HEARING PATTERNS**

1. HEARING <i>(Check only one.)</i>	<i>(With hearing appliance, if used)</i> <input type="checkbox"/> 0. HEARS ADEQUATELY—normal talk, TV, phone <input type="checkbox"/> 1. MINIMAL DIFFICULTY when not in quiet setting <input checked="" type="checkbox"/> 2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly <input type="checkbox"/> 3. HIGHLY IMPAIRED—absence of useful hearing
2. COMMUNICATION DEVICES/TECHNIQUES	<i>(Check all that apply during last 7 days.)</i> <input checked="" type="checkbox"/> a. Hearing aid, present and used <input type="checkbox"/> b. Hearing aid, present and not used regularly <input type="checkbox"/> c. Other receptive communication techniques used (e.g., lip reading) <input type="checkbox"/> d. NONE OF ABOVE
3. MAKING SELF UNDERSTOOD <i>(Check only one.)</i>	<i>(Expressing information content—however able)</i> <input checked="" type="checkbox"/> 0. UNDERSTOOD <input type="checkbox"/> 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts <input type="checkbox"/> 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests <input type="checkbox"/> 3. RARELY/NEVER UNDERSTOOD
4. ABILITY TO UNDERSTAND OTHERS <i>(Check only one.)</i>	<i>(Understanding information content—however able)</i> <input type="checkbox"/> 0. UNDERSTANDS <input checked="" type="checkbox"/> 1. USUALLY UNDERSTANDS—may miss some part / intent of message <input type="checkbox"/> 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication <input type="checkbox"/> 3. RARELY/NEVER UNDERSTANDS
5. COMMUNICATION	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. <input checked="" type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined

**SECTION D. VISION PATTERNS**

1. VISION <i>(Check only one.)</i>	<i>(Ability to see in adequate light and with glasses if used)</i> <input type="checkbox"/> 0. ADEQUATE—sees fine detail, including regular print in newspapers/books <input type="checkbox"/> 1. IMPAIRED—sees large print, but not regular print in newspapers/books <input type="checkbox"/> 2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects <input type="checkbox"/> 3. HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes b. Artificial eye <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes

**SECTION E. MOOD AND BEHAVIOR PATTERNS**

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	<i>(CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause)</i> 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)
	<b>VERBAL EXPRESSIONS OF DISTRESS</b> 0 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." 0 b. Repetitive questions—e.g., "Where do I go; What do I do?" 0 c. Repetitive verbalizations—e.g., calling out for help, ("God help me") 0 d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in facility; anger at care received 0 e. Self deprecation—e.g., "I am nothing; I am of no use to anyone" 0 f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others 0 g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack 0 h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions 0 i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues <i>(continued next page)</i>

**SECTION E. MOOD and BEHAVIOR PATTERNS (cont.)**

1.	<b>INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD</b>	<i>(CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause)</i>				
		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)				
		<b>SLEEP-CYCLE ISSUES</b>				
		0 j. Unpleasant mood in morning 0 k. Insomnia/change in usual sleep pattern <b>SAD, APATHETIC, ANXIOUS APPEARANCE</b> 0 l. Sad, pained, worried facial expressions—e.g., furrowed brows 0 m. Crying, tearfulness 0 n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking <b>LOSS OF INTEREST</b> 0 o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends 0 p. Reduced social interaction <b>INDICATORS OF MANIA</b> 2 q. Inflated self-worth, exaggerated self-opinion; inflated belief about one's own ability, etc. 1 r. Excited behavior, motor excitation (e.g., heightened physical activity; excited, loud or pressured speech; increased reactivity)				
2.	<b>MOOD PERSISTENCE</b> <i>(Check only one.)</i>	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 <b>over last 7 days.</b> X 0. No mood indicators <input type="checkbox"/> 1. Indicators present, easily altered <input type="checkbox"/> 2. Indicators present, not easily altered				
3.	<b>MOOD</b> <i>(Check only one.)</i>	Resident's current mood status compared to resident's status 180 days ago (or since admission if less than 180 days): X 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined				
4.	<b>BEHAVIORAL SYMPTOMS</b>	<i>(COLUMN A CODES: Record the appropriate code for the frequency of the symptom in last 7 days)</i>		<i>(COLUMN B CODES: Alterability of behavioral symptoms in last 7 days)</i>		
		0. Behavior not exhibited in last 7 days		0. Not present or easily altered		
		1. Behavior of this type occurred 1 to 3 days in last 7 days		1. Behavior not easily altered		
		2. Behavior of this type occurred 4 to 6 days but less than daily				
		3. Behavior of this type occurred daily				
		<i>(COLUMN C CODES: History of this behavior in the last 6 months)</i>				
		0. No    1. Yes				
		a.	WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	0	0	0
		b.	VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)	0	0	0
		c.	PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused, gross physical assault)	0	0	0
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)	0	0	0		
e.	RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)	0	0	0		
f.	INTIMIDATING BEHAVIOR (made others feel unsafe, at risk, privacy invaded)	0	0	0		
g.	ELOPEMENT	0	0	0		
h.	Dangerous non-violent behavior (e.g., falling asleep while smoking)	0	0	0		
i.	Dangerous violent behavior	0	0	0		
j.	FIRE SETTING	0	0	0		
5.	<b>SUICIDAL IDEATION</b>	Resident demonstrated suicidal thoughts or actions in the last 30 days: <input type="checkbox"/> 0. No    X 1. Yes				
6.	<b>SLEEP PROBLEMS</b>	Check all present on 2 or more days during last 7 days <input type="checkbox"/> a. Inability to awaken when desired    X d. Interrupted sleep <input type="checkbox"/> b. Difficulty falling asleep <input type="checkbox"/> e. NONE OF ABOVE <input type="checkbox"/> c. Restless or non-restful sleep				
7.	<b>INSIGHT INTO MENTAL HEALTH</b>	Resident has insight about his/her mental problem X 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No mental health problems				
8.	<b>BEHAVIORS</b> <i>(Check only one.)</i>	Resident's current behavior status compared to resident's status 180 days ago (or since admission if less than 180 days): X 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined				

**SECTION F. PSYCHOSOCIAL WELL-BEING**

1.	<b>SENSE OF INITIATIVE/ INVOLVEMENT</b> <i>(Check all that apply)</i>	X a. At ease interacting with others	
		X b. At ease doing planned or structured activities	
		X c. At ease doing self-initiated activities	
		<input type="checkbox"/> d. Establishes own goals	
		<input type="checkbox"/> 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)	
		<input type="checkbox"/> f. Accepts invitations into most group activities	
		<input type="checkbox"/> g. NONE OF ABOVE	
2.	<b>UNSETTLED RELATIONSHIPS</b> <i>(Check all that apply)</i>	<input type="checkbox"/> a. Covert/open conflict with or repeated criticism of staff	
		<input type="checkbox"/> b. Unhappy with roommate	
		<input type="checkbox"/> c. Unhappy with residents other than roommate	
		<input type="checkbox"/> d. Openly expresses conflict/anger with family/friends	
		<input type="checkbox"/> e. Absence of personal contact with family/friends	
		<input type="checkbox"/> f. Recent loss of close family member/friend	
		<input type="checkbox"/> g. Does not adjust easily to change in routines	
		X h. NONE OF ABOVE	
3.	<b>LIFE-EVENTS HISTORY</b> <i>(Check all that apply.)</i>	Events in past 2 years	
		<input type="checkbox"/> a. Serious accident or physical illness	
		<input type="checkbox"/> b. Health concerns for other person	
		<input type="checkbox"/> c. Death of family member or close friend	
		<input type="checkbox"/> d. Trouble with the law	
		<input type="checkbox"/> e. Robbed/physically attacked	
		<input type="checkbox"/> f. Conflict laden or severed relationship	
		X g. Loss of income leading to change in lifestyle	
		<input type="checkbox"/> h. Sexual assault/abuse	
		<input type="checkbox"/> i. Child custody issues	
<input type="checkbox"/> j. Change in marital/partner status			
<input type="checkbox"/> k. Review hearings (e.g., forensic, certification, capacity hearing)			
		<input type="checkbox"/> l. NONE OF ABOVE	

**SECTION G. PHYSICAL FUNCTIONING**

1.	<b>(A) ADL SELF-PERFORMANCE</b>			
	0. <b>INDEPENDENT</b> —No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days			
	1. <b>SUPERVISION</b> —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. <b>LIMITED ASSISTANCE</b> —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. <b>EXTENSIVE ASSISTANCE</b> —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. <b>TOTAL DEPENDENCE</b> —Full staff performance of activity during last 7 days			
	8. <b>ACTIVITY DID NOT OCCUR DURING LAST 7 DAYS</b>			
	<b>(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.</b>			
				A B
		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.	<b>BED MOBILITY</b> — How resident moves to and from lying position, turns side to side, and positions body while in bed	0	0	
b.	<b>TRANSFER</b> — How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	0	0	
c.	<b>LOCOMOTION</b> — 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	0	0	
d.	<b>DRESSING</b> — How resident puts on, fastens, and takes off all items of <b>street clothing</b> , including donning/removing prosthesis	0	0	
e.	<b>EATING</b> — How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	0	0	
f.	<b>TOILET USE</b> — How resident uses the toilet room (or commode, bed-pan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	0	0	
g.	<b>PERSONAL HYGIENE</b> — How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)	0	0	
h.	<b>STAIRS</b> — How resident climbs stairs	0	0	

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SECTION G. PHYSICAL FUNCTIONING (cont.)

2. BATHING SELF-PERFORMANCE
3A. MODES OF LOCOMOTION
3B. MAIN MODE OF LOCOMOTION
3C. BEDFAST/CHAIRFAST
4. SELF-PERFORMANCE IN ADLs
5A. IADL SELF-PERFORMANCE
5B. TRANSPORTATION
6. ADL AND IADL FUNCTIONAL REHABILITATION OR IMPROVEMENT POTENTIAL

SECTION G. PHYSICAL FUNCTIONING (cont.)

7. NEW DEVICES NEEDED
8. SELF-PERFORMANCE IN IADLs

SECTION H. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL CATEGORIES
a. BOWEL CONTINENCE
b. BLADDER CONTINENCE
2. BOWEL ELIMINATION PATTERN
3. APPLIANCES and PROGRAMS
4. USE OF INCONTINENCE SUPPLIES
5. CHANGES IN URINARY CONTINENCE

SECTION I. DIAGNOSES

1. DIAGNOSES
ENDOCRINE/METABOLIC/NUTRITIONAL
HEART/CIRCULATION

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SECTION I. DIAGNOSES (cont.)

Form for Section I containing checkboxes for Musculoskeletal, Neurological, Psychiatric/Mood, Pulmonary, Sensory, and Other conditions.

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

Form for Section J containing checkboxes for Pain Interferes, Pain Management, Accidents, and Danger of Fall.

SECTION K. ORAL/NUTRITIONAL STATUS

Form for Section K containing checkboxes for Oral Problems, Height and Weight, Weight Change, and Nutritional Problems.

SECTION J. HEALTH CONDITIONS AND POSSIBLE MEDICATION SIDE EFFECTS

Form for Section J containing checkboxes for Problem Conditions, Extra-Pyramidal Signs and Symptoms, Pain Symptoms, and Pain Site.

SECTION L. ORAL/DENTAL STATUS

Form for Section L containing checkboxes for Oral Status and Disease Prevention.

SECTION M. SKIN CONDITION

Form for Section M containing checkboxes for Skin Problems and ULCERS.

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**SECTION M. SKIN CONDITION**

<b>3. FOOT PROBLEMS</b>	a. Resident or someone else inspects resident's feet on a regular basis? <input type="checkbox"/> 0. No <input checked="" type="checkbox"/> 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? <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes

**SECTION N. ACTIVITY PURSUIT PATTERNS**

<b>1. TIME AWAKE</b>	<i>(Check appropriate time periods over last 7 days)</i> Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: <input checked="" type="checkbox"/> a. Morning <input type="checkbox"/> d. Night (Bedtime to A.M.) <input checked="" type="checkbox"/> b. Afternoon <input type="checkbox"/> e. NONE OF ABOVE <input checked="" type="checkbox"/> c. Evening
<b>2. AVERAGE TIME INVOLVED IN ACTIVITIES</b> <i>(Check only one.)</i>	<i>(When awake and not receiving treatments or ADL care)</i> <input checked="" type="checkbox"/> 1. Most—more than 2/3 of time <input type="checkbox"/> 2. Some—from 1/3 to 2/3 of time <input type="checkbox"/> 3. Little—less than 1/3 of time <input type="checkbox"/> 4. None
<b>3. PREFERRED ACTIVITY SETTINGS</b>	<i>(Check all settings in which activities are preferred)</i> <input checked="" type="checkbox"/> a. Own room <input checked="" type="checkbox"/> d. Away from facility <input checked="" type="checkbox"/> b. Day/activity room <input type="checkbox"/> e. NONE OF ABOVE <input checked="" type="checkbox"/> c. Outside facility (e.g., in yard)
<b>4. GENERAL ACTIVITY PREFERENCES</b> <i>(Adapted to resident's current abilities)</i>	<i>(Check all PREFERENCES whether or not activity is currently available to resident)</i> <input type="checkbox"/> a. Cards/other games <input checked="" type="checkbox"/> k. Gardening or plants <input type="checkbox"/> b. Crafts/arts <input checked="" type="checkbox"/> l. Talking or conversing <input type="checkbox"/> c. Exercise/sports <input checked="" type="checkbox"/> m. Helping others <input type="checkbox"/> d. Dancing <input checked="" type="checkbox"/> n. Doing chores around the house/facility <input checked="" type="checkbox"/> e. Music <input type="checkbox"/> o. Cooking/baking <input type="checkbox"/> f. Reading/writing <input type="checkbox"/> p. Computer activities <input checked="" type="checkbox"/> g. Spiritual/religious activity <input type="checkbox"/> q. Volunteering <input checked="" type="checkbox"/> h. Trips/shopping <input type="checkbox"/> r. Other (specify) _____ <input checked="" type="checkbox"/> i. Walking/wheeling outdoors <input type="checkbox"/> s. NONE OF ABOVE <input checked="" type="checkbox"/> j. Watching TV
<b>5. PREFERRED ACTIVITY SIZE</b>	<i>(Check all that apply)</i> <input type="checkbox"/> a. Individual <input type="checkbox"/> c. Larger group <input checked="" type="checkbox"/> b. Small group <input type="checkbox"/> d. No preference
<b>6. PREFERENCES IN DAILY ROUTINE</b> <i>(Check all that apply)</i>	<input type="checkbox"/> a. Resident prefers change in type of activity <input type="checkbox"/> b. Resident prefers change in extent of involvement in activities (e.g., more or less) <input type="checkbox"/> c. Resident prefers change in location of activities <input type="checkbox"/> d. Resident prefers activity at different time of day <input checked="" type="checkbox"/> e. Resident prefers stability in daily routine <input type="checkbox"/> f. NONE OF ABOVE
<b>7. INTERACTION WITH FAMILY AND FRIENDS</b>	a. How often has resident visited or been visited by family and friends in the last 30 days? <i>(check only one)</i> <input type="checkbox"/> 1. No family or friends outside facility <input type="checkbox"/> 4. Once a week <input type="checkbox"/> 2. None <input checked="" type="checkbox"/> 5. 2 or 3 times a week but not daily <input type="checkbox"/> 3. 1-3 times/month <input type="checkbox"/> 6. Daily b. How often has resident talked by telephone with family and friends in the last 30 days? <i>(check only one)</i> <input type="checkbox"/> 1. No family or friends outside facility <input type="checkbox"/> 4. Once a week <input type="checkbox"/> 2. None <input type="checkbox"/> 5. 2 or 3 times a week but not daily <input type="checkbox"/> 3. 1-3 times/month <input checked="" type="checkbox"/> 6. Daily
<b>8. VOTING</b>	Is resident registered to vote? <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
<b>9. SOCIAL ACTIVITIES</b> <i>(Check only one.)</i>	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): <input checked="" type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined

**SECTION O. MEDICATIONS**

<b>1. NUMBER OF MEDICATIONS</b>	<i>(Record the number of different medications used in the last 7 days; enter "0" if none used)</i>	<b>0</b>	<b>3</b>
<b>2. NEW MEDICATIONS</b>	<i>(Resident currently receiving medications that were initiated during the last 90 days)</i> <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes		
<b>3. INJECTIONS</b>	<i>(Record the number of DAYS injections of any type received during the last 30 days; enter "0" if none used)</i>	<b>0</b>	<b>0</b>

**SECTION O. MEDICATIONS (cont.)**

<b>4A. DAYS RECEIVED THE FOLLOWING MEDICATION</b>	<i>(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)</i> <input type="checkbox"/> 0 a. Antipsychotic <input type="checkbox"/> 0 d. Hypnotic <input type="checkbox"/> 0 g. Insulin <input type="checkbox"/> 0 b. Antianxiety <input type="checkbox"/> 0 e. Diuretic <input type="checkbox"/> 0 c. Antidepressant <input type="checkbox"/> 0 f. Aricept
<b>4B. PRN MEDICATIONS</b>	Does resident have a prescription for any PRN medication for a mental, emotional or nervous condition, or behavioral problem? <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
<b>5. SELF-ADMINISTERED MEDICATIONS</b> <i>(Check all that apply.)</i>	Did resident self-administer any of the following in the last 7 days: <input type="checkbox"/> a. Insulin <input type="checkbox"/> e. Glucosan <input type="checkbox"/> b. Oxygen <input type="checkbox"/> f. Over-the-counter Meds <input type="checkbox"/> c. Nebulizers <input type="checkbox"/> g. Other (specify) _____ <input type="checkbox"/> d. Nitropatch <input checked="" type="checkbox"/> h. NONE OF ABOVE
<b>6. MEDICATION PREPARATION ADMINISTRATION</b>	Did resident prepare and administer his/her own medications in last 7 days? <i>(Check only one.)</i> <input checked="" type="checkbox"/> 0. No Meds <input type="checkbox"/> 1. Resident prepared and administrated NONE of his/her own medications. <input type="checkbox"/> 2. Resident prepared and administrated SOME of his/her own medications. <input type="checkbox"/> 3. Resident prepared and administrated ALL of his/her own medications.
<b>7. MEDICATION COMPLIANCE</b> <i>(Check one)</i>	Resident's level of compliance with medications prescribed by a physician/psychiatrist during last 30 days: <input checked="" type="checkbox"/> 0. No Meds <input type="checkbox"/> 1. Always compliant <input type="checkbox"/> 2. Always compliant with reminder, verbal prompts <input type="checkbox"/> 3. Compliant some of the time (80% of time or more often) or with some medications <input type="checkbox"/> 4. Rarely or never compliant
<b>8. MISUSE OF MEDICATION</b>	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) <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes

**SECTION P. SPECIAL TREATMENTS AND PROCEDURES**

<b>1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS</b>	a. SPECIAL CARE—Check treatments or programs received during the last 14 days [Note—count only post admission treatments]			
	<input type="checkbox"/> a. Chemotherapy or radiation <input type="checkbox"/> i. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) <input type="checkbox"/> b. Oxygen therapy <input type="checkbox"/> j. Case management <input type="checkbox"/> c. Dialysis <input type="checkbox"/> k. Day treatment program <input type="checkbox"/> d. Alcohol/drug treatment program <input checked="" type="checkbox"/> l. Sheltered workshop/employment program <input type="checkbox"/> e. Alzheimer's/dementia special care unit <input checked="" type="checkbox"/> m. Job training <input type="checkbox"/> f. Hospice care <input type="checkbox"/> n. Transportation <input type="checkbox"/> g. Home health <input type="checkbox"/> o. Psychological rehabilitation <input type="checkbox"/> h. Home care <input type="checkbox"/> p. Formal education <input type="checkbox"/> 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)			
	<i>(Note—count only post admission therapies)</i>			
	(A) = # of days administered for 15 minutes or more	Days (A)	ON SITE (B)	OFF SITE (C)
	Check B if therapy was received at home or in facility			
	Check C if therapy was received out-of-home or facility			
	a. Speech-language pathology and auditory services	0		
b. Occupational therapy	0			
c. Physical therapy	0			
d. Respiratory therapy	0			
e. Psychological therapy (by any licensed mental health professional)	0			
<b>2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS</b>	<i>(Check all interventions or strategies used in the last 7 days unless other time specified—no matter where received)</i> <input type="checkbox"/> a. Special behavior symptom evaluation program <input type="checkbox"/> b. Special behavior management program <input type="checkbox"/> c. Evaluation by a licensed mental health specialist in last 90 days <input type="checkbox"/> d. Group therapy <input type="checkbox"/> e. Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage <input type="checkbox"/> f. Reorientation—e.g., cueing <input type="checkbox"/> g. Validation/Redirection <input type="checkbox"/> h. Crisis intervention in facility <input type="checkbox"/> i. Crisis stabilization unit in last 90 days <input type="checkbox"/> j. Other (specify) _____ <input checked="" type="checkbox"/> k. NONE OF ABOVE			



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**SECTION P. SPECIAL TREATMENTS AND PROCEDURES (cont.)**

3.	<b>NEED FOR ON-GOING MONITORING</b>	<i>(Code for person responsible for monitoring)</i>	
		0. No monitoring required	2. RCF Other Staff
		1. RCF nurse	3. Home health nurse
		0 a. Acute physical or psychiatric condition - not chronic	0 b. New treatment/medication
4.	<b>REHABILITATION/RESTORATIVE CARE</b>	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.)	
		0 a. Range of motion (passive)	
		0 b. Range of motion (active)	
		0 c. Splint or brace assistance	
		<b>TRAINING/SKILL PRACTICE IN:</b>	
		0 d. Bed mobility	0 i. Amputation/prosthesis care
		0 e. Transfer	0 j. Communication
		0 f. Walking	0 k. Time management
		0 g. Dressing or grooming	1 l. Other (specify) <b>MED PREP</b>
		0 h. Eating or swallowing	
5.	<b>SKILL TRAINING</b>	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.	
		00 a. Meal Preparation (snacks, light meals)	00 h. Arranges Shopping (makes list, acquires help)
		00 b. Telephone Use	00 i. Shopping (for groceries, clothes, or other incidentals)
		00 c. Light Housework (makes own bed, takes care of belongings)	00 j. Transportation (travel by various means to get to medical appointments or other necessary engagements)
		00 d. Laundry (sorts, folds, or washes own laundry)	00 k. Medications (preparation and administration of medications)
		00 e. Managing Incontinence Supplies (pads, briefs, ostomy, catheter)	01 l. Other (specify)
		00 f. Managing Cash (handles cash, makes purchases)	00
		00 g. Managing Finances (banking, handling checkbook, or paying bills)	
6.	<b>ADHERENCE WITH TREATMENTS/THERAPIES/PROGRAMS</b>	In the last 6 months, compliant all or most of the time with special treatments, therapies and programs:	
		X 0. Always compliant	3. No treatments or programs
		1. Compliant 80% of time	8. Unknown
		2. Compliant less than 80% of the time	
7.	<b>GENERAL HOSPITAL STAY(S)</b>	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)	0 0
8.	<b>EMERGENCY ROOM (ER) VISIT(S)</b>	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)	0 0
9.	<b>PHYSICIAN VISITS</b>	In the last 6 months (or since admission to facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter "0" if none)	0 3
10.	<b>PHYSICIAN ORDERS</b>	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)	0 2
11.	<b>ABNORMAL LAB VALUES</b>	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.	<b>PSYCHIATRIC HOSPITAL STAY(S)</b>	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)	0 0
13.	<b>OUTPATIENT SURGERY</b>	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)	0 0

**SECTION Q. SERVICE PLANNING**

1.	<b>RESIDENT GOALS</b>	<i>(Check all areas in which resident has self-identified goals)</i>	
		<input type="checkbox"/> a. Health promotion/wellness/exercise	<input type="checkbox"/> b. Social involvement/making friends
		<input type="checkbox"/> c. Activities/hobbies/adult learning	X d. Rehabilitation-skilled
		<input type="checkbox"/> e. Maintaining physical or cognitive function	<input type="checkbox"/> f. Participation in the community
		<input type="checkbox"/> g. Other (specify) _____	<input type="checkbox"/> h. No goals
2.	<b>CONFLICT</b>	a. Any disagreement between resident and family about goals or service plan? X 0. No <input type="checkbox"/> 1. Yes	
		b. Any disagreement between resident/family and staff about goals or service plan? X 0. No <input type="checkbox"/> 1. Yes	

**SECTION R. DISCHARGE POTENTIAL**

1.	<b>DISCHARGE POTENTIAL</b>	a. Does resident or family indicate a preference to return to community? X 0. No <input type="checkbox"/> 1. Yes
		b. Does resident have a support person who is positive towards discharge? X 0. No <input type="checkbox"/> 1. Yes
		c. Has resident's self-sufficiency changed compared to 6 months or since admission, if less than 6 months? X 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined

**SECTION S. ASSESSMENT INFORMATION**

1.	<b>PARTICIPATION IN ASSESSMENT</b>	a. Resident: <input type="checkbox"/> 0. No X 1. Yes	1
		b. Family: X 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No Family	0
		c. Other Non-Staff: X 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. None	0
2.	<b>SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:</b>		
	NANCY SMITH		
	a. Signature of Assessment Coordinator (sign on line above)		
	b. Date Assessment Coordinator signed as complete	07 - 17 - 2004 Month Day Year	
	c. Other Signatures	Title	Sections
			Date
			Date
3.	<b>CASE MIX GROUP</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

**SECTION T. Preventive Health/Health Behaviors**

1.	<b>PREVENTIVE HEALTH</b>	<i>(Check all the procedures the resident received during the past 12 months)</i>	
		<input type="checkbox"/> a. Blood pressure monitoring	<input type="checkbox"/> g. Breast exam or mammogram
		<input type="checkbox"/> b. Hearing assessment	<input type="checkbox"/> h. Pap smear
		<input type="checkbox"/> c. Vision test	<input type="checkbox"/> i. PSA or rectal exam
		X d. Dental visit	X j. Other (specify) <b>PSA</b>
		X e. Influenza vaccine	
		<input type="checkbox"/> f. Pneumococcal vaccine (ANY time)	

P11 = 1 (Yes)



**MINIMUM DATA SET (MDS)®**  
ASSISTED LIVING SERVICES (ALS)

FACE SHEET: BACKGROUND INFORMATION ONLY AT ADMISSION

**SECTION AA. IDENTIFICATION INFORMATION**

1. RESIDENT NAME	BERTHA D BROWN a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2. GENDER	<input type="checkbox"/> 1. Male <input checked="" type="checkbox"/> 2. Female
3. BIRTHDATE	03 — 07 — 1975 Month Day Year
4. RACE/ETHNICITY <i>(Check only one.)</i>	<input type="checkbox"/> 1. American Indian/Alaskan Native <input type="checkbox"/> 4. Hispanic <input type="checkbox"/> 2. Asian/Pacific Islander <input checked="" type="checkbox"/> 5. White, not of Hispanic origin <input type="checkbox"/> 3. Black, not of Hispanic origin <input type="checkbox"/> 6. Other
5. SOCIAL SECURITY and MEDICARE NUMBERS <i>(C in 1st box if no med. no.)</i>	a. Social Security Number: 529 — 75 — 8486 b. Medicare number (or comparable railroad insurance number): C — — — — — — — — — —
6. FACILITY NAME AND PROVIDER NO.	a. Facility Name: MCBVI b. Provider No.: 99999999
7. MAINECARE NO.	<i>[Record a "+" if pending, "N" if not a MaineCare recipient]</i> 04232791A

**SECTION AB. DEMOGRAPHIC INFORMATION**

1. DATE OF ENTRY	Date the stay began. <i>(Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date.)</i> 07 — 03 — 1994 Month Day Year
2. ADMITTED FROM (AT ENTRY) <i>(Check only one.)</i>	<input checked="" type="checkbox"/> 1. Private home/apt. <input type="checkbox"/> 2. Other board and care/assisted living/group home <input type="checkbox"/> 3. Nursing home <input type="checkbox"/> 4. Acute care hospital <input type="checkbox"/> 5. Psychiatric hospital <input type="checkbox"/> 6. MR/DD facility <input type="checkbox"/> 7. Rehabilitation hospital <input type="checkbox"/> 8. Other <i>(specify)</i> _____
3. LIVED ALONE (PRIOR TO ENTRY) <i>(Check only one.)</i>	<input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. In other facility
4. PRIOR PRIMARY RESIDENCE	Provide town, state, zip code for Resident's primary residence prior to admission SEBAGO LAKE MAINE 04075 Town State Zip Code
5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	<i>(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above)</i> <input checked="" type="checkbox"/> a. Prior stay at this home <input type="checkbox"/> b. Nursing home <input type="checkbox"/> c. Other residential facility—board and care home, assisted living, group home <input type="checkbox"/> d. MH/psychiatric hospital <input type="checkbox"/> e. MR/DD facility <input type="checkbox"/> f. NONE OF ABOVE
6. LIFETIME OCCUPATION	Put a "/" between two occupations. S T U D E N T

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

**SECTION AC. CUSTOMARY ROUTINE**

1. CUSTOMARY ROUTINE <i>(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)</i>	<i>(Check all that apply. If all information UNKNOWN, check last box [z] only)</i> <b>CYCLE OF DAILY EVENTS</b> <input type="checkbox"/> a. Stayed up late at night (e.g., after 9 pm) <input type="checkbox"/> b. Napped regularly during day (at least 1 hour) <input checked="" type="checkbox"/> c. Went out 1+ days a week <input checked="" type="checkbox"/> d. Stayed busy with hobbies, reading, or a fixed daily routine <input type="checkbox"/> e. Spent most of time alone or watching TV <input checked="" type="checkbox"/> f. Moved independently indoors (with appliances, if used) <input type="checkbox"/> g. Used tobacco products at least daily <input type="checkbox"/> h. NONE OF ABOVE <b>EATING PATTERNS</b> <input type="checkbox"/> i. Distinct food preferences <input type="checkbox"/> j. Ate between meals all or most days <input type="checkbox"/> k. Used alcoholic beverage(s) at least weekly <input checked="" type="checkbox"/> l. NONE OF ABOVE <b>ADL PATTERNS</b> <input type="checkbox"/> m. In bedclothes much of day <input type="checkbox"/> n. Wakened to toilet all or most nights <input checked="" type="checkbox"/> o. Had irregular bowel movement pattern <input checked="" type="checkbox"/> p. Shower for bathing <input type="checkbox"/> q. Sponge bath <input type="checkbox"/> r. Bathed in PM <input type="checkbox"/> s. NONE OF ABOVE <b>INVOLVEMENT PATTERNS</b> <input checked="" type="checkbox"/> t. Daily contact with relatives/close friends <input type="checkbox"/> u. Usually attended church, temple, synagogue (etc.) <input checked="" type="checkbox"/> v. Found strength in faith <input checked="" type="checkbox"/> w. Daily animal companion/presence <input type="checkbox"/> x. Involved in group activities <input type="checkbox"/> y. NONE OF ABOVE <input type="checkbox"/> 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
NANCY SMITH	RCA COORDINATOR	ALL	07/15/1994
b.			Date
2. DATE COMPLETED	Record date background information was completed.		
	07 — 15 — 1994 Month Day Year		



**SECTION E. MOOD and BEHAVIOR PATTERNS (cont.)**

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	<i>(CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause)</i>		
	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)		
<b>SLEEP-CYCLE ISSUES</b>			
0__ j. Unpleasant mood in morning			
0__ k. Insomnia/change in usual sleep pattern			
<b>SAD, APATHETIC, ANXIOUS APPEARANCE</b>			
0__ l. Sad, pained, worried facial expressions—e.g., furrowed brows			
0__ m. Crying, tearfulness			
0__ n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking			
<b>LOSS OF INTEREST</b>			
0__ o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends			
0__ p. Reduced social interaction			
<b>INDICATORS OF MANIA</b>			
2__ q. Inflated self-worth, exaggerated self-opinion; inflated belief about one's own ability, etc.			
0__ r. Excited behavior, motor excitation (e.g., heightened physical activity; excited, loud or pressured speech; increased reactivity)			
2. MOOD PERSISTENCE <i>(Check only one.)</i>	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 <b>over last 7 days.</b>		
	X 0. No mood indicators		
	<input type="checkbox"/> 1. Indicators present, easily altered		
	<input type="checkbox"/> 2. Indicators present, not easily altered		
3. MOOD <i>(Check only one.)</i>	Resident's current mood status compared to resident's status 180 days ago (or since admission if less than 180 days):		
	X 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined		
4. BEHAVIORAL SYMPTOMS	<i>(COLUMN A CODES: Record the appropriate code for the frequency of the symptom in last 7 days)</i>		<i>(COLUMN B CODES: Alterability of behavioral symptoms in last 7 days)</i>
	0. Behavior not exhibited in last 7 days		0. Not present or easily altered last 7 days
	1. Behavior of this type occurred 1 to 3 days in last 7 days		1. Behavior not easily altered last 7 days
	2. Behavior of this type occurred 4 to 6 days but less than daily		
3. Behavior of this type occurred daily			
<i>(COLUMN C CODES: History of this behavior in the last 6 months)</i>			
	0. No	1. Yes	
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	0	0	0
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)	0	0	0
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused, gross physical assault)	0	0	0
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)	0	0	0
e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)	0	0	0
f. INTIMIDATING BEHAVIOR (made others feel unsafe, at risk, privacy invaded)	0	0	0
g. ELOPEMENT	0	0	0
h. Dangerous non-violent behavior (e.g., falling asleep while smoking)	0	0	0
i. Dangerous violent behavior	0	0	0
j. FIRE SETTING	0	0	0
5. SUICIDAL IDEATION	Resident demonstrated suicidal thoughts or actions in the last 30 days:		
	X 0. No <input type="checkbox"/> 1. Yes		
6. SLEEP PROBLEMS	Check all present on 2 or more days during last 7 days		
	<input type="checkbox"/> a. Inability to awaken when desired <input type="checkbox"/> d. Interrupted sleep		
	X b. Difficulty falling asleep <input type="checkbox"/> e. NONE OF ABOVE		
	<input type="checkbox"/> c. Restless or non-restful sleep		
7. INSIGHT INTO MENTAL HEALTH	Resident has insight about his/her mental problem		
	X 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No mental health problems		
8. BEHAVIORS <i>(Check only one.)</i>	Resident's current behavior status compared to resident's status 180 days ago (or since admission if less than 180 days):		
	X 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined		

**SECTION F. PSYCHOSOCIAL WELL-BEING**

1. SENSE OF INITIATIVE/ INVOLVEMENT <i>(Check all that apply)</i>	X a. At ease interacting with others
	X b. At ease doing planned or structured activities
	X c. At ease doing self-initiated activities
	X d. Establishes own goals
	X 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)
	X f. Accepts invitations into most group activities
	<input type="checkbox"/> g. NONE OF ABOVE
2. UNSETTLED RELATIONSHIPS <i>(Check all that apply)</i>	<input type="checkbox"/> a. Covert/open conflict with or repeated criticism of staff
	<input type="checkbox"/> b. Unhappy with roommate
	<input type="checkbox"/> c. Unhappy with residents other than roommate
	X d. Openly expresses conflict/anger with family/friends
	<input type="checkbox"/> e. Absence of personal contact with family/friends
	<input type="checkbox"/> f. Recent loss of close family member/friend
	<input type="checkbox"/> g. Does not adjust easily to change in routines
	<input type="checkbox"/> h. NONE OF ABOVE
3. LIFE-EVENTS HISTORY <i>(Check all that apply.)</i>	Events in past 2 years
	<input type="checkbox"/> a. Serious accident or physical illness
	<input type="checkbox"/> b. Health concerns for other person
	<input type="checkbox"/> c. Death of family member or close friend
	<input type="checkbox"/> d. Trouble with the law
	<input type="checkbox"/> e. Robbed/physically attacked
	X f. Conflict laden or severed relationship
	<input type="checkbox"/> g. Loss of income leading to change in lifestyle
	<input type="checkbox"/> h. Sexual assault/abuse
	<input type="checkbox"/> i. Child custody issues
	<input type="checkbox"/> j. Change in marital/partner status
	<input type="checkbox"/> k. Review hearings (e.g., forensic, certification, capacity hearing)
	<input type="checkbox"/> 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 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. BED MOBILITY— How resident moves to and from lying position, turns side to side, and positions body while in bed	0	0	
b. TRANSFER – How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	0	0	
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	0	0	
d. DRESSING – How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis	0	0	
e. EATING – How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	0	0	
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	0	0	
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)	0	0	
h. STAIRS – How resident climbs stairs	0	0	

**SECTION G. PHYSICAL FUNCTIONING (cont.)**

2.	<b>BATHING SELF-PERFORMANCE</b>	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) <b>Check for most dependent in self-performance during last 7 days.</b> <input checked="" type="checkbox"/> 0. Independent—No help provided <input type="checkbox"/> 1. Supervision—Oversight help only <input type="checkbox"/> 2. Physical help limited to transfer only <input type="checkbox"/> 3. Physical help in part of bathing activity <input type="checkbox"/> 4. Total dependence <input type="checkbox"/> 8. Activity itself did not occur during entire 7 days																				
3A.	<b>MODES OF LOCOMOTION</b>	(Check all that apply during last 7 days) <input type="checkbox"/> a. Cane/walker/crutch <input type="checkbox"/> b. Wheeled self <input type="checkbox"/> c. Other person wheeled <input checked="" type="checkbox"/> d. NONE OF ABOVE																				
3B.	<b>MAIN MODE OF LOCOMOTION</b>	Was wheelchair the primary mode of locomotion during the last 7 days? <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes																				
3C.	<b>BEDFAST/ CHAIRFAST</b>	(Check if health condition keeps resident in his/her room 22+ hours per day in last 7 days) <input type="checkbox"/> a. Bedfast all or most of the time <input type="checkbox"/> b. Chairfast all or most of the time <input checked="" type="checkbox"/> c. NONE OF ABOVE																				
4.	<b>SELF-PERFORMANCE IN ADLs</b> (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): <input checked="" type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined																				
5A.	<b>IADL SELF-PERFORMANCE</b>	Code for level of independence in the last 30 days based on resident's involvement in the activity. <b>SELF-PERFORMANCE CODES:</b> 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.																				
		<table border="1"> <thead> <tr> <th>IADL</th> <th>SELF-PERFORMANCE</th> </tr> </thead> <tbody> <tr> <td>a. Resident arranged for shopping for clothing, snacks, other incidentals.</td> <td>0</td> </tr> <tr> <td>b. Resident shopped for clothing, snacks, or other incidentals.</td> <td>0</td> </tr> <tr> <td>c. Resident arranged for suitable transportation to get to appointments, outings, necessary engagements.</td> <td>0</td> </tr> <tr> <td>d. Resident managed finances including banking, handling checkbook, or paying bills.</td> <td>0</td> </tr> <tr> <td>e. Resident managed cash, personal needs allowance.</td> <td>0</td> </tr> <tr> <td>f. Resident prepared snacks, light meals.</td> <td>0</td> </tr> <tr> <td>g. Resident used phone.</td> <td>0</td> </tr> <tr> <td>h. Resident did light housework such as making own bed, dusting, or taking care of belongings.</td> <td>0</td> </tr> <tr> <td>i. Resident sorted, folded, or washed own laundry.</td> <td>0</td> </tr> </tbody> </table>	IADL	SELF-PERFORMANCE	a. Resident arranged for shopping for clothing, snacks, other incidentals.	0	b. Resident shopped for clothing, snacks, or other incidentals.	0	c. Resident arranged for suitable transportation to get to appointments, outings, necessary engagements.	0	d. Resident managed finances including banking, handling checkbook, or paying bills.	0	e. Resident managed cash, personal needs allowance.	0	f. Resident prepared snacks, light meals.	0	g. Resident used phone.	0	h. Resident did light housework such as making own bed, dusting, or taking care of belongings.	0	i. Resident sorted, folded, or washed own laundry.	0
IADL	SELF-PERFORMANCE																					
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h. Resident did light housework such as making own bed, dusting, or taking care of belongings.	0																					
i. Resident sorted, folded, or washed own laundry.	0																					
5B.	<b>TRANSPORTATION</b>	Check all that apply for level of independence in the last 30 days based on resident's involvement in the activity. <input type="checkbox"/> a. Resident drove car or used public transportation independently to get to medical, dental appointments, necessary engagements, or other activities. <input checked="" type="checkbox"/> b. Resident rode to destination with staff, family, others (in car, van, public transportation) but was <b>not accompanied</b> to medical, dental appointments, necessary engagements, or other activities. <input checked="" type="checkbox"/> c. Resident rode to destination with staff, family, others (in car, van, public transportation) and <b>was accompanied</b> to medical, dental appointments, necessary engagements, or other activities. <input type="checkbox"/> d. Activity did not occur.																				
6.	<b>ADL AND IADL FUNCTIONAL REHABILITATION OR IMPROVEMENT POTENTIAL</b> (Check all that apply.)	<input checked="" type="checkbox"/> a. Resident believes he/she is capable of increased independence in at least some ADLs or IADLs. <input checked="" type="checkbox"/> b. Direct care staff believes resident is capable of increased independence in at least some ADLs or IADLs. <input type="checkbox"/> c. Resident able to perform tasks/activity but is very slow <input type="checkbox"/> d. Difference in ADL/IADL Self-Performance comparing mornings to evenings <input type="checkbox"/> e. Resident requires or only understands a one-step direction. (continued in next column)																				

**SECTION G. PHYSICAL FUNCTIONING (cont.)**

		<input type="checkbox"/> f. Resident requires or only understands no more than a two-step direction. <input type="checkbox"/> g. Resident could be more independent if he/she had special equipment (e.g., cane, walker, plate guard, velcro closings on clothing or shoes) <input type="checkbox"/> h. Resident could perform more independently if some or all of ADL/ IADL activities were broken into subtasks (task segmentation) <input type="checkbox"/> i. Resident could be more independent if he/she received ADL or IADL skills training <input type="checkbox"/> j. NONE OF ABOVE
7.	<b>NEW DEVICES NEEDED</b> (Check all that apply.)	Resident expresses or gives evidence of needing new or additional assistive devices <input type="checkbox"/> a. Eyeglasses <input type="checkbox"/> f. Assistive dressing devices (e.g., button hook, velcro closings) <input type="checkbox"/> b. Hearing aid <input type="checkbox"/> g. Dentures <input type="checkbox"/> c. Cane or walker <input type="checkbox"/> h. Other (specify) _____ <input type="checkbox"/> d. Wheelchair <input checked="" type="checkbox"/> i. NONE OF ABOVE <input type="checkbox"/> e. Assistive feeding devices (e.g., plate guard, stabilized built-up utensil)
8.	<b>SELF-PERFORMANCE IN IADLs</b>	Resident's current IADL status or abilities compared to resident's status 180 days ago (or since admission if less than 180 days): <input checked="" type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined

**SECTION H. CONTINENCE IN LAST 14 DAYS**

1.	<b>CONTINENCE SELF-CONTROL CATEGORIES</b> (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.	<b>BOWEL CONTINENCE</b>	Control of bowel movement, with appliance or bowel continence programs, if employed <b>0</b>																				
b.	<b>BLADDER CONTINENCE</b>	Control of urinary bladder function with appliances (e.g. foley) or continence programs, if employed <b>0</b>																				
2.	<b>BOWEL ELIMINATION PATTERN</b>	<table border="1"> <tr> <td>Bowel elimination pattern regular—at least one movement every three days</td> <td></td> <td>Diarrhea</td> <td>c.</td> </tr> <tr> <td>Constipation</td> <td>a.</td> <td>Fecal Impaction</td> <td>d.</td> </tr> <tr> <td></td> <td>b. <input checked="" type="checkbox"/></td> <td>Resident is Independent</td> <td>e.</td> </tr> <tr> <td></td> <td></td> <td>NONE OF ABOVE</td> <td>f.</td> </tr> </table>	Bowel elimination pattern regular—at least one movement every three days		Diarrhea	c.	Constipation	a.	Fecal Impaction	d.		b. <input checked="" type="checkbox"/>	Resident is Independent	e.			NONE OF ABOVE	f.				
Bowel elimination pattern regular—at least one movement every three days		Diarrhea	c.																			
Constipation	a.	Fecal Impaction	d.																			
	b. <input checked="" type="checkbox"/>	Resident is Independent	e.																			
		NONE OF ABOVE	f.																			
3.	<b>APPLIANCES and PROGRAMS</b>	<table border="1"> <tr> <td>Any scheduled toileting plan</td> <td>a.</td> <td>Did not use toilet room/ commode/urinal</td> <td>f.</td> </tr> <tr> <td>Bladder retraining program</td> <td>b.</td> <td>Pads/briefs used</td> <td>g.</td> </tr> <tr> <td>External (condom) catheter</td> <td>c.</td> <td>Enemas/irrigation</td> <td>h.</td> </tr> <tr> <td>Indwelling catheter</td> <td>d.</td> <td>Ostomy present</td> <td>i.</td> </tr> <tr> <td>Intermittent catheter</td> <td>e.</td> <td>NONE OF ABOVE</td> <td>j. <input checked="" type="checkbox"/></td> </tr> </table>	Any scheduled toileting plan	a.	Did not use toilet room/ commode/urinal	f.	Bladder retraining program	b.	Pads/briefs used	g.	External (condom) catheter	c.	Enemas/irrigation	h.	Indwelling catheter	d.	Ostomy present	i.	Intermittent catheter	e.	NONE OF ABOVE	j. <input checked="" type="checkbox"/>
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Intermittent catheter	e.	NONE OF ABOVE	j. <input checked="" type="checkbox"/>																			
4.	<b>USE OF INCONTINENCE SUPPLIES</b> (Check only one.)	Resident's management of incontinence supplies (pads, briefs, ostomy, catheter) in last 14 days. <input checked="" type="checkbox"/> 0. Always continent <input type="checkbox"/> 1. Resident incontinent and able to manage incontinence supplies independently. <input type="checkbox"/> 2. Resident incontinent and receives assistance with managing incontinence supplies. <input type="checkbox"/> 3. Resident incontinent and does not use incontinence supplies.																				
5.	<b>CHANGES IN URINARY CONTINENCE</b>	Resident's urinary continence has changed as compared to status of 180 days ago (or since last assessment if less than 180 days): <input checked="" type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 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.	<b>DIAGNOSES</b>	<table border="1"> <tr> <td><b>ENDOCRINE/METABOLIC/ NUTRITIONAL</b></td> <td><b>HEART/CIRCULATION</b></td> </tr> <tr> <td><input type="checkbox"/> a. Diabetes mellitus</td> <td><input type="checkbox"/> d. Arteriosclerotic heart disease (ASHD)</td> </tr> <tr> <td><input type="checkbox"/> b. Hyperthyroidism</td> <td><input type="checkbox"/> e. Cardiac dysrhythmia</td> </tr> <tr> <td><input type="checkbox"/> c. Hypothyroidism</td> <td><input type="checkbox"/> f. Congestive heart failure</td> </tr> <tr> <td></td> <td><input type="checkbox"/> g. Deep vein thrombosis</td> </tr> <tr> <td></td> <td><input type="checkbox"/> h. Hypertension</td> </tr> <tr> <td></td> <td><input type="checkbox"/> i. Hypotension</td> </tr> <tr> <td></td> <td><input type="checkbox"/> j. Peripheral vascular disease</td> </tr> <tr> <td></td> <td><input type="checkbox"/> k. Other cardiovascular disease</td> </tr> </table> (continued on next page)	<b>ENDOCRINE/METABOLIC/ NUTRITIONAL</b>	<b>HEART/CIRCULATION</b>	<input type="checkbox"/> a. Diabetes mellitus	<input type="checkbox"/> d. Arteriosclerotic heart disease (ASHD)	<input type="checkbox"/> b. Hyperthyroidism	<input type="checkbox"/> e. Cardiac dysrhythmia	<input type="checkbox"/> c. Hypothyroidism	<input type="checkbox"/> f. Congestive heart failure		<input type="checkbox"/> g. Deep vein thrombosis		<input type="checkbox"/> h. Hypertension		<input type="checkbox"/> i. Hypotension		<input type="checkbox"/> j. Peripheral vascular disease		<input type="checkbox"/> k. Other cardiovascular disease
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Resident Name: Bertha D. Brown Date: 7/13/2004

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SECTION I. DIAGNOSES (cont.)

	MUSCULOSKELETAL	<input type="checkbox"/> ff. Manic depressive (Bipolar)
	<input type="checkbox"/> i. Arthritis	<input type="checkbox"/> gg. Schizophrenia
	<input type="checkbox"/> m. Hip fracture	PULMONARY
	<input type="checkbox"/> n. Missing limb (e.g., amputation)	<input type="checkbox"/> hh. Asthma
	<input type="checkbox"/> o. Osteoporosis	<input type="checkbox"/> ii. Emphysema/COPD
	<input type="checkbox"/> p. Pathological bone fracture	SENSORY
	NEUROLOGICAL	<input type="checkbox"/> jj. Cataracts
	<input type="checkbox"/> q. Alzheimer's disease	<input type="checkbox"/> kk. Diabetic retinopathy
	<input type="checkbox"/> r. Aphasia	<input type="checkbox"/> ll. Glaucoma
	<input type="checkbox"/> s. Cerebral palsy	<input type="checkbox"/> mm. Macular degeneration
	<input type="checkbox"/> t. Cerebrovascular accident (stroke)	OTHER
	<input type="checkbox"/> u. Dementia other than Alzheimer's disease	<input checked="" type="checkbox"/> nn. Allergies (specify) <u>LACTOSE</u>
	<input type="checkbox"/> v. Hemiplegia/hemiparesis	<input type="checkbox"/> oo. Anemia
	<input type="checkbox"/> w. Multiple sclerosis	<input type="checkbox"/> pp. Cancer
	<input type="checkbox"/> x. Paraplegia	<input type="checkbox"/> qq. Renal failure
	<input type="checkbox"/> y. Parkinson's disease	<input type="checkbox"/> rr. Tuberculosis-TB
	<input type="checkbox"/> z. Quadriplegia	<input type="checkbox"/> ss. HIV
	<input type="checkbox"/> aa. Seizure disorder	<input type="checkbox"/> tt. Mental retardation (e.g., Down's Syndrome, Autism, or other organic condition related to Mental Retardation or Developmental disability (MR/DD))
	<input type="checkbox"/> bb. Transient ischemic attack (TIA)	<input type="checkbox"/> uu. Substance abuse (alcohol or drug)
	<input type="checkbox"/> cc. Traumatic brain injury	<input type="checkbox"/> vv. Other psychiatric diagnosis (e.g., paranoia, phobias, personality disorder)
	PSYCHIATRIC/MOOD	<input type="checkbox"/> ww. Explicit terminal prognosis
	<input type="checkbox"/> dd. Anxiety disorder	<input type="checkbox"/> xx. NONE OF ABOVE
	<input type="checkbox"/> ee. Depression	
2.	OTHER CURRENT DIAGNOSIS AND ICD-9 CODES	a. _____ 008 . 45 b. _____ 435 . 9 c. _____ . _____

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? <input type="checkbox"/> 1. All of the time <input checked="" type="checkbox"/> 3. Little of the time <input type="checkbox"/> 2. Some of the time <input type="checkbox"/> 4. None of the time
6.	PAIN MANAGEMENT	<input type="checkbox"/> 1. No pain treatment <input type="checkbox"/> 3. Treated, partial control <input checked="" type="checkbox"/> 2. Treated, full control <input type="checkbox"/> 4. Treated, no or minimal control
7.	ACCIDENTS (Check all that apply)	<input type="checkbox"/> a. Fell in past 30 days <input type="checkbox"/> d. Other fracture in last 180 days <input type="checkbox"/> b. Fell in past 31-180 days <input checked="" type="checkbox"/> e. NONE OF ABOVE <input type="checkbox"/> c. Hip fracture in last 180 days
8.	DANGER OF FALL (Check all that apply)	<input type="checkbox"/> a. Has unsteady gait <input type="checkbox"/> b. Has balance problems when standing <input type="checkbox"/> c. Limits activity because resident or family fearful of resident falling <input type="checkbox"/> d. Unstable transition from seated to standing <input type="checkbox"/> e. Other (specify) _____ <input checked="" type="checkbox"/> f. NONE OF ABOVE

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS (Check all that apply)	<input type="checkbox"/> a. Mouth is "dry" when eating a meal <input type="checkbox"/> d. Mouth Pain <input type="checkbox"/> b. Chewing Problem <input checked="" type="checkbox"/> e. NONE OF ABOVE <input type="checkbox"/> c. Swallowing Problem
2.	HEIGHT AND WEIGHT	Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes. a. HT (in.) <input type="text" value="5"/> <input type="text" value="4"/> b. WT (lb.) <input type="text" value="1"/> <input type="text" value="0"/> <input type="text" value="7"/>
3.	WEIGHT CHANGE	a. Unintended weight loss—5% or more in last 30 days; or 10% or more in last 180 days <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes b. Unintended weight gain—5% or more in last 30 days; or 10% or more in last 180 days <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
4.	NUTRITIONAL PROBLEMS OR APPROACHES (Check all that apply)	<input type="checkbox"/> a. Complains about the taste of many foods <input type="checkbox"/> f. Noncompliance with diet <input type="checkbox"/> b. Regular or repetitive complaints of hunger <input type="checkbox"/> g. Eating disorders <input type="checkbox"/> c. Leaves 25% of food uneaten at most meals <input type="checkbox"/> h. Food allergies (specify) _____ <input type="checkbox"/> d. Therapeutic diet <input checked="" type="checkbox"/> i. Restrictions (specify) _____ <input type="checkbox"/> e. Mechanically altered (or pureed) diet <input checked="" type="checkbox"/> j. NONE OF ABOVE

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)	<input type="checkbox"/> a. Inability to lie flat due to shortness of breath <input type="checkbox"/> i. Headache <input type="checkbox"/> b. Shortness of breath <input type="checkbox"/> j. Numbness/tingling <input type="checkbox"/> c. Edema <input type="checkbox"/> k. Blurred vision <input type="checkbox"/> d. Dizziness/vertigo <input type="checkbox"/> l. Dry mouth <input type="checkbox"/> e. Delusions <input type="checkbox"/> m. Excessive salivation or drooling <input type="checkbox"/> f. Hallucinations <input type="checkbox"/> n. Change in normal appetite <input type="checkbox"/> g. Hostility <input type="checkbox"/> o. Other (specify) _____ <input type="checkbox"/> h. Suspiciousness <input checked="" type="checkbox"/> p. NONE OF ABOVE
2.	EXTRA-PYRAMIDAL SIGNS AND SYMPTOMS	Check all present at any point during last 3 days INCREASE IN MOTOR ACTIVITY <input checked="" type="checkbox"/> a. Akathisia—resident reports subjective feeling of restlessness or need for movement <input type="checkbox"/> b. Dyskinesia—chewing, puckering movements of mouth; abnormal irregular movements of lips; or rocking or writhing of trunk <input type="checkbox"/> c. Tremor—regular rhythmic movements of the fingers, limbs, head, mouth, or tongue DECREASE IN MOTOR ACTIVITY <input checked="" type="checkbox"/> d. Rigidity—resistance to flexion and extension of muscles (e.g., continuous or cogwheeling rigidity) <input type="checkbox"/> e. Slow shuffling gait—reduction in speed and stride length of gait, usually with a decrease in pendular arm movement <input type="checkbox"/> f. Bradykinesia—decrease in spontaneous movements (e.g., reduced body movement or poverty of facial expression, gestures, speech) MUSCLE CONTRACTIONS <input type="checkbox"/> g. Dystonia—muscle hypertonicity (e.g., muscle spasms or stiffness, protruding tongue, upward deviation of the eyes) <input type="checkbox"/> 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) <b>01</b>
4.	PAIN SITE (If pain is present in the last 7 days)	<input type="checkbox"/> a. Back pain <input type="checkbox"/> f. Incisional pain <input type="checkbox"/> b. Bone pain <input type="checkbox"/> g. Joint pain (other than hip) <input type="checkbox"/> c. Chest pain while doing usual activities <input type="checkbox"/> h. Soft tissue pain (e.g., lesion, muscle) <input checked="" type="checkbox"/> d. Headache <input type="checkbox"/> i. Stomach pain <input type="checkbox"/> e. Hip pain <input type="checkbox"/> j. Other (specify) _____

SECTION L. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION (check all that apply)	<input type="checkbox"/> a. Has dentures or removable bridge <input type="checkbox"/> b. Some/all natural teeth lost—does not have or does not use dentures (or partial plates) <input type="checkbox"/> c. Broken, loose or carious teeth <input type="checkbox"/> d. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes <input type="checkbox"/> e. Daily cleaning of teeth/dentures or daily mouth care—by resident or staff <input type="checkbox"/> f. Resident has difficulty brushing teeth or dentures <input checked="" type="checkbox"/> g. NONE OF ABOVE
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SECTION M. SKIN CONDITION

1.	SKIN PROBLEMS (Check all that apply)	Any troubling skin conditions or changes in the last 7 days? <input type="checkbox"/> a. Abrasions (scrapes) or cuts <input type="checkbox"/> e. Open sores or lesions <input type="checkbox"/> b. Bums (2nd or 3rd degree) <input type="checkbox"/> f. Other (specify) _____ <input type="checkbox"/> c. Bruises <input checked="" type="checkbox"/> d. Rashes, itchiness, body lice <input type="checkbox"/> 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. a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. <b>1</b> b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. <b>0</b> 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. <b>0</b> d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. <b>0</b>

Resident Name: Bertha D. Brown Date: 7/13/2004 Soc. Sec # \_\_\_\_\_ Facility Provider # \_\_\_\_\_

**SECTION M. SKIN CONDITION**

**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** (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  
*(Check only one.)*

**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** (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  o. Cooking/baking  
 f. Reading/writing  p. Computer activities  
 g. Spiritual/religious activity  q. Volunteering  
 h. Trips/shopping  r. Other (specify) \_\_\_\_\_  
 i. Walking/wheeling outdoors  s. NONE OF ABOVE  
 j. Watching TV

**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 ACTIVITIES** (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 (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)  
 0 a. Antipsychotic  0 d. Hypnotic  0 g. Insulin  
 0 b. Antianxiety  0 e. Diuretic  
 0 c. Antidepressant  0 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-ADMINISTERED MEDICATIONS** 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  
*(Check all that apply.)*

**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 administered NONE of his/her own medications.  
 2. Resident prepared and administered SOME of his/her own medications.  
 3. Resident prepared and administered ALL of his/her own medications.

**7. MEDICATION COMPLIANCE** 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  
*(Check one)*

**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]  
 a. Chemotherapy or radiation  i. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)  
 b. Oxygen therapy  j. Case management  
 c. Dialysis  k. Day treatment program  
 d. Alcohol/drug treatment program  l. Sheltered workshop/employment  
 e. Alzheimer's/dementia special care unit  m. Job training  
 f. Hospice care  n. Transportation  
 g. Home health  o. Psychological rehabilitation  
 h. Home care  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	0		
b. Occupational therapy	0		
c. Physical therapy	0		
d. Respiratory therapy	0		
e. Psychological therapy (by any licensed mental health professional)	0		

**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 environment to address mood/behavior patterns—e.g., providing bureau in which to rummage  
 b. Special behavior management program  f. Reorientation—e.g., cueing  
 c. Evaluation by a licensed mental health specialist in last 90 days  g. Validation/Redirection  
 d. Group therapy  h. Crisis intervention in facility  
 e. Resident-specific deliberate changes in the  i. Crisis stabilization unit in last 90 days  
 k. NONE OF ABOVE  j. Other (specify) \_\_\_\_\_

**SECTION O. MEDICATIONS**

**1. NUMBER OF MEDICATIONS** (Record the number of different medications used in the last 7 days; enter "0" if none used)

**2. NEW MEDICATIONS** (Resident currently receiving medications that were initiated during the last 90 days)  
 0. No  1. Yes

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



**SECTION P. SPECIAL TREATMENTS AND PROCEDURES (cont.)**

3.	<b>NEED FOR ON-GOING MONITORING</b>	(Code for person responsible for monitoring)	
		0. No monitoring required	2. RCF Other Staff
		1. RCF nurse	3. Home health nurse
		<u>0</u> a. Acute physical or psychiatric condition - not chronic	<u>2</u> b. New treatment/medication
4.	<b>REHABILITATION/RESTORATIVE CARE</b>	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.)	
		<u>0</u> a. Range of motion (passive)	
		<u>0</u> b. Range of motion (active)	
		<u>0</u> c. Splint or brace assistance	
		<b>TRAINING/SKILL PRACTICE IN:</b>	
		<u>0</u> d. Bed mobility	<u>0</u> i. Amputation/prosthesis care
		<u>0</u> e. Transfer	<u>0</u> j. Communication
		<u>0</u> f. Walking	<u>0</u> k. Time management
		<u>0</u> g. Dressing or grooming	<u>0</u> l. Other (specify) _____
		<u>0</u> h. Eating or swallowing	
5.	<b>SKILL TRAINING</b>	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.	
		<u>0</u> a. Meal Preparation (snacks, light meals)	<u>0</u> h. Arranges Shopping (makes list, acquires help)
		<u>0</u> b. Telephone Use	<u>0</u> i. Shopping (for groceries, clothes, or other incidentals)
		<u>0</u> c. Light Housework (makes own bed, takes care of belongings)	<u>0</u> j. Transportation (travel by various means to get to medical appointments or other necessary engagements)
		<u>0</u> d. Laundry (sorts, folds, or washes own laundry)	<u>0</u> k. Medications (preparation and administration of medications)
		<u>0</u> e. Managing Incontinence Supplies (pads, briefs, ostomy, catheter)	<u>0</u> l. Other (specify) _____
		<u>0</u> f. Managing Cash (handles cash, makes purchases)	
		<u>0</u> g. Managing Finances (banking, handling checkbook, or paying bills)	
6.	<b>ADHERENCE WITH TREATMENTS/THERAPIES/PROGRAMS</b>	In the last 6 months, compliant all or most of the time with special treatments, therapies and programs:	
		X 0. Always compliant	<input type="checkbox"/> 3. No treatments or programs
		<input type="checkbox"/> 1. Compliant 80% of time	<input type="checkbox"/> 8. Unknown
		<input type="checkbox"/> 2. Compliant less than 80% of the time	
7.	<b>GENERAL HOSPITAL STAY(S)</b>	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)	0 0
8.	<b>EMERGENCY ROOM (ER) VISIT(S)</b>	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)	0 0
9.	<b>PHYSICIAN VISITS</b>	In the last 6 months (or since admission to facility) how if less than 6 months many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter "0" if none)	0 3
10.	<b>PHYSICIAN ORDERS</b>	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)	0 1
11.	<b>ABNORMAL LAB VALUES</b>	Has the resident had any abnormal lab values during the last 90 days (or since admission if less than 90 days)? <input type="checkbox"/> 0. No <input checked="" type="checkbox"/> 1. Yes	
12.	<b>PSYCHIATRIC HOSPITAL STAY(S)</b>	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)	0 0
13.	<b>OUTPATIENT SURGERY</b>	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)	0 0

**SECTION Q. SERVICE PLANNING**

1.	<b>RESIDENT GOALS</b> <i>(Check all areas in which resident has self-identified goals)</i>	X a. Health promotion/wellness/exercise
		X b. Social involvement/making friends
		X c. Activities/hobbies/adult learning
		X d. Rehabilitation-skilled
		X e. Maintaining physical or cognitive function
		<input type="checkbox"/> f. Participation in the community
		<input type="checkbox"/> g. Other (specify) _____
		<input type="checkbox"/> h. No goals
2.	<b>CONFLICT</b>	a. Any disagreement between resident and family about goals or service plan? <input type="checkbox"/> 0. No <input checked="" type="checkbox"/> 1. Yes
		b. Any disagreement between resident/family and staff about goals or service plan? <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes

**SECTION R. DISCHARGE POTENTIAL**

1.	<b>DISCHARGE POTENTIAL</b>	a. Does resident or family indicate a preference to return to community? <input type="checkbox"/> 0. No <input checked="" type="checkbox"/> 1. Yes
		b. Does resident have a support person who is positive towards discharge? <input type="checkbox"/> 0. No <input checked="" type="checkbox"/> 1. Yes
		c. Has resident's self-sufficiency changed compared to 6 months or since admission, if less than 6 months? <input type="checkbox"/> 0. No change <input checked="" type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined

**SECTION S. ASSESSMENT INFORMATION**

1.	<b>PARTICIPATION IN ASSESSMENT</b>	a. Resident: <input type="checkbox"/> 0. No <input checked="" type="checkbox"/> 1. Yes	1	
		b. Family: <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No Family	0	
		c. Other Non-Staff: <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. None	0	
2.	<b>SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:</b>			
	a.	Signature of Assessment Coordinator (sign on line above)		
	b.	Date Assessment Coordinator signed as complete		
		07	18	2004
		Month	Day	Year
	c.	Other Signatures	Title Sections Date	
	d.		Date	
	e.		Date	
3.	<b>CASE MIX GROUP</b>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		

**SECTION T. Preventive Health/Health Behaviors**

1.	<b>PREVENTIVE HEALTH</b>	<i>(Check all the procedures the resident received during the past 12 months)</i>	
		X a. Blood pressure monitoring	<input type="checkbox"/> g. Breast exam or mammogram
		<input type="checkbox"/> b. Hearing assessment	<input type="checkbox"/> h. Pap smear
		<input type="checkbox"/> c. Vision test	<input type="checkbox"/> i. PSA or rectal exam
		<input type="checkbox"/> d. Dental visit	X j. Other (specify) _____
		X e. Influenza vaccine	<b>LACTOSE TESTING</b>
		<input type="checkbox"/> f. Pneumococcal vaccine (ANY time)	





**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	ANDREW W CAVANAUGH 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 0 0 4 — 7 8 — 8 9 7 4 b. Medicare number (or comparable railroad insurance number) C
3. FACILITY NAME AND PROVIDER NO.	a. Facility Name MCBVI b. Provider No. 9 9 9 9 9 9 9 9
4. MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient] 3 2 4 6 7 3 7 0 A
5. ASSESSMENT DATE	Last day of observation period 0 7 — 0 7 — 2 0 0 4 Month Day Year
6. REASON FOR ASSESSMENT	(Check primary reason for assessment) <input type="checkbox"/> 1. Admission assessment <input checked="" type="checkbox"/> 4. Semi-Annual <input type="checkbox"/> 2. Annual assessment <input type="checkbox"/> 5. Other (specify) <input type="checkbox"/> 3. Significant change in status assessment
7. MARITAL STATUS (Check only one.)	<input checked="" type="checkbox"/> 1. Never married <input type="checkbox"/> 3. Widowed <input type="checkbox"/> 5. Divorced <input type="checkbox"/> 2. Married <input type="checkbox"/> 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) <input checked="" type="checkbox"/> a. MaineCare <input type="checkbox"/> e. Private pay <input checked="" type="checkbox"/> b. SSI <input type="checkbox"/> f. Private insurance (including co-payment) <input type="checkbox"/> c. VA <input type="checkbox"/> g. SSDI <input type="checkbox"/> d. Social Security <input type="checkbox"/> h. Other (specify)
9. RESPONSIBILITY/LEGAL GUARDIAN	(Check all that apply) <input checked="" type="checkbox"/> a. Legal guardian <input checked="" type="checkbox"/> e. Family member responsible <input type="checkbox"/> b. Other legal oversight <input type="checkbox"/> f. Self <input type="checkbox"/> c. Durable power of attorney/health care <input type="checkbox"/> g. Legal Conservator <input type="checkbox"/> d. Durable power of attorney/financial <input type="checkbox"/> h. Representative Payee <input type="checkbox"/> i. NONE OF ABOVE
10. ADVANCED DIRECTIVES	Does resident have any of the following advanced directives in place? a. Living Will <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes b. Do not resuscitate (DNR) <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes c. Do not hospitalize <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes d. Organ donation <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes e. Other <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 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 <input type="checkbox"/> 0. Memory OK <input checked="" type="checkbox"/> 1. Memory problem b. Long-term memory OK—seems/appears to recall long past <input type="checkbox"/> 0. Memory OK <input checked="" type="checkbox"/> 1. Memory problem
2. MEMORY/RECALL ABILITY	(Check all that resident was normally able to recall during last 7 days) <input type="checkbox"/> a. Current season <input checked="" type="checkbox"/> d. That he/she is in a facility/home <input type="checkbox"/> b. Location of own room <input type="checkbox"/> e. NONE OF ABOVE are recalled <input type="checkbox"/> c. Staff names/faces
3. COGNITIVE SKILLS FOR DAILY DECISION-MAKING (Check only one.)	(Made decisions regarding tasks of daily life) <input type="checkbox"/> 0. INDEPENDENT—decisions consistent/reasonable <input type="checkbox"/> 1. MODIFIED INDEPENDENCE—some difficulty in new situations only <input checked="" type="checkbox"/> 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required <input type="checkbox"/> 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). <input checked="" type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined

**SECTION C. COMMUNICATION/HEARING PATTERNS**

1. HEARING (Check only one.)	(With hearing appliance, if used) <input checked="" type="checkbox"/> 0. HEARS ADEQUATELY—normal talk, TV, phone <input type="checkbox"/> 1. MINIMAL DIFFICULTY when not in quiet setting <input type="checkbox"/> 2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly <input type="checkbox"/> 3. HIGHLY IMPAIRED—absence of useful hearing
2. COMMUNICATION DEVICES/TECHNIQUES	(Check all that apply during last 7 days.) <input type="checkbox"/> a. Hearing aid, present and used <input type="checkbox"/> b. Hearing aid, present and not used regularly <input type="checkbox"/> c. Other receptive communication techniques used (e.g., lip reading) <input checked="" type="checkbox"/> d. NONE OF ABOVE
3. MAKING SELF UNDERSTOOD (Check only one.)	(Expressing information content—however able) <input checked="" type="checkbox"/> 0. UNDERSTOOD <input type="checkbox"/> 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts <input type="checkbox"/> 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests <input type="checkbox"/> 3. RARELY/NEVER UNDERSTOOD
4. ABILITY TO UNDERSTAND OTHERS (Check only one.)	(Understanding information content—however able) <input type="checkbox"/> 0. UNDERSTANDS <input checked="" type="checkbox"/> 1. USUALLY UNDERSTANDS—may miss some part / intent of message <input type="checkbox"/> 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication <input type="checkbox"/> 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. <input checked="" type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined

**SECTION D. VISION PATTERNS**

1. VISION (Check only one.)	(Ability to see in adequate light and with glasses if used) <input checked="" type="checkbox"/> 0. ADEQUATE—sees fine detail, including regular print in newspapers/books <input type="checkbox"/> 1. IMPAIRED—sees large print, but not regular print in newspapers/books <input type="checkbox"/> 2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects <input type="checkbox"/> 3. HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects <input type="checkbox"/> 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 <input type="checkbox"/> 0. No <input checked="" type="checkbox"/> 1. Yes b. Artificial eye <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 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)
	<b>VERBAL EXPRESSIONS OF DISTRESS</b> 0 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." 1 b. Repetitive questions—e.g., "Where do I go; What do I do?" 0 c. Repetitive verbalizations—e.g., calling out for help, ("God help me") 1 d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in facility; anger at care received 0 e. Self deprecation—e.g., "I am nothing; I am of no use to anyone" 0 f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others 0 g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack 0 h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions 2 i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues (continued next page)

**SECTION E. MOOD and BEHAVIOR PATTERNS (cont.)**

1.	<b>INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD</b>	<i>(CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause)</i>				
		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)				
		<b>SLEEP-CYCLE ISSUES</b>				
		1 j. Unpleasant mood in morning 0 k. Insomnia/change in usual sleep pattern <b>SAD, APATHETIC, ANXIOUS APPEARANCE</b> 0 l. Sad, pained, worried facial expressions—e.g., furrowed brows 0 m. Crying, tearfulness 1 n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking <b>LOSS OF INTEREST</b> 0 o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends 0 p. Reduced social interaction <b>INDICATORS OF MANIA</b> 0 q. Inflated self-worth, exaggerated self-opinion; inflated belief about one's own ability, etc. 1 r. Excited behavior, motor excitation (e.g., heightened physical activity; excited, loud or pressured speech; increased reactivity)				
2.	<b>MOOD PERSISTENCE</b> <i>(Check only one.)</i>	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 <b>over last 7 days.</b> X 0. No mood indicators <input type="checkbox"/> 1. Indicators present, easily altered <input type="checkbox"/> 2. Indicators present, not easily altered				
3.	<b>MOOD</b> <i>(Check only one.)</i>	Resident's current mood status compared to resident's status 180 days ago (or since admission if less than 180 days): X 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined				
4.	<b>BEHAVIORAL SYMPTOMS</b>	<i>(COLUMN A CODES: Record the appropriate code for the frequency of the symptom in last 7 days)</i>		<i>(COLUMN B CODES: Alterability of behavioral symptoms in last 7 days)</i>		
		0. Behavior not exhibited in last 7 days		0. Not present or easily altered		
		1. Behavior of this type occurred 1 to 3 days in last 7 days		1. Behavior not easily altered last 7 days		
		2. Behavior of this type occurred 4 to 6 days but less than daily				
		3. Behavior of this type occurred daily				
		<i>(COLUMN C CODES: History of this behavior in the last 6 months)</i>				
		0. No 1. Yes				
		a.	WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	0	0	0
		b.	VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)	2	0	1
		c.	PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused, gross physical assault)	0	0	0
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)	1	0	1		
e.	RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)	0	0	0		
f.	INTIMIDATING BEHAVIOR (made others feel unsafe, at risk, privacy invaded)	1	0	1		
g.	ELOPEMENT	0	0	0		
h.	Dangerous non-violent behavior (e.g., falling asleep while smoking)	1	0	1		
i.	Dangerous violent behavior	0	0	0		
j.	FIRE SETTING	0	0	0		
5.	<b>SUICIDAL IDEATION</b>	Resident demonstrated suicidal thoughts or actions in the <b>last 30 days:</b> X 0. No <input type="checkbox"/> 1. Yes				
6.	<b>SLEEP PROBLEMS</b>	Check all present on 2 or more days during last 7 days X a. Inability to awaken when desired <input type="checkbox"/> d. Interrupted sleep <input type="checkbox"/> b. Difficulty falling asleep <input type="checkbox"/> e. NONE OF ABOVE <input type="checkbox"/> c. Restless or non-restful sleep				
7.	<b>INSIGHT INTO MENTAL HEALTH</b>	Resident has insight about his/her mental problem X 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No mental health problems				
8.	<b>BEHAVIORS</b> <i>(Check only one.)</i>	Resident's current behavior status compared to resident's status 180 days ago (or since admission if less than 180 days): X 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined				

**SECTION F. PSYCHOSOCIAL WELL-BEING**

1.	<b>SENSE OF INITIATIVE/ INVOLVEMENT</b> <i>(Check all that apply)</i>	<input type="checkbox"/> a. At ease interacting with others <input type="checkbox"/> b. At ease doing planned or structured activities <input type="checkbox"/> c. At ease doing self-initiated activities <input type="checkbox"/> d. Establishes own goals X 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) X f. Accepts invitations into most group activities <input type="checkbox"/> g. NONE OF ABOVE
2.	<b>UNSETTLED RELATIONSHIPS</b> <i>(Check all that apply)</i>	<input type="checkbox"/> a. Covert/open conflict with or repeated criticism of staff <input type="checkbox"/> b. Unhappy with roommate <input type="checkbox"/> c. Unhappy with residents other than roommate <input type="checkbox"/> d. Openly expresses conflict/anger with family/friends <input type="checkbox"/> e. Absence of personal contact with family/friends <input type="checkbox"/> f. Recent loss of close family member/friend X g. Does not adjust easily to change in routines <input type="checkbox"/> h. NONE OF ABOVE
3.	<b>LIFE-EVENTS HISTORY</b> <i>(Check all that apply.)</i>	Events in past 2 years X a. Serious accident or physical illness <input type="checkbox"/> b. Health concerns for other person <input type="checkbox"/> c. Death of family member or close friend <input type="checkbox"/> d. Trouble with the law <input type="checkbox"/> e. Robbed/physically attacked <input type="checkbox"/> f. Conflict laden or severed relationship <input type="checkbox"/> g. Loss of income leading to change in lifestyle <input type="checkbox"/> h. Sexual assault/abuse <input type="checkbox"/> i. Child custody issues <input type="checkbox"/> j. Change in marital/partner status <input type="checkbox"/> k. Review hearings (e.g., forensic, certification, capacity hearing) <input type="checkbox"/> l. NONE OF ABOVE

**SECTION G. PHYSICAL FUNCTIONING**

1.	(A) ADL SELF-PERFORMANCE		
0.	<b>INDEPENDENT</b> —No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days		
1.	<b>SUPERVISION</b> —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.	<b>LIMITED ASSISTANCE</b> —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.	<b>EXTENSIVE ASSISTANCE</b> —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.	<b>TOTAL DEPENDENCE</b> —Full staff performance of activity during last 7 days		
8.	<b>ACTIVITY DID NOT OCCUR DURING LAST 7 DAYS</b>		
	(B) ADL SUPPORT CODES <i>(CODE for MOST SUPPORT PROVIDED OVER EACH 24 HOUR PERIOD) during last 7 days; code regardless of person's self-performance classification.</i>	A	B
	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.	<b>BED MOBILITY</b> — How resident moves to and from lying position, turns side to side, and positions body while in bed	0	0
b.	<b>TRANSFER</b> — How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	0	0
c.	<b>LOCOMOTION</b> — 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	0	0
d.	<b>DRESSING</b> — How resident puts on, fastens, and takes off all items of <b>street clothing</b> , including donning/removing prosthesis	0	0
e.	<b>EATING</b> — How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	0	0
f.	<b>TOILET USE</b> — How resident uses the toilet room (or commode, bed-pan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	0	0
g.	<b>PERSONAL HYGIENE</b> — How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)	0	0
h.	<b>STAIRS</b> — How resident climbs stairs	0	0

SECTION G. PHYSICAL FUNCTIONING (cont.)

2. BATHING SELF-PERFORMANCE
3A. MODES OF LOCOMOTION
3B. MAIN MODE OF LOCOMOTION
3C. BEDFAST/CHAIRFAST
4. SELF-PERFORMANCE IN ADLs
5A. IADL SELF-PERFORMANCE
5B. TRANSPORTATION
6. ADL AND IADL FUNCTIONAL REHABILITATION OR IMPROVEMENT POTENTIAL

SECTION G. PHYSICAL FUNCTIONING (cont.)

7. NEW DEVICES NEEDED
8. SELF-PERFORMANCE IN IADLs

SECTION H. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL CATEGORIES
a. BOWEL CONTINENCE
b. BLADDER CONTINENCE
2. BOWEL ELIMINATION PATTERN
3. APPLIANCES and PROGRAMS
4. USE OF INCONTINENCE SUPPLIES
5. CHANGES IN URINARY CONTINENCE

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.
1. DIAGNOSES
ENDOCRINE/METABOLIC/NUTRITIONAL
HEART/CIRCULATION

Resident Name: **ANDREW W CAVANAUGH**

Date: **07/07/2004**

Soc. Sec. # **004-78-8974**

Facility Provider # **99999999**

**SECTION I. DIAGNOSES (cont.)**

	<p><b>MUSCULOSKELETAL</b></p> <p><input type="checkbox"/> i. Arthritis</p> <p><input type="checkbox"/> m. Hip fracture</p> <p><input type="checkbox"/> n. Missing limb (e.g., amputation)</p> <p><input type="checkbox"/> o. Osteoporosis</p> <p><input type="checkbox"/> p. Pathological bone fracture</p> <p><b>NEUROLOGICAL</b></p> <p><input type="checkbox"/> q. Alzheimer's disease</p> <p><input type="checkbox"/> r. Aphasia</p> <p><input type="checkbox"/> s. Cerebral palsy</p> <p><input type="checkbox"/> t. Cerebrovascular accident (stroke)</p> <p><input type="checkbox"/> u. Dementia other than Alzheimer's disease</p> <p><input type="checkbox"/> v. Hemiplegia/hemiparesis</p> <p><input type="checkbox"/> w. Multiple sclerosis</p> <p><input type="checkbox"/> x. Paraplegia</p> <p><input type="checkbox"/> y. Parkinson's disease</p> <p><input type="checkbox"/> z. Quadriplegia</p> <p><input type="checkbox"/> aa. Seizure disorder</p> <p><input type="checkbox"/> bb. Transient ischemic attack (TIA)</p> <p><input type="checkbox"/> cc. Traumatic brain injury</p> <p><b>PSYCHIATRIC/MOOD</b></p> <p><input type="checkbox"/> dd. Anxiety disorder</p> <p><input type="checkbox"/> ee. Depression</p>	<p><input type="checkbox"/> ff. Manic depressive (Bipolar)</p> <p><input type="checkbox"/> gg. Schizophrenia</p> <p><b>PULMONARY</b></p> <p><input type="checkbox"/> hh. Asthma</p> <p><input type="checkbox"/> ii. Emphysema/COPD</p> <p><b>SENSORY</b></p> <p><input type="checkbox"/> jj. Cataracts</p> <p><input type="checkbox"/> kk. Diabetic retinopathy</p> <p><input type="checkbox"/> ll. Glaucoma</p> <p><input type="checkbox"/> mm. Macular degeneration</p> <p><b>OTHER</b></p> <p><input checked="" type="checkbox"/> nn. Allergies (specify) <b>BEE STING</b></p> <p><input type="checkbox"/> oo. Anemia</p> <p><input type="checkbox"/> pp. Cancer</p> <p><input type="checkbox"/> qq. Renal failure</p> <p><input type="checkbox"/> rr. Tuberculosis-TB</p> <p><input type="checkbox"/> ss. HIV</p> <p><input type="checkbox"/> tt. Mental retardation (e.g., Down's Syndrome, Autism, or other organic condition related to Mental Retardation or Developmental disability (MR/DD))</p> <p><input type="checkbox"/> uu. Substance abuse (alcohol or drug)</p> <p><input type="checkbox"/> vv. Other psychiatric diagnosis (e.g., paranoia, phobias, personality disorder)</p> <p><input type="checkbox"/> ww. Explicit terminal prognosis</p> <p><input type="checkbox"/> xx. <b>NONE OF ABOVE</b></p>
	<p><b>2. OTHER CURRENT DIAGNOSIS AND ICD-9 CODES</b></p> <p>a. _____ 715. 90</p> <p>b. _____ V66 . 6</p> <p>c. _____ □□□□ . □□</p>	

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

<b>5. PAIN INTERFERES</b>	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?
	<input type="checkbox"/> 1. All of the time <input checked="" type="checkbox"/> 3. Little of the time <input type="checkbox"/> 2. Some of the time <input type="checkbox"/> 4. None of the time
<b>6. PAIN MANAGEMENT</b>	<input type="checkbox"/> 1. No pain treatment <input checked="" type="checkbox"/> 3. Treated, partial control <input type="checkbox"/> 2. Treated, full control <input type="checkbox"/> 4. Treated, no or minimal control
<b>7. ACCIDENTS (Check all that apply)</b>	<input type="checkbox"/> a. Fell in <b>past 30 days</b> <input type="checkbox"/> d. Other fracture in last <b>180 days</b> <input checked="" type="checkbox"/> b. Fell in <b>past 31-180 days</b> <input type="checkbox"/> e. <b>NONE OF ABOVE</b> <input type="checkbox"/> c. Hip fracture in last <b>180 days</b>
<b>8. DANGER OF FALL (Check all that apply)</b>	<input type="checkbox"/> a. Has unsteady gait <input checked="" type="checkbox"/> b. Has balance problems when standing <input type="checkbox"/> c. Limits activity because resident or family fearful of resident falling <input type="checkbox"/> d. Unstable transition from seated to standing <input type="checkbox"/> e. Other (specify) _____ <input type="checkbox"/> f. <b>NONE OF ABOVE</b>

**SECTION K. ORAL/NUTRITIONAL STATUS**

<b>1. ORAL PROBLEMS (Check all that apply)</b>	<input type="checkbox"/> a. Mouth is "dry" when eating a meal <input type="checkbox"/> d. Mouth Pain <input type="checkbox"/> b. Chewing Problem <input checked="" type="checkbox"/> e. <b>NONE OF ABOVE</b> <input type="checkbox"/> c. Swallowing Problem
<b>2. HEIGHT AND WEIGHT</b>	Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in <b>last 30 days</b> ; 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>7 1</b> b. WT (lb.) <b>1 8 5</b>
<b>3. WEIGHT CHANGE</b>	<p>a. Unintended weight loss—5% or more in last 30 days; or 10% or more in last 180 days</p> <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes <p>b. Unintended weight gain—5% or more in last 30 days; or 10% or more in last 180 days</p> <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
<b>4. NUTRITIONAL PROBLEMS OR APPROACHES (Check all that apply)</b>	<input type="checkbox"/> a. Complains about the taste of many foods <input type="checkbox"/> f. Noncompliance with diet <input type="checkbox"/> b. Regular or repetitive complaints of hunger <input checked="" type="checkbox"/> g. Eating disorders <input type="checkbox"/> c. Leaves 25% of food uneaten at most meals <input type="checkbox"/> h. Food allergies (specify) <b>EGGS</b> <input type="checkbox"/> d. Therapeutic diet <input type="checkbox"/> i. Restrictions (specify) _____ <input type="checkbox"/> e. Mechanically altered (or pureed) diet <input type="checkbox"/> j. <b>NONE OF ABOVE</b>

**SECTION J. HEALTH CONDITIONS AND POSSIBLE MEDICATION SIDE EFFECTS**

<b>1. PROBLEM CONDITIONS</b>	(Check all problems present in last 7 days unless other time frame is indicated)
	<input type="checkbox"/> a. Inability to lie flat due to shortness of breath <input type="checkbox"/> i. Headache <input type="checkbox"/> b. Shortness of breath <input type="checkbox"/> j. Numbness/tingling <input type="checkbox"/> c. Edema <input type="checkbox"/> k. Blurred vision <input type="checkbox"/> d. Dizziness/vertigo <input type="checkbox"/> l. Dry mouth <input type="checkbox"/> e. Delusions <input type="checkbox"/> m. Excessive salivation or drooling <input type="checkbox"/> f. Hallucinations <input type="checkbox"/> n. Change in normal appetite <input checked="" type="checkbox"/> g. Hostility <input type="checkbox"/> o. Other (specify) _____ <input type="checkbox"/> h. Suspiciousness <input type="checkbox"/> p. <b>NONE OF ABOVE</b>
<b>2. EXTRA-PYRAMIDAL SIGNS AND SYMPTOMS</b>	Check all present at any point during <b>last 3 days</b>
	<p><b>INCREASE IN MOTOR ACTIVITY</b></p> <input type="checkbox"/> a. Akathisia—resident reports subjective feeling of restlessness or need for movement <input type="checkbox"/> b. Dyskinesia—chewing, puckering movements of mouth; abnormal irregular movements of lips; or rocking or writhing of trunk <input type="checkbox"/> c. Tremor—regular rhythmic movements of the fingers, limbs, head, mouth, or tongue <p><b>DECREASE IN MOTOR ACTIVITY</b></p> <input checked="" type="checkbox"/> d. Rigidity—resistance to flexion and extension of muscles (e.g., continuous or cogwheeling rigidity) <input type="checkbox"/> e. Slow shuffling gait—reduction in speed and stride length of gait, usually with a decrease in pendular arm movement <input type="checkbox"/> f. Bradykinesia—decrease in spontaneous movements (e.g., reduced body movement or poverty of facial expression, gestures, speech) <p><b>MUSCLE CONTRACTIONS</b></p> <input type="checkbox"/> g. Dystonia—muscle hypertonicity (e.g., muscle spasms or stiffness, protruding tongue, upward deviation of the eyes) <input type="checkbox"/> h. <b>NONE OF ABOVE</b>
<b>3. PAIN SYMPTOMS</b>	(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) <b>03</b>
<b>4. PAIN SITE</b>	(If pain is present in the last 7 days)
	<input type="checkbox"/> a. Back pain <input type="checkbox"/> f. Incisional pain <input checked="" type="checkbox"/> b. Bone pain <input type="checkbox"/> g. Joint pain (other than hip) <input type="checkbox"/> c. Chest pain while doing usual activities <input type="checkbox"/> h. Soft tissue pain (e.g., lesion, muscle) <input type="checkbox"/> d. Headache <input type="checkbox"/> i. Stomach pain <input type="checkbox"/> e. Hip pain <input type="checkbox"/> j. Other (specify) _____

**SECTION L. ORAL/DENTAL STATUS**

<b>1. ORAL STATUS AND DISEASE PREVENTION (check all that apply)</b>	<input type="checkbox"/> a. Has dentures or removable bridge <input checked="" type="checkbox"/> b. Some/all natural teeth lost—does not have or does not use dentures (or partial plates) <input type="checkbox"/> c. Broken, loose or carious teeth <input type="checkbox"/> d. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes <input type="checkbox"/> e. Daily cleaning of teeth/dentures or daily mouth care—by resident or staff <input type="checkbox"/> f. Resident has difficulty brushing teeth or dentures <input type="checkbox"/> g. <b>NONE OF ABOVE</b>
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**SECTION M. SKIN CONDITION**

<b>1. SKIN PROBLEMS (Check all that apply)</b>	Any troubling skin conditions or changes in the <b>last 7 days</b> ?
	<input type="checkbox"/> a. Abrasions (scrapes) or cuts <input type="checkbox"/> e. Open sores or lesions <input type="checkbox"/> b. Bums (2nd or 3rd degree) <input type="checkbox"/> f. Other (specify) _____ <input type="checkbox"/> c. Bruises <input type="checkbox"/> d. Rashes, itchiness, body lice <input checked="" type="checkbox"/> g. <b>NONE OF ABOVE</b>
<b>2. ULCERS (Due to any cause)</b>	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.
	<p>a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. <b>Number at Stage: 0</b></p> <p>b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. <b>3</b></p> <p>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. <b>1</b></p> <p>d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. <b>0</b></p>

Resident Name: **ANDREW W CAVANAUGH** Date: **07/07/2004** Soc. Sec. # **004-78-8974** Facility Provider # **999999999**

**SECTION M. SKIN CONDITION**

<b>3. FOOT PROBLEMS</b>	a. Resident or someone else inspects resident's feet on a regular basis? <input type="checkbox"/> 0. No <input checked="" type="checkbox"/> 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? <input type="checkbox"/> 0. No <input checked="" type="checkbox"/> 1. Yes

**SECTION N. ACTIVITY PURSUIT PATTERNS**

<b>1. TIME AWAKE</b>	<i>(Check appropriate time periods over last 7 days)</i> Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: <input checked="" type="checkbox"/> a. Morning <input type="checkbox"/> d. Night (Bedtime to A.M.) <input checked="" type="checkbox"/> b. Afternoon <input type="checkbox"/> e. NONE OF ABOVE <input checked="" type="checkbox"/> c. Evening
<b>2. AVERAGE TIME INVOLVED IN ACTIVITIES</b> <i>(Check only one.)</i>	<i>(When awake and not receiving treatments or ADL care)</i> <input type="checkbox"/> 1. Most—more than 2/3 of time <input checked="" type="checkbox"/> 2. Some—from 1/3 to 2/3 of time <input type="checkbox"/> 3. Little—less than 1/3 of time <input type="checkbox"/> 4. None
<b>3. PREFERRED ACTIVITY SETTINGS</b>	<i>(Check all settings in which activities are preferred)</i> <input checked="" type="checkbox"/> a. Own room <input checked="" type="checkbox"/> d. Away from facility <input checked="" type="checkbox"/> b. Day/activity room <input type="checkbox"/> e. NONE OF ABOVE <input checked="" type="checkbox"/> c. Outside facility (e.g., in yard)
<b>4. GENERAL ACTIVITY PREFERENCES</b> <i>(Adapted to resident's current abilities)</i>	<i>(Check all PREFERENCES whether or not activity is currently available to resident)</i> <input checked="" type="checkbox"/> a. Cards/other games <input type="checkbox"/> k. Gardening or plants <input type="checkbox"/> b. Crafts/arts <input type="checkbox"/> l. Talking or conversing <input type="checkbox"/> c. Exercise/sports <input checked="" type="checkbox"/> m. Helping others <input type="checkbox"/> d. Dancing <input checked="" type="checkbox"/> n. Doing chores around the house/facility <input checked="" type="checkbox"/> e. Music <input type="checkbox"/> o. Cooking/baking <input type="checkbox"/> f. Reading/writing <input checked="" type="checkbox"/> p. Computer activities <input type="checkbox"/> g. Spiritual/religious activity <input type="checkbox"/> q. Volunteering <input checked="" type="checkbox"/> h. Trips/shopping <input type="checkbox"/> r. Other (specify) _____ <input checked="" type="checkbox"/> i. Walking/wheeling outdoors <input type="checkbox"/> s. NONE OF ABOVE <input checked="" type="checkbox"/> j. Watching TV
<b>5. PREFERRED ACTIVITY SIZE</b>	<i>(Check all that apply)</i> <input type="checkbox"/> a. Individual <input type="checkbox"/> c. Larger group <input type="checkbox"/> b. Small group <input checked="" type="checkbox"/> d. No preference
<b>6. PREFERENCES IN DAILY ROUTINE</b> <i>(Check all that apply)</i>	<input type="checkbox"/> a. Resident prefers change in type of activity <input type="checkbox"/> b. Resident prefers change in extent of involvement in activities (e.g., more or less) <input type="checkbox"/> c. Resident prefers change in location of activities <input type="checkbox"/> d. Resident prefers activity at different time of day <input checked="" type="checkbox"/> e. Resident prefers stability in daily routine <input type="checkbox"/> f. NONE OF ABOVE
<b>7. INTERACTION WITH FAMILY AND FRIENDS</b>	a. How often has resident visited or been visited by family and friends in the last 30 days? <i>(check only one)</i> <input type="checkbox"/> 1. No family or friends outside facility <input checked="" type="checkbox"/> 4. Once a week <input type="checkbox"/> 2. None <input type="checkbox"/> 5. 2 or 3 times a week but not daily <input type="checkbox"/> 3. 1-3 times/month <input type="checkbox"/> 6. Daily b. How often has resident talked by telephone with family and friends in the last 30 days? <i>(check only one)</i> <input type="checkbox"/> 1. No family or friends outside facility <input checked="" type="checkbox"/> 4. Once a week <input type="checkbox"/> 2. None <input type="checkbox"/> 5. 2 or 3 times a week but not daily <input type="checkbox"/> 3. 1-3 times/month <input type="checkbox"/> 6. Daily
<b>8. VOTING</b>	Is resident registered to vote? <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
<b>9. SOCIAL ACTIVITIES</b> <i>(Check only one.)</i>	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): <input checked="" type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined

**SECTION O. MEDICATIONS**

<b>1. NUMBER OF MEDICATIONS</b>	<i>(Record the number of different medications used in the last 7 days; enter "0" if none used)</i>	<b>0</b>	<b>0</b>
<b>2. NEW MEDICATIONS</b>	<i>(Resident currently receiving medications that were initiated during the last 90 days)</i> <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes		
<b>3. INJECTIONS</b>	<i>(Record the number of DAYS injections of any type received during the last 30 days; enter "0" if none used)</i>	<b>0</b>	<b>0</b>

**SECTION O. MEDICATIONS (cont.)**

<b>4A. DAYS RECEIVED THE FOLLOWING MEDICATION</b>	<i>(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)</i> <input type="checkbox"/> 0 a. Antipsychotic <input type="checkbox"/> 0 d. Hypnotic <input type="checkbox"/> 0 g. Insulin <input type="checkbox"/> 0 b. Antianxiety <input type="checkbox"/> 0 e. Diuretic <input type="checkbox"/> 0 c. Antidepressant <input type="checkbox"/> 0 f. Aricept
<b>4B. PRN MEDICATIONS</b>	Does resident have a prescription for any PRN medication for a mental, emotional or nervous condition, or behavioral problem? <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
<b>5. SELF-ADMINISTERED MEDICATIONS</b> <i>(Check all that apply.)</i>	Did resident self-administer any of the following in the last 7 days: <input type="checkbox"/> a. Insulin <input type="checkbox"/> e. Glucosan <input type="checkbox"/> b. Oxygen <input type="checkbox"/> f. Over-the-counter Meds <input type="checkbox"/> c. Nebulizers <input type="checkbox"/> g. Other (specify) _____ <input type="checkbox"/> d. Nitropatch <input checked="" type="checkbox"/> h. NONE OF ABOVE
<b>6. MEDICATION PREPARATION ADMINISTRATION</b>	Did resident prepare and administer his/her own medications in last 7 days? <i>(Check only one.)</i> <input checked="" type="checkbox"/> 0. No Meds <input type="checkbox"/> 1. Resident prepared and administered <b>NONE</b> of his/her own medications. <input type="checkbox"/> 2. Resident prepared and administered <b>SOME</b> of his/her own medications. <input type="checkbox"/> 3. Resident prepared and administered <b>ALL</b> of his/her own medications.
<b>7. MEDICATION COMPLIANCE</b> <i>(Check one)</i>	Resident's level of compliance with medications prescribed by a physician/psychiatrist <b>during last 30 days:</b> <input type="checkbox"/> 0. No Meds <input type="checkbox"/> 1. Always compliant <input type="checkbox"/> 2. Always compliant with reminder, verbal prompts <input checked="" type="checkbox"/> 3. Compliant some of the time (80% of time or more often) <b>or</b> with some medications <input type="checkbox"/> 4. Rarely or never compliant
<b>8. MISUSE OF MEDICATION</b>	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) <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes

**SECTION P. SPECIAL TREATMENTS AND PROCEDURES**

<b>1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS</b>	a. <b>SPECIAL CARE—Check treatments or programs received during the last 14 days</b> [Note—count only post admission treatments] <b>TREATMENTS</b> <input type="checkbox"/> a. Chemotherapy or radiation <input checked="" type="checkbox"/> i. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) <input type="checkbox"/> b. Oxygen therapy <input checked="" type="checkbox"/> j. Case management <input type="checkbox"/> c. Dialysis <input checked="" type="checkbox"/> k. Day treatment program <input type="checkbox"/> d. Alcohol/drug treatment program <input checked="" type="checkbox"/> l. Sheltered workshop/employment program <input type="checkbox"/> e. Alzheimer's/dementia special care unit <input checked="" type="checkbox"/> m. Job training <input type="checkbox"/> f. Hospice care <input checked="" type="checkbox"/> n. Transportation <input type="checkbox"/> g. Home health <input checked="" type="checkbox"/> o. Psychological rehabilitation <input type="checkbox"/> h. Home care <input type="checkbox"/> q. NONE OF ABOVE			
	b. <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</b> (Enter 0 if none or less than 15 min. a day) <b>(Note—count only post admission therapies)</b> <b>(A) = # of days administered for 15 minutes or more</b> <b>Check B if therapy was received at home or in facility</b> <b>Check C if therapy was received out-of-home or facility</b>	<b>Days (A)</b>	<b>ON SITE (B)</b>	<b>OFF SITE (C)</b>
	a. Speech-language pathology and auditory services	<b>0</b>		
	b. Occupational therapy	<b>5</b>		<b>X</b>
	c. Physical therapy	<b>5</b>		<b>X</b>
	d. Respiratory therapy	<b>0</b>		
	e. Psychological therapy (by any licensed mental health professional)	<b>1</b>		<b>X</b>
<b>2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS</b>	<i>(Check all interventions or strategies used in the last 7 days unless other time specified—no matter where received)</i> <input type="checkbox"/> a. Special behavior symptom evaluation program <input type="checkbox"/> b. Special behavior management program <input checked="" type="checkbox"/> f. Reorientation—e.g., cueing <input type="checkbox"/> c. Evaluation by a licensed mental health specialist in last 90 days <input checked="" type="checkbox"/> g. Validation/Redirection <input checked="" type="checkbox"/> d. Group therapy <input type="checkbox"/> h. Crisis intervention in facility <input type="checkbox"/> e. Resident-specific deliberate changes in the <input type="checkbox"/> i. Crisis stabilization unit in last 90 days <input type="checkbox"/> j. Other (specify) _____ <input type="checkbox"/> k. NONE OF ABOVE	environment to address mood/behavior patterns—e.g., providing bureau in which to rummage		



**SECTION P. SPECIAL TREATMENTS AND PROCEDURES (cont.)**

3.	<b>NEED FOR ON-GOING MONITORING</b>	(Code for person responsible for monitoring)	
		0. No monitoring required	2. RCF Other Staff
		1. RCF nurse	3. Home health nurse
		3 a. Acute physical or psychiatric condition - not chronic	0 b. New treatment/medication
4.	<b>REHABILITATION/RESTORATIVE CARE</b>	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.)	
		7 a. Range of motion (passive)	
		0 b. Range of motion (active)	
		0 c. Splint or brace assistance	
		<b>TRAINING/SKILL PRACTICE IN:</b>	
		0 d. Bed mobility	0 i. Amputation/prosthesis care
		0 e. Transfer	0 j. Communication
		4 f. Walking	7 k. Time management
		0 g. Dressing or grooming	0 l. Other (specify) _____
		0 h. Eating or swallowing	
5.	<b>SKILL TRAINING</b>	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.	
		30 a. Meal Preparation (snacks, light meals)	00 h. Arranges Shopping (makes list, acquires help)
		00 b. Telephone Use	04 i. Shopping (for groceries, clothes, or other incidentals)
		30 c. Light Housework (makes own bed, takes care of belongings)	20 j. Transportation (travel by various means to get to medical appointments or other necessary engagements)
		04 d. Laundry (sorts, folds, or washes own laundry)	
		00 e. Managing Incontinence Supplies (pads, briefs, ostomy, catheter)	00 k. Medications (preparation and administration of medications)
		04 f. Managing Cash (handles cash, makes purchases)	01 l. Other (specify) <u>DOING TAXES</u>
		00 g. Managing Finances (banking, handling checkbook, or paying bills)	
6.	<b>ADHERENCE WITH TREATMENTS/THERAPIES/PROGRAMS</b>	In the last 6 months, compliant all or most of the time with special treatments, therapies and programs:	
		<input type="checkbox"/> 0. Always compliant <input checked="" type="checkbox"/> 1. Compliant 80% of time <input type="checkbox"/> 2. Compliant less than 80% of the time	<input type="checkbox"/> 3. No treatments or programs <input type="checkbox"/> 8. Unknown
7.	<b>GENERAL HOSPITAL STAY(S)</b>	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)	0 0
8.	<b>EMERGENCY ROOM (ER) VISIT(S)</b>	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)	0 0
9.	<b>PHYSICIAN VISITS</b>	In the last 6 months (or since admission to facility) how if less than 6 months many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter "0" if none)	0 1
10.	<b>PHYSICIAN ORDERS</b>	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)	0 0
11.	<b>ABNORMAL LAB VALUES</b>	Has the resident had any abnormal lab values during the last 90 days (or since admission if less than 90 days)? <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes	
12.	<b>PSYCHIATRIC HOSPITAL STAY(S)</b>	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)	0 0
13.	<b>OUTPATIENT SURGERY</b>	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)	0 0

**SECTION Q. SERVICE PLANNING**

1.	<b>RESIDENT GOALS</b>	(Check all areas in which resident has self-identified goals)
		<input type="checkbox"/> a. Health promotion/wellness/exercise <input type="checkbox"/> b. Social involvement/making friends <input type="checkbox"/> c. Activities/hobbies/adult learning <input type="checkbox"/> d. Rehabilitation-skilled <input type="checkbox"/> e. Maintaining physical or cognitive function <input type="checkbox"/> f. Participation in the community <input type="checkbox"/> g. Other (specify) _____ <input checked="" type="checkbox"/> h. No goals
2.	<b>CONFLICT</b>	a. Any disagreement between resident and family about goals or service plan? <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes b. Any disagreement between resident/family and staff about goals or service plan? <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes

**SECTION R. DISCHARGE POTENTIAL**

1.	<b>DISCHARGE POTENTIAL</b>	a. Does resident or family indicate a preference to return to community? <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
		b. Does resident have a support person who is positive towards discharge? <input type="checkbox"/> 0. No <input checked="" type="checkbox"/> 1. Yes
		c. Has resident's self-sufficiency changed compared to 6 months or since admission, if less than 6 months? <input checked="" type="checkbox"/> 0. No change <input type="checkbox"/> 1.Improved <input type="checkbox"/> 2. Declined

**SECTION S. ASSESSMENT INFORMATION**

1.	<b>PARTICIPATION IN ASSESSMENT</b>	a. Resident: <input type="checkbox"/> 0. No <input checked="" type="checkbox"/> 1. Yes	1
		b. Family: <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No Family	0
		c. Other Non-Staff: <input type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes <input checked="" type="checkbox"/> 2. None	2
2.	<b>SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:</b>		
	<b>NANCY SMITH</b>		
	a. Signature of Assessment Coordinator (sign on line above)		
	b. Date Assessment Coordinator signed as complete		
	07 - 07 - 2004 Month Day Year		
3.	<b>CASE MIX GROUP</b>	c. Other Signatures Title Sections Date	
		d. Date	
		e. Date	
		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

**SECTION T. Preventive Health/Health Behaviors**

1.	<b>PREVENTIVE HEALTH</b>	(Check all the procedures the resident received during the past 12 months)	
		<input checked="" type="checkbox"/> a. Blood pressure monitoring	<input type="checkbox"/> g. Breast exam or mammogram
		<input type="checkbox"/> b. Hearing assessment	<input type="checkbox"/> h. Pap smear
		<input type="checkbox"/> c. Vision test	<input type="checkbox"/> i. PSA or rectal exam
		<input type="checkbox"/> d. Dental visit	<input type="checkbox"/> j. Other (specify) _____
		<input type="checkbox"/> e. Influenza vaccine	
		<input type="checkbox"/> f. Pneumococcal vaccine (ANY time)	

P11 = 1 (Yes)



**MINIMUM DATA SET (MDS)<sup>®</sup>**  
**ASSISTED LIVING SERVICES (ALS)**

FACE SHEET: BACKGROUND INFORMATION ONLY AT ADMISSION

**SECTION AA. IDENTIFICATION INFORMATION**

1.	<b>RESIDENT NAME</b>	<b>THOMAS B ANTHONY</b>																						
	a. (First)      b. (Middle Initial)      c. (Last)      d. (Jr/Sr)																							
2.	<b>GENDER</b>	X 1. Male <input type="checkbox"/> 2. Female																						
3.	<b>BIRTHDATE</b>	<table border="1"> <tr> <td>0</td><td>8</td><td>—</td><td>1</td><td>3</td><td>—</td><td>1</td><td>9</td><td>0</td><td>8</td> </tr> <tr> <td colspan="2">Month</td> <td colspan="2">Day</td> <td colspan="4">Year</td> </tr> </table>	0	8	—	1	3	—	1	9	0	8	Month		Day		Year							
0	8	—	1	3	—	1	9	0	8															
Month		Day		Year																				
4.	<b>RACE/ETHNICITY</b> <i>(Check only one.)</i>	<input type="checkbox"/> 1. American Indian/Alaskan Native <input type="checkbox"/> 4. Hispanic <input type="checkbox"/> 2. Asian/Pacific Islander      X 5. White, not of Hispanic origin <input type="checkbox"/> 3. Black, not of Hispanic origin <input type="checkbox"/> 6. Other																						
5.	<b>SOCIAL SECURITY and MEDICARE NUMBERS</b> <i>(C in 1<sup>st</sup> box if no med. no.)</i>	a. Social Security Number <table border="1"> <tr> <td>0</td><td>0</td><td>7</td><td>—</td><td>0</td><td>2</td><td>—</td><td>7</td><td>9</td><td>0</td><td>7</td> </tr> </table> b. Medicare number (or comparable railroad insurance number) <table border="1"> <tr> <td>0</td><td>0</td><td>7</td><td>0</td><td>2</td><td>7</td><td>9</td><td>0</td><td>7</td><td>—</td><td>A</td> </tr> </table>	0	0	7	—	0	2	—	7	9	0	7	0	0	7	0	2	7	9	0	7	—	A
0	0	7	—	0	2	—	7	9	0	7														
0	0	7	0	2	7	9	0	7	—	A														
6.	<b>FACILITY NAME AND PROVIDER NO.</b>	a. Facility Name <b>MCBVI</b> b. Provider No. <table border="1"> <tr> <td>9</td><td>9</td><td>9</td><td>9</td><td>9</td><td>9</td><td>9</td><td>9</td><td>9</td> </tr> </table>	9	9	9	9	9	9	9	9	9													
9	9	9	9	9	9	9	9	9																
7.	<b>MAINECARE NO.</b>	<i>[Record a "+" if pending, "N" if not a MaineCare recipient]</i> <table border="1"> <tr> <td>4</td><td>4</td><td>0</td><td>2</td><td>7</td><td>6</td><td>9</td><td>1</td><td>A</td> </tr> </table>	4	4	0	2	7	6	9	1	A													
4	4	0	2	7	6	9	1	A																

**SECTION AB. DEMOGRAPHIC INFORMATION**

1.	<b>DATE OF ENTRY</b>	<i>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.)</i> <table border="1"> <tr> <td>0</td><td>8</td><td>—</td><td>2</td><td>7</td><td>—</td><td>1</td><td>9</td><td>9</td><td>3</td> </tr> <tr> <td colspan="2">Month</td> <td colspan="2">Day</td> <td colspan="4">Year</td> </tr> </table>	0	8	—	2	7	—	1	9	9	3	Month		Day		Year					
0	8	—	2	7	—	1	9	9	3													
Month		Day		Year																		
2.	<b>ADMITTED FROM (AT ENTRY)</b> <i>(Check only one.)</i>	<input type="checkbox"/> 1. Private home/apt. X 2. Other board and care/assisted living/group home <input type="checkbox"/> 3. Nursing home <input type="checkbox"/> 4. Acute care hospital <input type="checkbox"/> 5. Psychiatric hospital <input type="checkbox"/> 6. MR/DD facility <input type="checkbox"/> 7. Rehabilitation hospital <input type="checkbox"/> 8. Other <i>(specify)</i> _____																				
3.	<b>LIVED ALONE (PRIOR TO ENTRY)</b> <i>(Check only one.)</i>	X 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. In other facility																				
4.	<b>PRIOR PRIMARY RESIDENCE</b>	<i>Provide town, state, zip code for Resident's primary residence prior to admission</i> <b>BERWICK</b> <b>MAINE</b> <table border="1"> <tr> <td>0</td><td>3</td><td>9</td><td>0</td><td>1</td> </tr> </table> Town      State      Zip Code	0	3	9	0	1															
0	3	9	0	1																		
5.	<b>RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY</b>	<i>(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above)</i> <input type="checkbox"/> a. Prior stay at this home <input type="checkbox"/> b. Nursing home X c. Other residential facility—board and care home, assisted living, group home <input type="checkbox"/> d. MH/psychiatric hospital <input type="checkbox"/> e. MR/DD facility <input type="checkbox"/> f. <b>NONE OF ABOVE</b>																				
6.	<b>LIFETIME OCCUPATION</b>	<i>Put a "/" between two occupations.</i> <table border="1"> <tr> <td>F</td><td>L</td><td>O</td><td>W</td><td>E</td><td>R</td><td>/</td><td>G</td><td>R</td><td>O</td><td>W</td><td>E</td><td>R</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>	F	L	O	W	E	R	/	G	R	O	W	E	R							
F	L	O	W	E	R	/	G	R	O	W	E	R										

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

**SECTION AC. CUSTOMARY ROUTINE**

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

**SECTION AD. FACE SHEET SIGNATURES and DATES**

<b>1. SIGNATURE(S) OF PERSON(S) COMPLETING FACE SHEET:</b>																					
a. Signatures	Title	Sections	Date																		
<b>NANCY SMITH</b>	<b>RCA COORDINATOR</b>	<b>ALL</b>	<b>8/30/1993</b>																		
b.			Date																		
2.	<b>DATE COMPLETED</b>	Record date background information was completed.																			
		<table border="1"> <tr> <td>0</td><td>8</td><td>—</td><td>3</td><td>0</td><td>—</td><td>1</td><td>9</td><td>9</td><td>3</td> </tr> <tr> <td colspan="2">Month</td> <td colspan="2">Day</td> <td colspan="4">Year</td> </tr> </table>	0	8	—	3	0	—	1	9	9	3	Month		Day		Year				
0	8	—	3	0	—	1	9	9	3												
Month		Day		Year																	

**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	THOMAS B ANTHONY 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 0 0 7 — 0 2 — 7 9 0 7 b. Medicare number (or comparable railroad insurance number) 0 0 7 0 2 7 9 0 7 — A
3. FACILITY NAME AND PROVIDER NO.	a. Facility Name MCBVI b. Provider No. 9 9 9 9 9 9 9 9 9
4. MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient] 4 4 0 2 7 6 9 1 A
5. ASSESSMENT DATE	Last day of observation period 0 8 — 1 3 — 2 0 0 4 Month Day Year
6. REASON FOR ASSESSMENT	(Check primary reason for assessment) <input type="checkbox"/> 1. Admission assessment <input type="checkbox"/> 4. Semi-Annual <input checked="" type="checkbox"/> 2. Annual assessment <input type="checkbox"/> 5. Other (specify) <input type="checkbox"/> 3. Significant change in status assessment _____
7. MARITAL STATUS (Check only one.)	<input type="checkbox"/> 1. Never married <input checked="" type="checkbox"/> 3. Widowed <input type="checkbox"/> 5. Divorced <input type="checkbox"/> 2. Married <input type="checkbox"/> 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) <input checked="" type="checkbox"/> a. MaineCare <input type="checkbox"/> e. Private pay <input checked="" type="checkbox"/> b. SSI <input type="checkbox"/> f. Private insurance/PENSION (including co-payment) <input type="checkbox"/> c. VA <input type="checkbox"/> g. SSDI <input checked="" type="checkbox"/> d. Social Security <input type="checkbox"/> h. Other (specify) _____
9. RESPONSIBILITY/LEGAL GUARDIAN	(Check all that apply) <input type="checkbox"/> a. Legal guardian <input checked="" type="checkbox"/> e. Family member responsible <input type="checkbox"/> b. Other legal oversight <input checked="" type="checkbox"/> f. Self <input type="checkbox"/> c. Durable power of attorney/health care <input type="checkbox"/> g. Legal Conservator <input type="checkbox"/> d. Durable power of attorney/financial <input type="checkbox"/> h. Representative Payee <input type="checkbox"/> i. NONE OF ABOVE
10. ADVANCED DIRECTIVES	Does resident have any of the following advanced directives in place? a. Living Will <input type="checkbox"/> 0. No <input checked="" type="checkbox"/> 1. Yes b. Do not resuscitate (DNR) <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes c. Do not hospitalize <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes d. Organ donation <input type="checkbox"/> 0. No <input checked="" type="checkbox"/> 1. Yes e. Other <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 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 <input type="checkbox"/> 0. Memory OK <input checked="" type="checkbox"/> 1. Memory problem b. Long-term memory OK—seems/appears to recall long past <input checked="" type="checkbox"/> 0. Memory OK <input type="checkbox"/> 1. Memory problem
2. MEMORY/RECALL ABILITY	(Check all that resident was normally able to recall during last 7 days) <input checked="" type="checkbox"/> a. Current season <input type="checkbox"/> d. That he/she is in a facility/home <input type="checkbox"/> b. Location of own room <input type="checkbox"/> e. NONE OF ABOVE are recalled <input checked="" type="checkbox"/> c. Staff names/faces
3. COGNITIVE SKILLS FOR DAILY DECISION-MAKING (Check only one.)	(Made decisions regarding tasks of daily life) <input type="checkbox"/> 0. INDEPENDENT—decisions consistent/reasonable <input type="checkbox"/> 1. MODIFIED INDEPENDENCE—some difficulty in new situations only <input checked="" type="checkbox"/> 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required <input type="checkbox"/> 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). <input type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input checked="" type="checkbox"/> 2. Declined

**SECTION C. COMMUNICATION/HEARING PATTERNS**

1. HEARING (Check only one.)	(With hearing appliance, if used) <input checked="" type="checkbox"/> 0. HEARS ADEQUATELY—normal talk, TV, phone <input type="checkbox"/> 1. MINIMAL DIFFICULTY when not in quiet setting <input type="checkbox"/> 2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly <input type="checkbox"/> 3. HIGHLY IMPAIRED—absence of useful hearing
2. COMMUNICATION DEVICES/TECHNIQUES	(Check all that apply during last 7 days.) <input type="checkbox"/> a. Hearing aid, present and used <input type="checkbox"/> b. Hearing aid, present and not used regularly <input type="checkbox"/> c. Other receptive communication techniques used (e.g., lip reading) <input checked="" type="checkbox"/> d. NONE OF ABOVE
3. MAKING SELF UNDERSTOOD (Check only one.)	(Expressing information content—however able) <input checked="" type="checkbox"/> 0. UNDERSTOOD <input type="checkbox"/> 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts <input type="checkbox"/> 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests <input type="checkbox"/> 3. RARELY/NEVER UNDERSTOOD
4. ABILITY TO UNDERSTAND OTHERS (Check only one.)	(Understanding information content—however able) <input checked="" type="checkbox"/> 0. UNDERSTANDS <input type="checkbox"/> 1. USUALLY UNDERSTANDS—may miss some part / intent of message <input type="checkbox"/> 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication <input type="checkbox"/> 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. <input type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input checked="" type="checkbox"/> 2. Declined

**SECTION D. VISION PATTERNS**

1. VISION (Check only one.)	(Ability to see in adequate light and with glasses if used) <input type="checkbox"/> 0. ADEQUATE—sees fine detail, including regular print in newspapers/books <input type="checkbox"/> 1. IMPAIRED—sees large print, but not regular print in newspapers/books <input type="checkbox"/> 2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects <input checked="" type="checkbox"/> 3. HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects <input type="checkbox"/> 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 <input type="checkbox"/> 0. No <input checked="" type="checkbox"/> 1. Yes b. Artificial eye <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 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)
	<b>VERBAL EXPRESSIONS OF DISTRESS</b> 0 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." 0 b. Repetitive questions—e.g., "Where do I go; What do I do?" 0 c. Repetitive verbalizations—e.g., calling out for help, ("God help me") 0 d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in facility; anger at care received 0 e. Self deprecation—e.g., "I am nothing; I am of no use to anyone" 0 f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others 0 g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack 0 h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions 0 i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues (continued next page)

**SECTION E. MOOD and BEHAVIOR PATTERNS (cont.)**

1.	<b>INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD</b>	<i>(CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause)</i>																																																									
		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)																																																									
		<b>SLEEP-CYCLE ISSUES</b>																																																									
		0 j. Unpleasant mood in morning 0 k. Insomnia/change in usual sleep pattern <b>SAD, APATHETIC, ANXIOUS APPEARANCE</b> 0 l. Sad, pained, worried facial expressions—e.g., furrowed brows 0 m. Crying, tearfulness 0 n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking <b>LOSS OF INTEREST</b> 0 o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends 0 p. Reduced social interaction <b>INDICATORS OF MANIA</b> 0 q. Inflated self-worth, exaggerated self-opinion; inflated belief about one's own ability, etc. 0 r. Excited behavior, motor excitation (e.g., heightened physical activity; excited, loud or pressured speech; increased reactivity)																																																									
2.	<b>MOOD PERSISTENCE</b> <i>(Check only one.)</i>	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 <b>over last 7 days.</b> X 0. No mood indicators <input type="checkbox"/> 1. Indicators present, easily altered <input type="checkbox"/> 2. Indicators present, not easily altered																																																									
3.	<b>MOOD</b> <i>(Check only one.)</i>	Resident's current mood status compared to resident's status 180 days ago (or since admission if less than 180 days): X 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined																																																									
4.	<b>BEHAVIORAL SYMPTOMS</b>	<i>(COLUMN A CODES: Record the appropriate code for the frequency of the symptom in last 7 days)</i>																																																									
		<i>(COLUMN B CODES: Alterability of behavioral symptoms in last 7 days)</i>																																																									
		<i>(COLUMN C CODES: History of this behavior in the last 6 months)</i>																																																									
		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																																																									
		0. Not present or easily altered 1. Behavior not easily altered																																																									
		<table border="1"> <thead> <tr> <th></th> <th>A</th> <th>B</th> <th>C</th> </tr> <tr> <th>FREQUENCY</th> <td></td> <td></td> <td></td> </tr> <tr> <th>ALTERABILITY</th> <td></td> <td></td> <td></td> </tr> <tr> <th>HISTORY</th> <td></td> <td></td> <td></td> </tr> </thead> <tbody> <tr> <td>a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused, gross physical assault)</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>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)</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>f. INTIMIDATING BEHAVIOR (made others feel unsafe, at risk, privacy invaded)</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>g. ELOPEMENT</td> <td>1</td> <td>0</td> <td>0</td> </tr> <tr> <td>h. Dangerous non-violent behavior (e.g., falling asleep while smoking)</td> <td>2</td> <td>1</td> <td>1</td> </tr> <tr> <td>i. Dangerous violent behavior</td> <td>0</td> <td>0</td> <td>0</td> </tr> <tr> <td>j. FIRE SETTING</td> <td>0</td> <td>0</td> <td>0</td> </tr> </tbody> </table>			A	B	C	FREQUENCY				ALTERABILITY				HISTORY				a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	0	0	0	b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)	0	0	0	c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused, gross physical assault)	0	0	0	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)	0	0	0	e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)	0	0	0	f. INTIMIDATING BEHAVIOR (made others feel unsafe, at risk, privacy invaded)	0	0	0	g. ELOPEMENT	1	0	0	h. Dangerous non-violent behavior (e.g., falling asleep while smoking)	2	1	1	i. Dangerous violent behavior	0	0	0	j. FIRE SETTING	0	0	0
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5.	<b>SUICIDAL IDEATION</b>	Resident demonstrated suicidal thoughts or actions in the <b>last 30 days:</b> X 0. No <input type="checkbox"/> 1. Yes																																																									
6.	<b>SLEEP PROBLEMS</b>	Check all present on 2 or more days during last 7 days <input type="checkbox"/> a. Inability to awaken when desired <input type="checkbox"/> d. Interrupted sleep X b. Difficulty falling asleep <input type="checkbox"/> e. <b>NONE OF ABOVE</b> <input type="checkbox"/> c. Restless or non-restful sleep																																																									
7.	<b>INSIGHT INTO MENTAL HEALTH</b>	Resident has insight about his/her mental problem X 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No mental health problems																																																									
8.	<b>BEHAVIORS</b> <i>(Check only one.)</i>	Resident's current behavior status compared to resident's status 180 days ago (or since admission if less than 180 days): X 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined																																																									

**SECTION F. PSYCHOSOCIAL WELL-BEING**

1.	<b>SENSE OF INITIATIVE/ INVOLVEMENT</b> <i>(Check all that apply)</i>	X a. At ease interacting with others
		X b. At ease doing planned or structured activities
		X c. At ease doing self-initiated activities
2.	<b>UNSETTLED RELATIONSHIPS</b> <i>(Check all that apply)</i>	<input type="checkbox"/> d. Establishes own goals
		X 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)
		<input type="checkbox"/> f. Accepts invitations into most group activities
3.	<b>LIFE-EVENTS HISTORY</b> <i>(Check all that apply.)</i>	<input type="checkbox"/> g. <b>NONE OF ABOVE</b>
		Events in past 2 years
		X a. Serious accident or physical illness
4.	<b>PSYCHOSOCIAL WELL-BEING</b>	<input type="checkbox"/> b. Unhappy with roommate
		<input type="checkbox"/> c. Unhappy with residents other than roommate
		<input type="checkbox"/> d. Openly expresses conflict/anger with family/friends
		<input type="checkbox"/> e. Absence of personal contact with family/friends
		<input type="checkbox"/> f. Recent loss of close family member/friend
		<input type="checkbox"/> g. Does not adjust easily to change in routines
		X h. <b>NONE OF ABOVE</b>
		<input type="checkbox"/> i. Trouble with the law
		<input type="checkbox"/> j. Robbed/physically attacked
		<input type="checkbox"/> k. Conflict laden or severed relationship
5.	<b>PHYSICAL FUNCTIONING</b>	<input type="checkbox"/> l. Loss of income leading to change in lifestyle
		<input type="checkbox"/> m. Sexual assault/abuse
		<input type="checkbox"/> n. Child custody issues
		X o. Change in marital/partner status
		<input type="checkbox"/> p. Review hearings (e.g., forensic, certification, capacity hearing)
		<input type="checkbox"/> q. <b>NONE OF ABOVE</b>
		<input type="checkbox"/> r. <b>NONE OF ABOVE</b>
		<input type="checkbox"/> s. <b>NONE OF ABOVE</b>
		<input type="checkbox"/> t. <b>NONE OF ABOVE</b>
		<input type="checkbox"/> u. <b>NONE OF ABOVE</b>

**SECTION G. PHYSICAL FUNCTIONING**

1.	<b>(A) ADL SELF-PERFORMANCE</b>	0. <b>INDEPENDENT</b> —No help or oversight—OR— Help/oversight provided only 1 or 2 times during last 7 days		
		1. <b>SUPERVISION</b> —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. <b>LIMITED ASSISTANCE</b> —Resident highly involved in activity; received physical help in 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. <b>EXTENSIVE ASSISTANCE</b> —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. <b>TOTAL DEPENDENCE</b> —Full staff performance of activity during last 7 days		
		8. <b>ACTIVITY DID NOT OCCUR DURING LAST 7 DAYS</b>		
		<b>(B) ADL SUPPORT CODES</b> <i>(CODE for MOST SUPPORT PROVIDED OVER EACH 24 HOUR PERIOD) during last 7 days; code regardless of person's self-performance classification.</i>		
		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				
2.	<b>PHYSICAL FUNCTIONING</b>	a. <b>BED MOBILITY</b> — How resident moves to and from lying position, turns side to side, and positions body while in bed	0	0
		b. <b>TRANSFER</b> — How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	0	0
		c. <b>LOCOMOTION</b> — 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	0	0
		d. <b>DRESSING</b> — How resident puts on, fastens, and takes off all items of <b>street clothing</b> , including donning/removing prosthesis	2	2
		e. <b>EATING</b> — How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	0	0
		f. <b>TOILET USE</b> — How resident uses the toilet room (or commode, bed-pan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	0	0
		g. <b>PERSONAL HYGIENE</b> — How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)	1	2
		h. <b>STAIRS</b> — How resident climbs stairs	0	0

**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.	2
b. Resident shopped for clothing, snacks, or other incidentals.	1
c. Resident arranged for suitable transportation to get to appointments, outings, necessary engagements.	2
d. Resident managed finances including banking, handling checkbook, or paying bills.	2
e. Resident managed cash, personal needs allowance.	0
f. Resident prepared snacks, light meals.	8
g. Resident used phone.	1
h. Resident did light housework such as making own bed, dusting, or taking care of belongings.	2
i. Resident sorted, folded, or washed own laundry.	2

**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.) Resident expresses or gives evidence of needing new or additional assistive devices

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

**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	1
b. BLADDER CONTINENCE	Control of urinary bladder function with appliances (e.g. foley) or continence programs, if employed	2
2. BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days Constipation	c. Diarrhea
		d. Fecal Impaction
3. APPLIANCES and PROGRAMS	Any scheduled toileting plan Bladder retraining program External (condom) catheter Indwelling catheter Intermittent catheter	e. Resident is Independent
		f. NONE OF ABOVE
		a. X Did not use toilet room/ commode/urinal
		b. Pads/briefs used
		c. Enemas/irrigation
		d. Ostomy present
4. USE OF INCONTINENCE SUPPLIES	Resident's management of incontinence supplies (pads, briefs, ostomy, catheter) in last 14 days. <input type="checkbox"/> 0. Always continent <input checked="" type="checkbox"/> 1. Resident incontinent and able to manage incontinence supplies independently. <input type="checkbox"/> 2. Resident incontinent and receives assistance with managing incontinence supplies. <input type="checkbox"/> 3. Resident incontinent and does not use incontinence supplies.	i. NONE OF ABOVE
		j.
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): <input checked="" type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 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	HEART/CIRCULATION
	<input type="checkbox"/> a. Diabetes mellitus <input type="checkbox"/> b. Hyperthyroidism <input type="checkbox"/> c. Hypothyroidism	<input type="checkbox"/> d. Arteriosclerotic heart disease (ASHD) <input type="checkbox"/> e. Cardiac dysrhythmia <input type="checkbox"/> f. Congestive heart failure <input type="checkbox"/> g. Deep vein thrombosis <input checked="" type="checkbox"/> h. Hypertension <input type="checkbox"/> i. Hypotension <input checked="" type="checkbox"/> j. Peripheral vascular disease <input type="checkbox"/> k. Other cardiovascular disease

(continued on next page)

SECTION I. DIAGNOSES (cont.)

Form for Section I containing checkboxes for various medical conditions such as Musculoskeletal, Neurological, Psychiatric/Mood, and Pulmonary.

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

Form for Section J containing checkboxes for health conditions like Pain Interferes, Pain Management, Accidents, and Danger of Fall.

SECTION K. ORAL/NUTRITIONAL STATUS

Form for Section K containing checkboxes for oral problems, height and weight, weight change, and nutritional problems.

SECTION J. HEALTH CONDITIONS AND POSSIBLE MEDICATION SIDE EFFECTS

Form for Section J containing checkboxes for various health conditions and symptoms such as Problem Conditions, Extra-Pyramidal Signs, Pain Symptoms, and Pain Site.

SECTION L. ORAL/DENTAL STATUS

Form for Section L containing checkboxes for oral status and disease prevention.

SECTION M. SKIN CONDITION

Form for Section M containing checkboxes for skin problems and ulcers, including a table for ulcer stages.

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**SECTION M. SKIN CONDITION**

<b>3. FOOT PROBLEMS</b>	a. Resident or someone else inspects resident's feet on a regular basis? <input type="checkbox"/> 0. No <input checked="" type="checkbox"/> 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? <input type="checkbox"/> 0. No <input checked="" type="checkbox"/> 1. Yes

**SECTION N. ACTIVITY PURSUIT PATTERNS**

<b>1. TIME AWAKE</b>	<i>(Check appropriate time periods over last 7 days)</i> Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: <input type="checkbox"/> a. Morning <input type="checkbox"/> d. Night (Bedtime to A.M.) <input type="checkbox"/> b. Afternoon <input type="checkbox"/> e. NONE OF ABOVE <input checked="" type="checkbox"/> c. Evening
<b>2. AVERAGE TIME INVOLVED IN ACTIVITIES</b> <i>(Check only one.)</i>	<i>(When awake and not receiving treatments or ADL care)</i> <input type="checkbox"/> 1. Most—more than 2/3 of time <input type="checkbox"/> 2. Some—from 1/3 to 2/3 of time <input checked="" type="checkbox"/> 3. Little—less than 1/3 of time <input type="checkbox"/> 4. None
<b>3. PREFERRED ACTIVITY SETTINGS</b>	<i>(Check all settings in which activities are preferred)</i> <input checked="" type="checkbox"/> a. Own room <input checked="" type="checkbox"/> d. Away from facility <input checked="" type="checkbox"/> b. Day/activity room <input type="checkbox"/> e. NONE OF ABOVE <input checked="" type="checkbox"/> c. Outside facility (e.g., in yard)
<b>4. GENERAL ACTIVITY PREFERENCES</b> <i>(Adapted to resident's current abilities)</i>	<i>(Check all PREFERENCES whether or not activity is currently available to resident)</i> <input type="checkbox"/> a. Cards/other games <input checked="" type="checkbox"/> k. Gardening or plants <input type="checkbox"/> b. Crafts/arts <input checked="" type="checkbox"/> l. Talking or conversing <input checked="" type="checkbox"/> c. Exercise/sports <input checked="" type="checkbox"/> m. Helping others <input checked="" type="checkbox"/> d. Dancing <input checked="" type="checkbox"/> n. Doing chores around the house/facility <input checked="" type="checkbox"/> e. Music <input type="checkbox"/> o. Cooking/baking <input type="checkbox"/> f. Reading/writing <input type="checkbox"/> p. Computer activities <input type="checkbox"/> g. Spiritual/religious activity <input checked="" type="checkbox"/> q. Volunteering <input checked="" type="checkbox"/> h. Trips/shopping <input type="checkbox"/> r. Other (specify) _____ <input checked="" type="checkbox"/> i. Walking/wheeling outdoors <input type="checkbox"/> s. NONE OF ABOVE <input checked="" type="checkbox"/> j. Watching TV
<b>5. PREFERRED ACTIVITY SIZE</b>	<i>(Check all that apply)</i> <input type="checkbox"/> a. Individual <input type="checkbox"/> c. Larger group <input type="checkbox"/> b. Small group <input checked="" type="checkbox"/> d. No preference
<b>6. PREFERENCES IN DAILY ROUTINE</b> <i>(Check all that apply)</i>	<input type="checkbox"/> a. Resident prefers change in type of activity <input type="checkbox"/> b. Resident prefers change in extent of involvement in activities (e.g., more or less) <input type="checkbox"/> c. Resident prefers change in location of activities <input type="checkbox"/> d. Resident prefers activity at different time of day <input checked="" type="checkbox"/> e. Resident prefers stability in daily routine <input type="checkbox"/> f. NONE OF ABOVE
<b>7. INTERACTION WITH FAMILY AND FRIENDS</b>	a. How often has resident visited or been visited by family and friends in the last 30 days? <i>(check only one)</i> <input type="checkbox"/> 1. No family or friends outside facility <input type="checkbox"/> 4. Once a week <input type="checkbox"/> 2. None <input type="checkbox"/> 5. 2 or 3 times a week but not daily <input checked="" type="checkbox"/> 3. 1-3 times/month <input type="checkbox"/> 6. Daily b. How often has resident talked by telephone with family and friends in the last 30 days? <i>(check only one)</i> <input type="checkbox"/> 1. No family or friends outside facility <input checked="" type="checkbox"/> 4. Once a week <input type="checkbox"/> 2. None <input type="checkbox"/> 5. 2 or 3 times a week but not daily <input type="checkbox"/> 3. 1-3 times/month <input type="checkbox"/> 6. Daily
<b>8. VOTING</b>	Is resident registered to vote? <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
<b>9. SOCIAL ACTIVITIES</b> <i>(Check only one.)</i>	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): <input checked="" type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined

**SECTION O. MEDICATIONS**

<b>1. NUMBER OF MEDICATIONS</b>	<i>(Record the number of different medications used in the last 7 days; enter "0" if none used)</i>	<b>0</b>	<b>3</b>
<b>2. NEW MEDICATIONS</b>	<i>(Resident currently receiving medications that were initiated during the last 90 days)</i> <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes		
<b>3. INJECTIONS</b>	<i>(Record the number of DAYS injections of any type received during the last 30 days; enter "0" if none used)</i>	<b>0</b>	<b>0</b>

**SECTION O. MEDICATIONS (cont.)**

<b>4A. DAYS RECEIVED THE FOLLOWING MEDICATION</b>	<i>(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)</i> <b>0</b> a. Antipsychotic <b>0</b> d. Hypnotic <b>0</b> g. Insulin <b>0</b> b. Antianxiety <b>0</b> e. Diuretic <b>0</b> c. Antidepressant <b>0</b> f. Arcept
<b>4B. PRN MEDICATIONS</b>	Does resident have a prescription for any PRN medication for a mental, emotional or nervous condition, or behavioral problem? <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes
<b>5. SELF-ADMINISTERED MEDICATIONS</b> <i>(Check all that apply.)</i>	Did resident self-administer any of the following in the last 7 days: <input type="checkbox"/> a. Insulin <input type="checkbox"/> e. Glucosan <input type="checkbox"/> b. Oxygen <input type="checkbox"/> f. Over-the-counter Meds <input type="checkbox"/> c. Nebulizers <input type="checkbox"/> g. Other (specify) _____ <input type="checkbox"/> d. Nitropatch <input checked="" type="checkbox"/> h. NONE OF ABOVE
<b>6. MEDICATION PREPARATION ADMINISTRATION</b>	Did resident prepare and administer his/her own medications in last 7 days? <i>(Check only one.)</i> <input type="checkbox"/> 0. No Meds <input checked="" type="checkbox"/> 1. Resident prepared and administered <b>NONE</b> of his/her own medications. <input type="checkbox"/> 2. Resident prepared and administered <b>SOME</b> of his/her own medications. <input type="checkbox"/> 3. Resident prepared and administered <b>ALL</b> of his/her own medications.
<b>7. MEDICATION COMPLIANCE</b> <i>(Check one)</i>	Resident's level of compliance with medications prescribed by a physician/psychiatrist <b>during last 30 days:</b> <input type="checkbox"/> 0. No Meds <input checked="" type="checkbox"/> 1. Always compliant <input type="checkbox"/> 2. Always compliant with reminder, verbal prompts <input type="checkbox"/> 3. Compliant some of the time (80% of time or more often) <b>or</b> with some medications <input type="checkbox"/> 4. Rarely or never compliant
<b>8. MISUSE OF MEDICATION</b>	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) <input type="checkbox"/> 0. No <input checked="" type="checkbox"/> 1. Yes

**SECTION P. SPECIAL TREATMENTS AND PROCEDURES**

<b>1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS</b>	a. <b>SPECIAL CARE—Check treatments or programs received during the last 14 days</b> [Note—count only post admission treatments] <input type="checkbox"/> a. Chemotherapy or radiation <input type="checkbox"/> i. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) <input type="checkbox"/> b. Oxygen therapy <input type="checkbox"/> j. Case management <input type="checkbox"/> c. Dialysis <input type="checkbox"/> k. Day treatment program <input type="checkbox"/> d. Alcohol/drug treatment program <input type="checkbox"/> l. Sheltered workshop/employment <input type="checkbox"/> e. Alzheimer's/dementia special care unit <input checked="" type="checkbox"/> m. Job training <input checked="" type="checkbox"/> f. Hospice care <input type="checkbox"/> n. Transportation <input checked="" type="checkbox"/> g. Home health <input type="checkbox"/> o. Psychological rehabilitation <input checked="" type="checkbox"/> h. Home care <input type="checkbox"/> p. Formal education <input type="checkbox"/> q. NONE OF ABOVE			
	b. <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</b> (Enter 0 if none or less than 15 min. a day) <i>(Note—count only post admission therapies)</i> <b>(A) = # of days administered for 15 minutes or more</b> <b>Check B if therapy was received at home or in facility</b> <b>Check C if therapy was received out-of-home or facility</b>	<b>Days (A)</b>	<b>ON SITE (B)</b>	<b>OFF SITE (C)</b>
	a. Speech-language pathology and auditory services	<b>0</b>		
	b. Occupational therapy	<b>0</b>		
	c. Physical therapy	<b>0</b>		
	d. Respiratory therapy	<b>0</b>		
	e. Psychological therapy (by any licensed mental health professional)	<b>0</b>		
<b>2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS</b>	<i>(Check all interventions or strategies used in the last 7 days unless other time specified—no matter where received)</i> <input type="checkbox"/> a. Special behavior symptom evaluation program <input type="checkbox"/> b. Special behavior management program <input type="checkbox"/> c. Evaluation by a licensed mental health specialist in last 90 days <input type="checkbox"/> d. Group therapy <input type="checkbox"/> e. Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage <input checked="" type="checkbox"/> f. Reorientation—e.g., cueing <input type="checkbox"/> g. Validation/Redirection <input type="checkbox"/> h. Crisis intervention in facility <input type="checkbox"/> i. Crisis stabilization unit in last 90 days <input type="checkbox"/> j. Other (specify) _____ <input type="checkbox"/> 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  3 a. Acute physical or psychiatric condition - not chronic      0 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.) 0 a. Range of motion (passive) 0 b. Range of motion (active) 0 c. Splint or brace assistance TRAINING/SKILL PRACTICE IN: 0 d. Bed mobility      0 i. Amputation/prosthesis care 0 e. Transfer              0 j. Communication 0 f. Walking                0 k. Time management 0 g. Dressing or grooming      0 l. Other (specify) _____ 0 h. Eating or swallowing
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. 0 a. Meal Preparation (snacks, light meals)      0 h. Arranges Shopping (makes list, acquires help) 0 b. Telephone Use                      0 i. Shopping (for groceries, clothes, or other incidentals) 0 c. Light Housework (makes own bed, takes care of belongings)      0 j. Transportation (travel by various means to get to medical appointments or other necessary engagements) 0 d. Laundry (sorts, folds, or washes own laundry)      0 k. Medications (preparation and administration of medications) 0 e. Managing Incontinence Supplies (pads, briefs, ostomy, catheter)      0 l. Other (specify) _____ 0 f. Managing Cash (handles cash, makes purchases) 0 g. Managing Finances (banking, handling checkbook, or paying bills)
6. ADHERENCE WITH TREATMENTS/THERAPIES/PROGRAMS	In the last 6 months, compliant all or most of the time with special treatments, therapies and programs: X 0. Always compliant <input type="checkbox"/> 3. No treatments or programs <input type="checkbox"/> 1. Compliant 80% of time <input type="checkbox"/> 8. Unknown <input type="checkbox"/> 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) 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)? <input type="checkbox"/> 0. No <input type="checkbox"/> 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 <i>(Check all areas in which resident has self-identified goals)</i>	<input type="checkbox"/> a. Health promotion/wellness/exercise <input checked="" type="checkbox"/> b. Social involvement/making friends <input type="checkbox"/> c. Activities/hobbies/adult learning <input checked="" type="checkbox"/> d. Rehabilitation-skilled <input type="checkbox"/> e. Maintaining physical or cognitive function <input type="checkbox"/> f. Participation in the community <input type="checkbox"/> g. Other (specify) _____ <input type="checkbox"/> h. No goals
2. CONFLICT	a. Any disagreement between resident and family about goals or service plan?      X 0. No <input type="checkbox"/> 1. Yes b. Any disagreement between resident/family and staff about goals or service plan?      X 0. No <input type="checkbox"/> 1. Yes

**SECTION R. DISCHARGE POTENTIAL**

1. DISCHARGE POTENTIAL	a. Does resident or family indicate a preference to return to community? <input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes b. Does resident have a support person who is positive towards discharge?      X 0. No <input type="checkbox"/> 1. Yes c. Has resident's self-sufficiency changed compared to 6 months or since admission, if less than 6 months? X 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined
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**SECTION S. ASSESSMENT INFORMATION**

1. PARTICIPATION IN ASSESSMENT	a. Resident: <input type="checkbox"/> 0. No      X 1. Yes b. Family:              X 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. No Family c. Other Non-Staff:      X 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. None	1 0 0
2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT: NANCY SMITH      RCA COORINATOR a. Signature of Assessment Coordinator (sign on line above) b. Date Assessment Coordinator signed as complete      0 8 - 1 8 - 2 0 4 <small>Month      Day      Year</small> c. Other Signatures      Title      Sections      Date d. _____ Date e. _____ Date		
3. CASE MIX GROUP	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

**SECTION T. Preventive Health/Health Behaviors**

1. PREVENTIVE HEALTH	(Check all the procedures the resident received during the past 12 months) <input checked="" type="checkbox"/> a. Blood pressure monitoring <input type="checkbox"/> g. Breast exam or mammogram <input type="checkbox"/> b. Hearing assessment <input type="checkbox"/> h. Pap smear <input type="checkbox"/> c. Vision test <input type="checkbox"/> i. PSA or rectal exam <input type="checkbox"/> d. Dental visit <input type="checkbox"/> j. Other (specify) _____ <input checked="" type="checkbox"/> e. Influenza vaccine <input type="checkbox"/> f. Pneumococcal vaccine (ANY time)	
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P11 = 0 (No)



**MINIMUM DATA SET (MDS)<sup>®</sup>**  
**ASSISTED LIVING SERVICES (ALS)**

FACE SHEET: BACKGROUND INFORMATION ONLY AT ADMISSION

**SECTION AA. IDENTIFICATION INFORMATION**

1. RESIDENT NAME	LAURA B BAKER a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2. GENDER	<input type="checkbox"/> 1. Male <input checked="" type="checkbox"/> 2. Female
3. BIRTHDATE	07 — 19 — 1959 Month Day Year
4. RACE/ETHNICITY <i>(Check only one.)</i>	<input type="checkbox"/> 1. American Indian/Alaskan Native <input type="checkbox"/> 4. Hispanic <input type="checkbox"/> 2. Asian/Pacific Islander <input type="checkbox"/> 5. White, not of Hispanic origin <input type="checkbox"/> 3. Black, not of Hispanic origin <input checked="" type="checkbox"/> 6. Other
5. SOCIAL SECURITY and MEDICARE NUMBERS <i>(C in 1st box if no med. no.)</i>	a. Social Security Number: 002 — 42 — 4314 b. Medicare number (or comparable railroad insurance number): 001056944 — C 1
6. FACILITY NAME AND PROVIDER NO.	a. Facility Name: MCBVI b. Provider No.: 99999999
7. MAINECARE NO.	<i>[Record a "+" if pending, "N" if not a MaineCare recipient]</i> 95458031A

**SECTION AB. DEMOGRAPHIC INFORMATION**

1. DATE OF ENTRY	Date the stay began. <i>(Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date.)</i> 07 — 06 — 2004 Month Day Year
2. ADMITTED FROM (AT ENTRY) <i>(Check only one.)</i>	<input type="checkbox"/> 1. Private home/apt. <input type="checkbox"/> 2. Other board and care/assisted living/group home <input checked="" type="checkbox"/> 3. Nursing home <input type="checkbox"/> 4. Acute care hospital <input type="checkbox"/> 5. Psychiatric hospital <input type="checkbox"/> 6. MR/DD facility <input type="checkbox"/> 7. Rehabilitation hospital <input type="checkbox"/> 8. Other <i>(specify)</i> _____
3. LIVED ALONE (PRIOR TO ENTRY) <i>(Check only one.)</i>	<input checked="" type="checkbox"/> 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> 2. In other facility
4. PRIOR PRIMARY RESIDENCE	Provide town, state, zip code for Resident's primary residence prior to admission DEERFIELD MAINE 03261 Town State Zip Code
5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	<i>(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above)</i> <input type="checkbox"/> a. Prior stay at this home <input checked="" type="checkbox"/> b. Nursing home <input type="checkbox"/> c. Other residential facility—board and care home, assisted living, group home <input type="checkbox"/> d. MH/psychiatric hospital <input type="checkbox"/> e. MR/DD facility <input type="checkbox"/> f. NONE OF ABOVE
6. LIFETIME OCCUPATION	Put a "/" between two occupations. P R O D U C T I O N W O R K E R

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

**SECTION AC. CUSTOMARY ROUTINE**

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

**SECTION AD. FACE SHEET SIGNATURES and DATES**

1. SIGNATURE(S) OF PERSON(S) COMPLETING FACE SHEET:			
a. Signatures	Title	Sections	Date
NANCY SMITH	RCA DIRECTOR	ALL	7/15/2004
b.			Date
2. DATE COMPLETED	Record date background information was completed.		
	07 — 15 — 2004 Month Day Year		

**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	<b>LAURA B BAKER</b> a. (First)      b. (Middle Initial)      c. (Last)      d. (Jr/Sr)
2. SOCIAL SECURITY and MEDICARE NUMBERS (C in 1st box if non med. no.)	a. Social Security Number 0 0 2 — 4 2 — 4 3 1 4 b. Medicare number (or comparable railroad insurance number) 0 0 1 0 5 6 9 4 4 — C 1
3. FACILITY NAME AND PROVIDER NO.	a. Facility Name <b>MCBVI</b> b. Provider No. 9 9 9 9 9 9 9 9
4. MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient] 9 5 4 5 8 0 3 1 A
5. ASSESSMENT DATE	Last day of observation period 0 7 — 1 3 — 2 0 0 4 Month      Day      Year
6. REASON FOR ASSESSMENT	(Check primary reason for assessment) X 1. Admission assessment <input type="checkbox"/> 4. Semi-Annual <input type="checkbox"/> 2. Annual assessment <input type="checkbox"/> 5. Other (specify) <input type="checkbox"/> 3. Significant change in status assessment
7. MARITAL STATUS (Check only one.)	X 1. Never married <input type="checkbox"/> 3. Widowed <input type="checkbox"/> 5. Divorced <input type="checkbox"/> 2. Married <input type="checkbox"/> 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) X a. MaineCare <input type="checkbox"/> e. Private pay X b. SSI <input type="checkbox"/> f. Private insurance (including co-payment) <input type="checkbox"/> c. VA <input type="checkbox"/> g. SSDI <input type="checkbox"/> d. Social Security <input type="checkbox"/> h. Other (specify)
9. RESPONSIBILITY/LEGAL GUARDIAN	(Check all that apply) <input type="checkbox"/> a. Legal guardian <input type="checkbox"/> e. Family member responsible <input type="checkbox"/> b. Other legal oversight      X f. Self <input type="checkbox"/> c. Durable power of attorney/health care <input type="checkbox"/> g. Legal Conservator <input type="checkbox"/> d. Durable power of attorney/financial <input type="checkbox"/> h. Representative Payee <input type="checkbox"/> i. NONE OF ABOVE
10. ADVANCED DIRECTIVES	Does resident have any of the following advanced directives in place? a. Living Will      X 0. No <input type="checkbox"/> 1. Yes b. Do not resuscitate (DNR)      X 0. No <input type="checkbox"/> 1. Yes c. Do not hospitalize      X 0. No <input type="checkbox"/> 1. Yes d. Organ donation      X 0. No <input type="checkbox"/> 1. Yes e. Other      X 0. No <input type="checkbox"/> 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 X 0. Memory OK <input type="checkbox"/> 1. Memory problem b. Long-term memory OK—seems/appears to recall long past X 0. Memory OK <input type="checkbox"/> 1. Memory problem
2. MEMORY/RECALL ABILITY	(Check all that resident was normally able to recall during last 7 days) X a. Current season      X d. That he/she is in a facility/home X b. Location of own room <input type="checkbox"/> e. NONE OF ABOVE are recalled X c. Staff names/faces
3. COGNITIVE SKILLS FOR DAILY DECISION-MAKING (Check only one.)	(Made decisions regarding tasks of daily life) X 0. INDEPENDENT—decisions consistent/reasonable <input type="checkbox"/> 1. MODIFIED INDEPENDENCE—some difficulty in new situations only <input type="checkbox"/> 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required <input type="checkbox"/> 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). X 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 2. Declined

**SECTION C. COMMUNICATION/HEARING PATTERNS**

1. HEARING (Check only one.)	(With hearing appliance, if used) <input type="checkbox"/> 0. HEARS ADEQUATELY—normal talk, TV, phone X 1. MINIMAL DIFFICULTY when not in quiet setting <input type="checkbox"/> 2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly <input type="checkbox"/> 3. HIGHLY IMPAIRED—absence of useful hearing
2. COMMUNICATION DEVICES/TECHNIQUES	(Check all that apply during last 7 days.) <input type="checkbox"/> a. Hearing aid, present and used <input type="checkbox"/> b. Hearing aid, present and not used regularly <input type="checkbox"/> c. Other receptive communication techniques used (e.g., lip reading) X d. NONE OF ABOVE
3. MAKING SELF UNDERSTOOD (Check only one.)	(Expressing information content—however able) X 0. UNDERSTOOD <input type="checkbox"/> 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts <input type="checkbox"/> 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests <input type="checkbox"/> 3. RARELY/NEVER UNDERSTOOD
4. ABILITY TO UNDERSTAND OTHERS (Check only one.)	(Understanding information content—however able) X 0. UNDERSTANDS <input type="checkbox"/> 1. USUALLY UNDERSTANDS—may miss some part / intent of message <input type="checkbox"/> 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication <input type="checkbox"/> 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. <input type="checkbox"/> 0. No change      X 1. Improved <input type="checkbox"/> 2. Declined

**SECTION D. VISION PATTERNS**

1. VISION (Check only one.)	(Ability to see in adequate light and with glasses if used) <input type="checkbox"/> 0. ADEQUATE—sees fine detail, including regular print in newspapers/books <input type="checkbox"/> 1. IMPAIRED—sees large print, but not regular print in newspapers/books X 2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects <input type="checkbox"/> 3. HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects <input type="checkbox"/> 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 <input type="checkbox"/> 0. No      X 1. Yes b. Artificial eye      X 0. No <input type="checkbox"/> 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)
	<b>VERBAL EXPRESSIONS OF DISTRESS</b> 0 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." 0 b. Repetitive questions—e.g., "Where do I go; What do I do?" 0 c. Repetitive verbalizations—e.g., calling out for help, ("God help me") 0 d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in facility; anger at care received 0 e. Self deprecation—e.g., "I am nothing; I am of no use to anyone" 0 f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others 0 g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack 0 h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions 0 i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues (continued next page)

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)
2. MOOD PERSISTENCE (Check only one.)
3. MOOD (Check only one.)
4. BEHAVIORAL SYMPTOMS (COLUMN A CODES: Record the appropriate code for the frequency of the symptom in last 7 days)
5. SUICIDAL IDEATION
6. SLEEP PROBLEMS
7. INSIGHT INTO MENTAL HEALTH
8. BEHAVIORS (Check only one.)

SECTION F. PSYCHOSOCIAL WELL-BEING

1. SENSE OF INITIATIVE/INVOLVEMENT (Check all that apply)
2. UNSETTLED RELATIONSHIPS (Check all that apply)
3. LIFE-EVENTS HISTORY (Check all that apply.)

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
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 during last 7 days
3. EXTENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
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.
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

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 the 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.	0
b. Resident shopped for clothing, snacks, or other incidentals.	0
c. Resident arranged for suitable transportation to get to appointments, outings, necessary engagements.	0
d. Resident managed finances including banking, handling checkbook, or paying bills.	1
e. Resident managed cash, personal needs allowance.	0
f. Resident prepared snacks, light meals.	1
g. Resident used phone.	0
h. Resident did light housework such as making own bed, dusting, or taking care of belongings.	0
i. Resident sorted, folded, or washed own laundry.	0

**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.)  
 Resident expresses or gives evidence of needing new or additional assistive devices  
 a. Eyeglasses  f. Assistive dressing devices (e.g., button hook, velcro closings)  
 b. Hearing aid  g. Dentures  
 c. Cane or walker  h. Other (specify) \_\_\_\_\_  
 d. Wheelchair  i. NONE OF ABOVE  
 e. Assistive feeding devices (e.g., plate guard, stabilized built-up utensil)

**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	0
b. BLADDER CONTINENCE	Control of urinary bladder function with appliances (e.g. foley) or continence programs, if employed	0
2. BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days Constipation	c. Diarrhea
		d. Fecal Impaction
3. APPLIANCES and PROGRAMS	Any scheduled toileting plan Bladder retraining program External (condom) catheter Indwelling catheter Intermittent catheter	e. Resident is Independent
		f. NONE OF ABOVE
		a. Did not use toilet room/commode/urinal
		b. Pads/briefs used
		c. Enemas/irrigation
4. USE OF INCONTINENCE SUPPLIES	Resident's management of incontinence supplies (pads, briefs, ostomy, catheter) in last 14 days. <input checked="" type="checkbox"/> 0. Always continent <input type="checkbox"/> 1. Resident incontinent and able to manage incontinence supplies independently. <input type="checkbox"/> 2. Resident incontinent and receives assistance with managing incontinence supplies. <input type="checkbox"/> 3. Resident incontinent and does not use incontinence supplies.	d. NONE OF ABOVE
		e. Ostomy present
		f. NONE OF ABOVE
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): <input checked="" type="checkbox"/> 0. No change <input type="checkbox"/> 1. Improved <input type="checkbox"/> 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	HEART/CIRCULATION
	<input checked="" type="checkbox"/> a. Diabetes mellitus <input type="checkbox"/> b. Hyperthyroidism <input type="checkbox"/> c. Hypothyroidism	<input type="checkbox"/> d. Arteriosclerotic heart disease (ASHD) <input type="checkbox"/> e. Cardiac dysrhythmia <input type="checkbox"/> f. Congestive heart failure <input type="checkbox"/> g. Deep vein thrombosis <input type="checkbox"/> h. Hypertension <input type="checkbox"/> i. Hypotension <input type="checkbox"/> j. Peripheral vascular disease <input type="checkbox"/> k. Other cardiovascular disease

*(continued on next page)*

Resident Name: LAURA B BAKER

Date: 7/13/2004

Soc. Sec # 002-42-4314

Facility Provider # 9999999999

SECTION I. DIAGNOSES (cont.)

Form for Section I containing checkboxes for Musculoskeletal, Neurological, Psychiatric/Mood, Pulmonary, Sensory, and Other conditions.

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

Form for Section J containing checkboxes for Pain Interferes, Pain Management, Accidents, and Danger of Fall.

SECTION K. ORAL/NUTRITIONAL STATUS

Form for Section K containing checkboxes for Oral Problems, Height and Weight, Weight Change, and Nutritional Problems.

SECTION J. HEALTH CONDITIONS AND POSSIBLE MEDICATION SIDE EFFECTS

Form for Section J containing checkboxes for Problem Conditions, Extra-Pyramidal Signs and Symptoms, Pain Symptoms, and Pain Site.

SECTION L. ORAL/DENTAL STATUS

Form for Section L containing checkboxes for Oral Status and Disease Prevention.

SECTION M. SKIN CONDITION

Form for Section M containing checkboxes for Skin Problems and ULCERS.

Resident Name: \_\_\_\_\_ Date: \_\_\_\_\_ Soc. Sec # \_\_\_\_\_ Facility Provider # \_\_\_\_\_

SECTION M. SKIN CONDITION

3. FOOT PROBLEMS
a. Resident or someone else inspects resident's feet on a regular basis?
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?

SECTION N. ACTIVITY PURSUIT PATTERNS

1. TIME AWAKE (Check appropriate time periods over last 7 days)
2. AVERAGE TIME INVOLVED IN ACTIVITIES (When awake and not receiving treatments or ADL care)
3. PREFERRED ACTIVITY SETTINGS (Check all settings in which activities are preferred)
4. GENERAL ACTIVITY PREFERENCES (Check all PREFERENCES whether or not activity is currently available to resident)
5. PREFERRED ACTIVITY SIZE (Check all that apply)
6. PREFERENCES IN DAILY ROUTINE (Check all that apply)
7. INTERACTION WITH FAMILY AND FRIENDS
8. VOTING
9. SOCIAL ACTIVITIES (Check only one.)

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)
4B. PRN MEDICATIONS Does resident have a prescription for any PRN medication for a mental, emotional or nervous condition, or behavioral problem?
5. SELF-ADMINISTERED MEDICATIONS Did resident self-administer any of the following in the last 7 days:
6. MEDICATION PREPARATION ADMINISTRATION Did resident prepare and administer his/her own medications in last 7 days?
7. MEDICATION COMPLIANCE Resident's level of compliance with medications prescribed by a physician/psychiatrist during last 30 days:
8. MISUSE OF MEDICATION Misuse of prescription or over-the-counter medications in the last 6 months

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]
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
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)

SECTION O. MEDICATIONS

1. NUMBER OF MEDICATIONS (Record the number of different medications used in the last 7 days; enter "0" if none used)
2. NEW MEDICATIONS (Resident currently receiving medications that were initiated during the last 90 days)
3. INJECTIONS (Record the number of DAYS injections of any type received during the last 30 days; enter "0" if none used)



Resident Name: \_\_\_\_\_ Date: \_\_\_\_\_ Soc. Sec # \_\_\_\_\_ Facility Provider # \_\_\_\_\_

SECTION P. SPECIAL TREATMENTS AND PROCEDURES (cont.)

3.	<b>NEED FOR ON-GOING MONITORING</b>	(Code for person responsible for monitoring) 0. No monitoring required 1. RCF nurse 2. RCF Other Staff 3. Home health nurse		
		1 a. Acute physical or psychiatric condition - not chronic 0 b. New treatment/medication		
4.	<b>REHABILITATION/RESTORATIVE CARE</b>	RECORD THE number of days each of the following rehabilitation or restorative techniques or practices was provided 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.) 0 a. Range of motion (passive) 0 b. Range of motion (active) 0 c. Splint or brace assistance <b>TRAINING/SKILL PRACTICE IN:</b> 0 d. Bed mobility 0 e. Transfer 0 f. Walking 0 g. Dressing or grooming 0 h. Eating or swallowing 0 i. Amputation/prosthesis care 0 j. Communication 0 k. Time management 7 l. Other (specify) STRETCHES		
5.	<b>SKILL TRAINING</b>	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. 0 a. Meal Preparation (snacks, light meals) 0 b. Telephone Use 2 c. Light Housework (makes own bed, takes care of belongings) 0 d. Laundry (sorts, folds, or washes own laundry) 0 e. Managing Incontinence Supplies (pads, briefs, ostomy, catheter) 1 f. Managing Cash (handles cash, makes purchases) 0 g. Managing Finances (banking, handling checkbook, or paying bills) 0 h. Arranges Shopping (makes list, acquires help) 0 i. Shopping (for groceries, clothes, or other incidentals) 1 j. Transportation (travel by various means to get to medical appointments or other necessary engagements) 30 k. Medications (preparation and administration of medications) 1 l. Other (specify) HAIR CUTTING		
6.	<b>ADHERENCE WITH TREATMENTS/THERAPIES/PROGRAMS</b>	In the last 6 months, compliant all or most of the time with special treatments, therapies and programs: X 0 Always compliant 1. Compliant 80% of time 2. Compliant less than 80% of the time 3. No treatments or programs 8. Unknown		
7.	<b>GENERAL HOSPITAL STAY(S)</b>	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)	0	0
8.	<b>EMERGENCY ROOM (ER) VISIT(S)</b>	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)	0	0
9.	<b>PHYSICIAN VISITS</b>	In the last 6 months (or since admission to facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter "0" if none)	0	4
10.	<b>PHYSICIAN ORDERS</b>	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)	0	1
11.	<b>ABNORMAL LAB VALUES</b>	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.	<b>PSYCHIATRIC HOSPITAL STAY(S)</b>	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)	0	0
13.	<b>OUTPATIENT SURGERY</b>	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)	0	0

SECTION Q. SERVICE PLANNING

1.	<b>RESIDENT GOALS</b>	(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) _____ X h. No goals
2.	<b>CONFLICT</b>	a. Any disagreement between resident and family about goals or service plan? X 0. No 1. Yes b. Any disagreement between resident/family and staff about goals or service plan? X 0. No 1. Yes

SECTION R. DISCHARGE POTENTIAL

1.	<b>DISCHARGE POTENTIAL</b>	a. Does resident or family indicate a preference to return to community? 0. No X 1. Yes b. Does resident have a support person who is positive towards discharge? 0. No X 1. Yes since admission, if less than 6 months? 0. No change X 1. Improved 2. Declined
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SECTION S. ASSESSMENT INFORMATION

1.	<b>PARTICIPATION IN ASSESSMENT</b>	a. Resident: 0. No X 1. Yes b. Family: X 0. No 1. Yes 2. No Family c. Other Non-Staff: X 0. No 1. Yes 2. None	1 0 0
2.	<b>SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:</b> NANCY SMITH a. Signature of Assessment Coordinator (sign on line above) b. Date Assessment Coordinator signed as complete 07 - 16 - 2004 Month Day Year c. Other Signatures Title Sections Date d. Date e. Date		
3.	<b>CASE MIX GROUP</b>	[ ] [ ] [ ] [ ] [ ]	

SECTION T. Preventive Health/Health Behaviors

1.	<b>PREVENTIVE HEALTH</b>	(Check all the procedures the resident received during the past 12 months) X a. Blood pressure monitoring b. Hearing assessment c. Vision test X d. Dental visit X e. Influenza vaccine f. Pneumococcal vaccine (ANY time) g. Breast exam or mammogram X h. Pap smear X i. PSA or rectal exam j. Other (specify) _____
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P11 = 0 (No)

