MINIMUM DATA SET (MDS)[©] RESIDENTIAL CARE ASSESSMENT (RCA)

BASIC ASSESSMENT TRACKING FORM

GENERAL INSTRUCTIONS:

Complete this form for all assessments and discharges.

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	Thomas B Anthony
		a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER	X 1. Male 2. Female
3.	BIRTHDATE	0 8 - 1 3 - 1 9 0 8 Month Day Year
4.	RACE/ ETHNICITY (Check only one.)	□ 1. American Indian/Alaskan Native □ 4. Hispanic □ 2. Asian/Pacific Islander X 5. White, not of Hispanic origin □ 3. Black, not of Hispanic origin □ 6. Other
5.	SOCIAL SECURITY and MEDICARE NUMBERS (C in 1 st 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
6.	FACILITY NAME AND PROVIDER NO.	a. Facility Name MCBVI b. Provider No. 9
7.	MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient]
8.	SIGNATURE(S)	OF PERSON(S) COMPLETING FACE SHEET:
ÎN	ancy Sm	hith RCA Diffector All ^{Sections} 8/30/2004
b.		Date
C.	DATE Completed	Record date background information was completed. 0 8

MINIMUM DATA SET (MDS)[®] RESIDENTIAL CARE ASSESSMENT (RCA)

FACE SHEET: BACKGROUND INFORMATION ONLY AT ADMISSION

Resident Name: THOMAS B ANTHONY

Date:_____

Soc. Sec. #___007-02-7907

___ Facility Provider #____999999999

SECTION AB. DEMOGRAPHIC INFORMATION

-		CUSTOMARY ROUTINE
1	CUSTOMARY	(Check all that apply. If all information

1.	DATE OF ENTRY	Date the stay began. (Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date.)
		0 8 2 7 1 9 9 3 Month Day Year
2.	ADMITTED FROM (AT ENTRY) (Check only one.)	
3.	LIVED ALONE (PRIOR TO ENTRY) (Check only one.)	X 0. No 1. Yes 2. In other facility
4.	Prior Primary Residence	Provide town, state, zip code for Resident's primary residence prior to admission MAINE 0 3 9 0 1 BERWICK MAINE Zip Code
5.	RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	 (Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above) a. Prior stay at this home b. Nursing home X c. Other residential facility—board and care home, assisted living, group home d. MH/psychiatric hospital e. MR/DD facility f. NONE OF ABOVE
6.	LIFETIME Occupation	Put a "/" between two occupations. F L O W E R O W E R
7.	EDUCATION (Highest Level Completed) (Check only one.)	1. No schooling 5. Technical or trade school 2. 8th grade or less X 6. Some college 3. 9–11 grades 7. Bachelor's degree 4. High school 8. Graduate degree
8.	PRIMARY LANGUAGE (Check only one.)	X 0. English 2. French 1. Spanish 3. Other (specify)
9.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of the following? a. Mental retardation X 0. No 1. Yes b. Mental illness X 0. No 1. Yes c. Developmental disability X 0. No 1. Yes
10.	CONDITIONS RELATED TO MR/DD STATUS	(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely) X a. Not applicable—no MR/DD (<i>Skip to AB11</i>) MR/DD with organic condition b. Down's syndrome e. Cerebral palsy c. Autism f. Other organic condition related to MR/DD d. Epilepsy 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 1. Yes b. Dementia other than Alzheimer's disease 0. No X 1. Yes

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

SECTION AD. FACE SHEET SIGNATURES and DATES

1. SI	1. SIGNATURE(S) OF PERSON(S) COMPLETING FACE SHEET:								
a. Sig	natures NANCY	SMITH	Title RCA	DIRECTOR	Sections ALL	Date 8/30/1993			
b.						Date			
2.	DATE Completed	Record of 0 Mor	8 –	round information 3 0 - 1 Day	was completed. 9 9 3 Year				

CONFIDENTIAL MINIMUM DATA SET (MDS)[®] RESIDENTIAL CARE ASSESSMENT (RCA)

(STATUS IN LAST 7 DAYS UNLESS OTHERWISE NOTED)

1. 2.	CTION A. I	DENTIFICATION and BACKGROUND INFORMATION			COMMUNICATION/HEARING PATTERNS
2.	RESIDENT	THOMAS B ANTHONY] 1.	HEARING	(With hearing appliance, if used)
2.	NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)	_	(Check only one.)	X 0. HEARS ADEQUATELY—normal talk, TV, phone
	SOCIAL SECURITY and	a. Social Security Number			1. MINIMAL DIFFICULTY when not in quiet setting
	MEDICARE	0 0 7 0 2 7 9 0 7			2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly
	(C in 1 st box if	b. Medicare number (or comparable railroad insurance number)			3. HIGHLY IMPAIRED – absence of useful hearing
	no med. no.)	0 0 7 0 2 7 9 0 7 - A	2.	COMMUNICA- TION DEVICES/	(Check all that apply during last 7 days.)
3.		a. Facility Name		TECHNIQUES	a. Hearing aid, present and used
	NAME AND	b. Provider No.			b. Hearing aid, present and not used regularly
	PROVIDER NO.				C. Other receptive communication techniques used (e.g., lip reading) X d. NONE OF ABOVE
		9 9 9 9 9 9 9 9 9 9	3.	MAKING SELF	(Expressing information content—however able)
4.	MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient]	0.	UNDERSTOOD	X 0. UNDERSTOOD
	NO.	4 4 0 2 7 6 9 1 A		(Check only one.)	1. USUALLY UNDERSTOOD—difficulty finding words or
5.	ASSESSMENT	Last day of observation period	-		finishing thoughts
5.	DATE				2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests
		Month Day Year			3. RARELY/NEVER UNDERSTOOD
6.	REASON FOR	(Check primary reason for assessment)	4.	ABILITY TO	(Understanding information content—however able)
	ASSESSMENT	1. Admission assessment 4. Semi-Annual		UNDERSTAND OTHERS	X 0. UNDERSTANDS
		X 2. Annual assessment 5. Other (specify)		(Check only one.)	1. USUALLY UNDERSTANDS—may miss some part / intent of
_	MADITAL	Significant change in status assessment	-		message 2. SOMETIMES UNDERSTANDS—responds adequately to simple,
7.	MARITAL Status	1. Never married X 3. Widowed 5. Divorced			direct communication
	(Check only one.)	2. Married 4. Separated			3. RARELY/NEVER UNDERSTANDS
8.	CURRENT	(Billing Office to indicate; check all that apply in last 30 days or since last admission if less than 30 days)	5.	COMMUNICA-	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
	SOURCES FOR	X a. MaineCare 🗌 e. Private pay		TION (Check only one.)	180 days.
	STAY	X b. SSI f. Private insurance		(<i>, , ,</i>	0. No change 1. Improved X 2. Declined
		C. VA (including co-payment) X d. Social Security g. SSDI			
		X d. Social Security			VISION PATTERNS
Э.	RESPONSI-	(Check all that apply)	1.	VISION	(Ability to see in adequate light and with glasses if used)
	BILITY/ Legal	a. Legal guardian X e. Family member responsible		(Check only one.)	O. ADEQUATE—sees fine detail, including regular print in newspapers/books
	GUARDIAN	b. Other legal oversight X f. Self			I. IMPAIRED—sees large print, but not regular print in newspapers/
		c. Durable power of attorney/health care h. Representative Payee			books
		□ d. Durable power of □ i. NONE OF ABOVE			ODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects
_		attorney/financial Does resident have any of the <u>fol</u> lowing advanced directives in place?	-		X 3. <i>HIGHLY IMPAIRED</i> —object identification in question, but eyes
0.	ADVANCED DIRECTIVES	a. Living Will 0 . No X 1 . Yes			appear to follow objects
		b. Do not resuscitate (DNR) X 0. No			4. SEVERELY IMPAIRED—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects
		c. Do not hospitalize X 0. No 1. Yes	2.	VISUAL	a. Glasses, contact lenses 0. No X 1. Yes
		d. Organ donation Image: 0 No X 1. Yes e. Other X 0. No Image: 1 Yes		APPLIANCES	
					b. Artificial eye X 0. No 🗆 1. Yes
	1 1	(If "yes," specify)			b . Artificial eye X 0 . No 1 . Yes
		(If "yes," specify)		CTION E. I	MOOD AND BEHAVIOR PATTERNS
ε	CTION B. (SE		
	CTION B. (MEMORY	(If "yes," specify) COGNITIVE PATTERNS (Recall of what was learned or known)		CTION E. I INDICATORS OF DEPRESSION,	MOOD AND BEHAVIOR PATTERNS (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
		(If "yes," specify) COGNITIVE PATTERNS (Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes		CTION E. I	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause)
		(If "yes," specify) COGNITIVE PATTERNS (Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK X 1. Memory problem		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	 MOOD AND BEHAVIOR PATTERNS (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)
		(If "yes," specify) COGNITIVE PATTERNS (Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK X 1. Memory problem b. Long-term memory OK—seems/appears to recall long past		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS 0 a. Resident made negative statements—e.g., "Nothing matters;
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2.	MEMORY MEMORY/ RECALL ABILITY COGNITIVE	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS 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
2.	MEMORY MEMORY/ RECALL ABILITY COGNITIVE SKILLS FOR	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS 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
2.	MEMORY/ RECALL ABILITY COGNITIVE SKILLS FOR DAILY DECISION-	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS 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, ange at placement in facility; anger at care received 0 e. Self deprecation—e.g., "I am nothing; I am of no use to anyone"
2.	MEMORY/ RECALL ABILITY COGNITIVE SKILLS FOR DAILY DECISION- MAKING	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS 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 or being abandoned, left alone, being with others
2.	MEMORY/ RECALL ABILITY COGNITIVE SKILLS FOR DAILY DECISION-	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS 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, ange 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 happer
-	MEMORY/ RECALL ABILITY COGNITIVE SKILLS FOR DAILY DECISION- MAKING (Check only one.)	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	 MOOD AND BEHAVIOR PATTERNS (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 daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die." b. Repetitive questions—e.g., "Where do I go; What do I do?" C. Repetitive verbalizations—e.g., calling out for help, ("God help me") d. Persistent anger with self or others—e.g., easily annoyed, ange at placement in facility; anger at care received e. Self deprecation—e.g.,"I am nothing; I am of no use to anyone" f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack
1.	MEMORY MEMORY/ RECALL ABILITY COGNITIVE SKILLS FOR DAILY DECISION- MAKING (Check only one.) COGNITIVE STATUS	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS 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, ange 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 happer
1. 2. 3.	MEMORY MEMORY/ RECALL ABILITY COGNITIVE SKILLS FOR DAILY DECISION- MAKING (Check only one.) COGNITIVE	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	 MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die." 0. B. Repetitive questions—e.g., "Where do I go; What do I do?" c. Repetitive verbalizations—e.g., calling out for help, ("God help me") d. Persistent anger with self or others—e.g., easily annoyed, ange at placement in facility; anger at care received o. Self deprecation—e.g., "I am nothing; I am of no use to anyone" f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happer—e.g., believes he or she is about to die, have a heart attack h. Repetitive health complaints—e.g., persistently seeks medical
1.	MEMORY MEMORY/ RECALL ABILITY COGNITIVE SKILLS FOR DAILY DECISION- MAKING (Check only one.) COGNITIVE STATUS	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	 MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die." b. Repetitive questions—e.g., "Where do I go; What do I do?" c. Repetitive verbalizations—e.g., calling out for help, ("God help me") d. Persistent anger with self or others—e.g., easily annoyed, ange at placement in facility; anger at care received e. Self deprecation—e.g.,"I am nothing; I am of no use to anyone" f. Expressions of what appear to be unrealistic fears—e.g., fear or being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happer —e.g., believes he or she is about to die, have a heart attack h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions

CONFIDENTIAL 08/13/2004

Date:

007-02-7907 Soc. Sec. #

SECTION E MOOD and REHAVIOR PATTERNS (cont.)

		ICOD and DEMANOITT ATTENNS (CONL)				
1.	INDICATORS OF Depression,	(CODE: Record the appropriate code for the frequency of the sympthing in last 30 days, irrespective of the assumed cause)	ntom(s	s) obs	erved	
	ANXIETY, SAD MOOD	 Not exhibited in last 30 days This type exhibited up to 5 days a week This type exhibited daily or almost daily (6, 7 days/v) 	veek			
		SLEEP-CYCLE ISSUES	10010			-
		0 k. Insomnia/change in usual sleep pattern				
		SAD, APATHETIC, ANXIOUS APPEARANCE				
		0 I. Sad, pained, worried facial expressions—e.g., f	urrow	ed br	OWS	
		m. Crying, tearfulness				
		0 n. Repetitive physical movements—e.g., pacing, h restlessness, fidgeting, picking	and \	wringi	ng,	
		LOSS OF INTEREST				
		• Withdrawal from activities of interest—e.g., no ir	nteres	st in Ic	ong	
		o standing activities or being with family/friends				
		p. Reduced social interaction				
		INDICATORS OF MANIA 0 a Inflated self-worth exaggerated self-oninion; infl	ام ما م	I I' - 4		
		about one's own ability, etc.				
•	MOOD	r. Excited behavior, motor excitation (e.g., heighte activity; excited, loud or pressured speech; incre Check if one or more indicators of depressed, sad or anxiou	ased	l reac		_
2.	PERSISTENCE	(above) were not easily altered by attempts to "cheer up", o reassure the resident over last 7 days .				
	(Check only one.)	X 0. No mood indicators				
		1. Indicators present, easily altered				
		2. Indicators present, not easily altered				
3.	MOOD	Resident's current mood status compared to resident's statu	ıs 18	0 day	s ago	
	(Check only one.)	(or since admission if less than 180 days):				
		X 0. No change 1. Improved 2. Dec (COLUMN A CODES: Record the appropriate (COLUMN B		c.		_
4.	BEHAVIORAL	(COLUMN A CODES: Record the appropriate code for the frequency of the symptom <u>Alterability</u> o				
	SYMPTOMS	<u>in last 7 days</u>) symptoms <u>in</u>				
		0. Behavior not exhibited in last 7 days 0. Not preserved				
		1. Behavior of this type occurred 1 to 3 days in last 7 days 1. Behavior r	not ea			
		2. Behavior of this type occurred 4 to 6 days but less than daily	A	B ≻	C	
		3. Behavior of this type occurred daily	ENC		ORV	
		(COLUMN C CODES: <u>History of this behavior in the last 6 months</u>)	FREQUENCY	ALTERABILITY	HISTORY	
		0. No 1. Yes	Æ	ALTI	-	
a.	needs or safe		0	0	0	
b.	threatened, so	BUSIVE BEHAVIORAL SYMPTOMS (others were creamed at, cursed at)	0	0	0	
c.		ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, check, sexually abused, gross physical assault)	0	0	0	
d.		APPROPRIATE/DISRUPTIVE BEHAVIORAL				
u.	SYMPTOMS public, smear	(made disruptive sounds, sexual behavior, disrobing in ed/threw food/feces, hoarding, rummaged through others' tealing, self-abusive acts, substance abuse, self-mutilation)	0	0	0	
e.	RESISTS CA assistance, or	RE (resisted taking medications/ injections, ADL	0	0	0	
f.		G BEHAVIOR (made others feel unsafe, at risk, privacy	0	0	0	
g.	ELOPEMENT	r	1	0	0	
9. h.	-	on-violent behavior (e.g., falling asleep while smoking)	2	1	1	
i.	_	blent behavior	0	0	0	
 j.	FIRE SETTIN		0	0	0	
ر 5.	_	Resident demonstrated suicidal thoughts or actions in the la	ı ıst 30) dav	⊥⊥ s:	+
J.	SUICIDAL Ideation	X 0. No				
6.	SLEEP PROBLEMS	Check all present on 2 or more days during last 7 days a. Inability to awaken when desired X b. Difficulty falling asleep c. Restless or non-restful sleep				
	INSIGHT					-
7.	INTO MENTAL HEALTH	Resident has insight about his/her mental problem X 0. No 1. Yes 2. No mental he	alth p	oroble	ems	
8.	BEHAVIORS	Resident's current behavior status compared to resident's sta	itus 1	80		-
	(Check only one.)	days ago (or since admission if less than 180 days):	eclin			
				u		

SECTION F. PSYCHOSOCIAL WELL-BEING X a. At ease interacting with others SENSE OF X b. At ease doing planned or structured activities INVOLVEMENT X c. At ease doing self-initiated activities (Check all that Establishes own goals apply) х e. Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) f. Accepts invitations into most group activities **g.** NONE OF ABOVE UNSETTLED 2. a. Covert/open conflict with or repeated criticism of staff **RELATION**b. Unhappy with roommate SHIPS c. Unhappy with residents other than roommate (Check all that d. Openly expresses conflict/anger with family/friends apply) e. Absence of personal contact with family/friends f. Recent loss of close family member/friend **g.** Does not adjust easily to change in routines X h. NONE OF ABOVE Events in past 2 years 3. LIFE EVENTS HISTORY X a. Serious accident or physical illness **b.** Health concerns for other person Х c. Death of family member or close friend (Check all that apply.) d. Trouble with the law e. Robbed/physically attacked **f.** Conflict laden or severed relationship g. Loss of income leading to change in lifestyle h. Sexual assault/abuse i. Child custody issues X j. Change in marital/partner status k. Review hearings (e.g., forensic, certification, capacity hearing) □ I. NONE OF ABOVE ECTION G. PHYSICAL FUNCTIONING (A) ADL SELF-PERFORMANCE 0. INDEPENDENT-No help or oversight -OR- Help/oversight provided only 1 or 2 times during last 7 days 1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days -OR- Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days 2. LIMITED ASSISTANCE-Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times Limited assistance (3 or more times,) plus weight-bearing support provided 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 В A self-performance classification. SELF-PERFORMANCE 0. No setup or physical help from staff 1. Setup help only SUPPORT 2. One-person physical assist 3. Two+ persons physical assist 8. Activity did not occur during entire 7 days BED MOBILITY- How resident moves to and from lying position, turns side to 0 0 side, and positions body while in bed TRANSFER - How resident moves between surfaces-to/from: bed, chair, n 0 wheelchair, standing position (EXCLUDE to/from bath/toilet) 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, 0 how resident moves to and from distant areas on the floor. If in wheelchair, self-0 sufficiency once in chair DRESSING - How resident puts on, fastens, and takes off all items of street 2 2 clothing, including donning/removing prosthesis EATING - How resident eats and drinks (regardless of skill). Includes intake of 0 0 nourishment by other means (e.g., tube feeding, total parenteral nutrition) TOILET USE - How resident uses the toilet room (or commode, bed- pan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or 0 catheter, adjusts clothes

Res	ident Name: TI	HOMAS B ANTHONY Date: 08-13-20	004	Soc.	Sec. #0	007-02-7907	_ Facility	Provider #	
		HYSICAL FUNCTIONING (cont.)		SE	CTION G.	PHYSICAL FUNCTION	ING (cc	ont.)	
2.	BATHING Self- Performance	How resident takes full-body bath/shower, sponge bath, and transfe of tub/shower (EXCLUDE washing of back and hair.) <i>Check for mo</i>				f. Resident requires or or direction. g. Resident could be more equipment (e.g., can clothing or shoes) h. Resident could perfor IADL activities were being a straight of the straight of t	pre indepe e, walker, j m more ir roken into	rstands no more than a two-step endent if he/she had special plate guard, velcro closings on ndependently if some or all of AL o subtasks (task segmentation) endent if he/she received ADL or	DL/
3A.	MODES OF Locomotion	 (Check all that apply during last 7 days) a. Cane/walker/crutch b. Wheeled self c. Other person wheeled X d. NONE OF ABOVE 		7.	NEW DEVICES NEEDED (Check all that apply.)	Resident expresses or gives assistive devices a. Eyeglasses b. Hearing aid c. Cane or walker	☐ f.	of needing new or additional Assistive dressing devices (e.g., button hook, velcro closing Dentures	ugs)
3B.	MAIN Mode of Locomotion	Was wheelchair the primary mode of locomotion during the last 7 di X 0. No I Yes	ays?			d. Wheelchair e. Assistive feeding	□ h.	Other (specify)	
3C.	BEDFAST/ Chairfast	(Check if health condition keeps resident in his/her room 22+ hours in last 7 days) a. Bedfast all or most of time b. Chairfast all or most of the time X c. NONE OF ABOVE	per day	8.	SELF- Performance in Iadls				is 180
4.	SELF- PERFORMANCE IN ADLs (Check only one.)	Resident's current ADL status or abilities compared to resident's sta days ago (or since admission if less than 180 days): 0. No change 1. Improved X 2. Declined	tus 180	SE	CONTINEN (Code for res 0. CONTIN ostomy c	levice that does not leak urine	ORIES <i>L SHIFTS</i> des use o or stool)) of indwelling urinary catheter o	
54	. IADL SELF- PERFOR- Mance	 Code for level of independence in the last 30 days based on reside involvement in the activity. SELF-PERFORMANCE CODES: INDEPENDENT : (with/without assistive devices)—No help in the activity but help (in supervision, reminders, and/or physical help) is provided. DONE BY OTHERS: Full performance of the activity is done by others. The resident involved at all when the activity is performed. 	provided. cluding	a.	BOWEL, 2. OCCAS daily; BO 3. FREQUE some co 4. INCONT	ILLY CONTINENT—BLADDER, Incontinent episodes once a week or less EL, less than weekly ASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not 3OWEL, once a week VUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but control present (e.g. on day shift); BOWEL, 2-3 times a week VTINENT—Had inadequate control BLADDER, multiple daily episodes; BOW almost all) of the time Control of bowel movement, with appliance or bowel continence programs, if employed			
		8. Activity did not occur in the last 30 days.	SELF- PERFORMANCE	b. 2.	BLADDER CONTINENCE BOWEL ELIMINATION	Bowel elimination pattern	loyed	appliances (e.g. foley) or Diarrhea Fecal Impaction	2 <u>c.</u> d.
		 a. Resident arranged for shopping for clothing, snacks, other incidentals. 	1 2 2		PATTERN	movement every three days Constipation	a. X b.	Resident is Independent	e. f.
		b. Resident shopped for clothing, snacks, or other incidentals.	1	3.	and	Any scheduled toileting plan Bladder retraining program	a.X b.	Did not use toilet room/ commode/urinal	f.
		c. Resident arranged for suitable transportation to get to appointments, outings, necessary engagements.	2		PROGRAMS	External (condom) catheter	с.	Pads/briefs used	g.
		d. Resident managed finances including banking,				Indwelling catheter	d.	Enemas/irrigation	h. i.
		handling checkbook, or paying bills.e. Resident managed cash, personal needs allowance.	2			Intermittent catheter	e.	Ostomy present NONE OF ABOVE	ı. j.
		f. Resident prepared snacks, light meals.	8	4.	USE OF		ncontiner	nce supplies (pads, briefs, ostor	ny,
		g. Resident used phone.h. Resident did light housework such as making own bed,	1		SUPPLIES (Check only one.)	0. Always continent	and able t	o manage incontinence supplies	C
		dusting, or taking care of belongings. i. Resident sorted, folded, or washed own laundry.	2		,	independently.		ves assistance with managing	5
5B.	TRANSPOR- TATION	Check all that apply for level of independence in the last 30 days ba on resident's involvement in the activity.				incontinence supplie	5.	not use incontinence supplies.	
	IATION	 a. Resident drove car or used public transportation independer get to medical, dental appointments, necessary engagemen other activities. b. Resident rode to destination with staff, family, others (in car, public transportation) but was <u>not accompanied</u> to medical, 	ts, or /an,	5.	CHANGES IN Urinary Continence	Resident's urinary continen days ago (or since last asse	ce has ch	anged as compared to status of less than 180 days):	f 180
		 dental appointments, necessary engagements, or other activ X c. Resident rode to destination with staff, family, others (in car, vapublic transportation) and <u>was accompanied</u> to medical, de appointments, necessary engagements, or other activities. d. Activity did not occur. 	rities. an,	Che and	ck only those behavior statu	is, medical treatments, nurse m he apply, CHECK item xx. <i>NON</i>	onitoring, E OF ABC		
6.	ADL AND IADL FUNCTIONAL REHABILI- TATION OR IMPROVE- MENT POTENTIAL (Check all that apply.)	a. Resident believes he/she is capable of increased independed 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 mornin evenings e. Resident requires or only understands a one-step direction. (continued in next column)		1.	DIAGNOSES	ENDOCRINE/METABOLIC/ NUTRITIONAL a. Diabetes mellitus b. Hyperthyroidism c. Hypothyroidism		 ART/CIRCULATION Arteriosclerotic heart disea (ASHD) e. Cardiac dysrhythmia f. Congestive heart failure g. Deep vein thrombosis h. Hypertension i. Hypotension j. Peripheral vascular disea k. Other cardiovascular disea 	ISE

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

Roci	dent Name:	THOMAS B ANTHONY	08/13/2004 Date:	Soc. S		02-7907	999999999 Facility Provider #)
	_	NOSES (cont.)	Date	-		LTH CONDITIONS AND P	POSSIBLE MEDICATION SIDE EFFECTS	S (cont.)
		MUSCULOSKELETAL I. Arthritis M. Hip fracture N. Missing limb (e.g., amputation) O. Osteoporosis P. Pathological bone fracture	ff. Manic depressive (Bipolar) gg. Schizophrenia PULMONARY hh. Asthma ii. Emphysema/COPD SENSORY	5.	PAIN INTERFERES PAIN MANAGE-	During the last 7 days, h	 a wow much of the time did pain interfere with s visiting with friends, going out, and so on a so in a so in	n resident's
		NEUROLOGICAL 	jj. Cataracts kk. Diabetic retinopathy II. Glaucoma	7.	ACCIDENTS	 2. Treated, full cont a. Fell in past 30 da 	,	
		disease r. Aphasia s. Cerebral palsy	X mm. Macular degeneration OTHER In n. Allergies (specify)		(Check all that apply)	b. Fell in past 31-13 c. Hip fracture in last	80 days X e. NONE OF ABOVE	oo uuyo
		accident (stroke) U. Dementia other than Alzheimer's disease V. Hemiplegia/ hemiparesis W. Multiple sclerosis X. Paraplegia	 oo. Anemia pp. Cancer qq. Renal failure rr. Tuberculosis-TB ss. HIV tt. Mental retardation(e.g., Down's Syndrome, Autism, or other organic condition related to 	8.	DANGER OF FALL (Check all that apply)	c. Limits activity be	olems when standing ecause resident or family fearful of resident ion from seated to standing	t falling
		y. Parkinson's disease	Mental Retardation or Developmental disability (MR/	SEC	TION K. ORA	L/NUTRITIONAL STATUS	S	
		z. Quadriplegia aa. Seizure disorder bb. Transient ischemic attack (TIA)	DD) uu. Substance abuse (alcohol or drug) v. Other psychiatric diagnosis (e.g., paranoia, phobias,	1.	ORAL PROBLEMS (Check all that apply)	 a. Mouth is "dry"wh X b. Chewing Problem X c. Swallowing Probl 	m e. NONE OF AE	BOVE
		cc. Traumatic brain injury PSYCHIATRIC/MOOD dd. Anxiety disorder	ww. Explicit terminal prognosis xx. NONE OF ABOVE	2.	HEIGHT AND WEIGHT	measure in last 30 days ; me practice–e.g., in a.m. after ve	es and (b.) weight in pounds. Base weight on me easure weight consistently in accord with standa voiding, before meal, with shoes off, and in night HT (in) 67 b WT (lb) 1	ard facility
		ee. Depression		3.	WEIGHT		HT (in.) 6 7 b. WT (lb.) 1 loss–5% or more in last 30 days; or 10%	
2. SEC	OTHER CURRENT DIAGNOSIS AND ICD-9 CODES TION J. HEAL	a b c TH CONDITIONS AND POSSIBI		0.	CHANGE	more in last 180 day X 0. No	/s 1. Yes gain–5% or more in last 30 days; or 10%	
1.	PROBLEM CONDITIONS	 (Check all problems present in last a. Inability to lie flat due to shortness of breath b. Shortness of breath c. Edema d. Dizziness/vertigo e. Delusions f. Hallucinations 	7 days unless other time frame is indicated)	4.	NUTRI- TIONAL PROBLEMS OR AP- PROACHES (Check all that apply)	 a. Complains about of many foods b. Regular or repeti complaints of hu X c. Leaves 25% of fo uneaten at most d. Therapeutic diet e. Mechanically alta pureed) diet 	g. Eating disorders itive h. Food allergies inger (specify) bod i. Restrictions immeals (specify) i. NONE OF ABOVE	
		g. Hostility	o. Other (specify)	SEC	TION L. ORA	L/DENTAL STATUS		
2.	EXTRA- Pyramidal Signs and Symptoms	 need for movement b. Dyskinesia–chewing, pu irregular movements of I c. Tremor–regular rhythmic mouth, or tongue DECREASE IN MOTOR ACTIVITY 	X p. NONE OF ABOVE uring last 3 days rts subjective feeling of restlessness or uckering movements of mouth; abnormal lips; or rocking or writhing of trunk c movements of the fingers, limbs, head, exion and extension of muscles (e.g.,	1.	ORAL STATUS AND DISEASE PREVENTION (check all that apply)	(or partial plates) C. Broken, loose or d. Inflamed gums (ulcers or rashes e. Daily cleaning of staff	I teeth lost-does not have or does not use) r carious teeth (gingiva); swollen or bleeding gums; oral at f teeth/dentures or daily mouth care-by res iculty brushing teeth or dentures	bscesses;
		continuous or cogwheel		SEC	TION M. SKI			
		usually with a decrease f. Bradykinesis–decrease body movement or <i>pove</i> MUSCLE CONTRACTIONS	ction in speed and stride length of gait, in pendular arm movement in spontaneous movements (e.g., reduced <i>erty of</i> facial expression, gestures, speech) tonicity (e.g., muscle spasms or stiffness,	1.	SKIN PROBLEMS (Check all that apply)		rd degree) f. Other (specify)	_
		protruding tongue, upwa Xh. NONE OF ABOVE	ard deviation of the eyes)	2.	ULCERS	Record the number of ulce If none present at a stage,	ers at each ulcer stage-regardless of cause , record "0" (zero). Code all that apply during	
3.	PAIN Symptoms	(Code the highest level of resident's			(Due to any cause)	last 7 days. Code 9=9 or n	more) Requires full body exam.	Nun at Si
			(If no pain, code 0 and skip to J7)			the skin) that does not dis	rea of skin redness (without a break in sappear when pressure is relieved. ness loss of skin layers that presents	0
4.	PAIN SITE	(If pain is present in the last 7 days) a. Back pain	f. Incisional pain			clinically as an abrasion, t	blister, or shallow crater.	0
		 b. Bone pain c. Chest pain while doing 	 g. Joint pain (other than hip) h. Soft tissue pain (e.g., lesion, 				s of skin is lost, exposing the subcutane- a deep crater with or without sue.	0

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

muscle)

i. Stomach pain

j. Other (specify)

c. Chest pain while doing usual activities

d. Headache

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d. Stage 4. A full thickness of skin and subcutaneous tissue is lost,

exposing muscle or bone.

0

Re	esident Name:	THOMAS B ANTHONY 08-13-2004 Date:	Soc.	007-0 Sec. #	02-7907 99999999 Facility Provider #	Э		
SE	ECTION M. SKIN		SEC	TION O. MED	ICATIONS (cont.)			
;	3. FOOT PROBLEMS	 a. Resident or someone else inspects resident's feet on a regular basis? O. No X 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? 	4A 4B	DAYS RECEIVED THE FOLLOWING MEDICATION PRN	(Record the number of DAYS during the last 7 days; enter "0" used. Note-enter "1" for long-acting meds used less than weekl 0 a. Antipsychotic 0d. Hypnotic 0 0b. Antianxiety _0e. Diuretic c. Antidepressant _0f. Aricept Does resident have a prescription for any PRN medication for any PRN	y) g. Insi		
SE		UITY PURSUIT PATTERNS		MEDICATIONS		menta	Ι,	
	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 X c. Evening	5.	SELF- ADMINSTERED MEDICATIONS (Check all that apply.)	Did resident self-administer any of the following in the last 7 da a. Insulin e. Glucosan b. Oxygen f. Over-the-counter Mee c. Nebulizers g. Other (specify) d. Nitropatch X h. NONE OF ABOVE	-		
	2. AVERAGE TIME INVOLVED IN ACTIVITIES (Check only one.) 3. PREFERBED	(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 X 3. Little-less than 1/3 of time 4. None	6.	MEDICATION PREPARATION Administra- tion	Did resident prepare and administer his/her own medications in (Check only one.) 0. No Meds X 1. Resident prepared and administrated NONE of his/her own r 2. Resident prepared and administrated SOME of his/her own r 3. Resident prepared and administrated ALL of his/her own me	nedicati nedicati	ions. tions.	
	3. PREFERRED ACTIVITY Settings	(Check all settings in which activities are preferred) X a. Own room X b. Day/activity room X b. Day/activity room X c. Outside facility (e.g., in yard)	7.	MEDICATION COMPLIANCE (Check one)	Resident's level of compliance with medications prescribed by a psychiatrist during last 30 days: 0. No Meds X 1. Always compliant	physic	;ian/	
4	4. GENERAL ACTIVITY PREFER- ENCES (Adapted to	(Check all PREFERENCES whether or not activity is currently available to resident) a. Cards/other games X k. Gardening or plants b. Crafts/arts X I. Talking or conversing X c. Exercise/sports X m. Helping others			 Always compliant 2. Always compliant with reminder, verbal prompts 3. Compliant some of the time (80% of time or more often) some medications 4. Rarely or never compliant 	<u>or</u> with	1	
	resident's current abilities)	X d. Dancing X n. Doing chores around the house/facility X e. Music house/facility X f. Reading/writing o. Cooking/baking	8.	MISUSE OF Medication	Misuse of prescription or over-the-counter medications in the last (e.g., resident uses more or less than the directed dose, is using for a purpose other than intended) \Box 0. No X 1.	g medic		
		g. Spiritual/religious activity p. Computer activities	SEC	TION P. SPEC	CIAL TREATMENTS AND PROCEDURES			
		X h. Trips/shopping X q. Volunteering X i. Walking/wheeling outdoors r. Other (specify) X j. Watching TV s. NONE OF ABOVE	1.	SPECIAL TREATMENTS, PROCE- DURES,	a. SPECIAL CARE-Check treatments or programs received during days [Note-count only post admission treatments] TREATMEMTS a. Chemotherapy or i. Training in skills requi			'n
	5. PREFERRED ACTIVITY SIZE	(Check all that apply) a. Individual c. Larger group b. Small group X d. No preference		AND PROGRAMS	a. Chemotherapy or radiation i. Training in skiis required to the community (e.g. medications, house w shopping, transportations) b. Oxygen therapy c. Dialysis j. Case management	g., takin vork,	ıg	
	6. PREFER- ENCES IN DAILY ROUTINE	 a. Resident prefers change in type of activity b. Resident prefers change in extent of involvement in activities (e.g., more or less) 			PROGRAMS , , Last of the second		ment	t
	(Check all that apply)	 c. Resident prefers change in location of activities d. Resident prefers activity at different time of day X e. Resident prefers stability in daily routine f. NONE OF ABOVE 			Special care unit X n. Transportation X f. Hospice care o. Psychological rehabil X g. Home health p. Formal education X h. Home care q. NONE OF ABOVE	itation		
7	7. INTERACTION WITH FAMILY AND FRIENDS	last 30 days? (check only one)			b. THERAPIES-Record the number of days each of the following the administered (for at least 15 minutes a day) in the last 7 calendar 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	r days (Was (Enter (E) SITE (C)	
		X 3. 1-3 times/month 6. Daily			Check C if therapy was received out-of-home or facility		ON SI	CF7 0
		b. How often has resident talked by telephone with family and friends in the last 30 days? (check only one)			a. Speech-language pathology and auditory services	0	+	
		1. No family or friends outside X 4. Once a week			b. Occupational therapy c. Physical therapy	0	+	_
		facility 5. 2 or 3 times a week but not			d. Respiratory therapy	0	_	_
		2. None daily 3. 1-3 times/month 6. Daily			e. Psychological therapy (by any licensed mental health professional)	0		
-	8. VOTING	Is resident registered to vote? X 0. No I. Yes	2.	INTER-	(Check all interventions or strategies used in the last 7 days unle. specified-no matter where received)	ss othe	r tim	e
	9. SOCIAL ACTIVITES (Check only one.)	Resident's current level of participation in social, religious or other personal activities compared to resident's status 180 days ago (since admission if less than 180 days): X 0. No change 1. Improved 2. Declined		VENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	a. Special behavior symptom evaluation program b. Special behavior	terns-e	•	
SF	ECTION O. MED	ICATIONS			management program X f. Reorientation-e.g.,	•		
	1. NUMBER OF MEDICATIONS	(Record the number of different medications used in the last 7 days;			c. Evaluation by a licensed mental health specialist in h. Crisis intervention i	n facilit	-	
:	2. NEW MEDICATIONS	(Resident currently receiving medicatons that were initiated during the last 90 days)			last 90 days i. Crisis stabilization d. Group therapy 90 days e. Resident-specific j. Other (specify)	unit in la	ast	
;	3. INJECTIONS	(Record the number of DAYS injections of any type received during the last 30 days ; enter "0" if none used)			deliberate changes in the k. NONE OF ABOVE			

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Resident Name:__ SECTION P. SPEC

THOMAS	в	ANTHONY
IAL TREA	TME	ENTS 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		
		<u>3</u> a. Acute physical or <u>0</u> b. New treatment/med psychiatric condition - not chronic	dicat	tion
4.	REHABILITA- TION/ 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 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 e. Transfer 0 f. Walking 0 g. Dressing or grooming 0 h. Eating or swallowing	s ca	ıre
5.	SKILL TRAINING	Record the number of days, in the last 30 days that each of the following were performed with assistance from staff as a skill training activity identified the resident's service plan. 0 a. Meal Preparation (snacks, light meals) 0 h. Arranges Shopping (makes list, acquire help) 0 b. Telephone Use 0 i. Shopping (for groot clothes, or other incidentals) 0 c. Light Housework (makes own bed, takes care of belongings) 0 j. Transportation (trav various means to grow ashes own laundry) 0 e. Managing Incontinence Supplies (pads, briefs, ostomy, catheter) 0 k. Medications (preparation attain and administration and administration and administration and administration and administration (trav various means to grow attain and administration attain and administration and administration attain a distribution and administration and administration and administration attain administration attain a distribution and administration attain a dministration attain administration attain a dministration attain a dministration attain administration attain attain a dministration attain attain a dministration attain attain a dministra	fied s eries el b et to nts o ra-	in s, y
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 3. No treatments or programs: I 1. Compliant 80% of time 8. Unknown I 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)	0	0
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)	0	1
9.	PHYSICIAN VISITS	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.	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)	0	0
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)? \Box 0. No \Box 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)	0	0
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)	0	0

CONFIDENTIAL

_ Date:____

	Soc.	. Sec. #0	07-02-7907	Facility Provider #	999999999
	SE	ECTION Q. SERV	/ICE PLANNING		
1	1	1. RESIDENT GOALS (Check all areas in which resident has self-identified goals)	f. Participation in the	nt/making friends s/adult learning illed sical or cognitive function	
	2	2. CONFLICT	service plan?	petween resident/family an	Yes

999999999

SECTION R. DISCHARGE POTENTIAL

007-02-7907

1.	DISCHARGE Potential	a.	Does resident or family indicate a preference to return to community? $\$ 0. No $\$ 1. Yes
		b.	Does resident have a support person who is positive towards discharge? X 0. No I 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 L 1.Improved L 2. Declined

SECTION S. ASSESSMENT INFORMATION

1.	PARTICIPA- Tion In Assess- Ment	a. Resident:[b. Family:>c. Other Non-Staff:>	K 0. No	(1. Yes] 1. Yes] 1. Yes	2. No Family 2. None	
2.	SIGNATURE	S OF PERSONS COM			COMENT	
Z .						
	NANCY	SMITH F	RCA COO	RINATO	R	
	a. Signatu	re of Assessment Coord	dinator (sign o	on line ab	ove)	
	b. Date As	sessment Coordinator s	signed as cor	nplete		
				0	8 - 1 8 - 2	2 0 0 4
				Mo	onth Day	Year
c. Other Signatures Title Section			Sections	Date		
	C. Other Sign	latures	The		Decilor 15	Dale
	d.					Date
	e.					Date
3.	CASE MIX GROUP					
SEC	SECTION T. Preventive Health/Health Behaviors					
1.	PREVENTIVE HFATH	(Check all the proced	lures the resi	dent rece	ived during the past	12 months)
	1164111	X a. Blood pressur	e monitoring		. Breast exam or m	ammogram

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

P11=0

Facility Provider #_____

SECTION U. MEDICATIONS LIST

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

1. List the medication name and the dosage

2. RA (Route of Administration). Use the appropriate code from the following list:

1 = by mouth (PO)	3 = intramuscular (IM)	5 = subcutaneous (SubQ)	7 = topical	9 = enteral tube
2 = sublingual (SL)	4 = intravenous (IV)	6 = rectally	8 = inhalation	10 = other
0 ()		,		

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

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

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

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

1. Medication Name and Dosage	2. RA	3. Freq	4. PRN-n	5. NDC Codes
EXAMPLE: Coumadin 2.5 mg Digoxin 0.125 mg Humulin R 25 Units Robitussin 15cc	1 1 5 1	1W 1D 1D PR	2	
ACELAMINOPHEN 325 MG	01	PR	00	0 0 8 7 1 1 2 9 4 0 0
LOTRISONE CR	07	PR	02	0 0 0 8 5 0 9 2 4 0 2

MINIMUM DATA SET - RESIDENTIAL CARE ASSESSMENT (MDS-RCA)

CORRECTION REQUEST FORM

Use this form:

- 1. To request correction of error(s) in an MDS-RCA assessment record or error(s) in an MDS-RCA Discharge Tracking
- record that has been previously accepted into the State MDS-RCA database; and
- 2. To identify the inaccurate record.

A correction request can be made to either MODIFY or INACTIVATE a record.

TO MODIFY A RECORD IN THE STATE DATABASE:

- 1. Complete a new corrected assessment or discharge tracking form. Include all the items on the form, not just those in need of correction;
- 2. Complete and attach this Correction Request Form to the corrected assessment or discharge tracking form;
- 3. Place a hard copy of the complete assessment and correction form in the Clinical Record;
- 4. Create a new electronic record including the corrected assessment or tracking form AND the Correction Request Form; and
- 5. Electronically submit the new record (as in #3) to the MDS-RCA database at the State.
- TO INACTIVATE A RECORD IN THE STATE DATABASE:
- 1. Complete this correction request form;
- 2. Create an electronic record of the Correction Request Form;
- 3. Place a hard copy of the complete assessment and correction form in the Clinical Record; and
- 4. Electronically submit this Correction Request record to the MDS-RCA database at the State.

PRIOR RECORD SECTION:

THIS SECTION IDENTIFIES THE ASSESSMENT OR TRACKING FORM THAT IS IN ERROR. (In this section, reproduce the information EXACTLY as it appeared in the erroneous record, even if the information is wrong. This information is necessary in order to locate the record in the State database.)

Prior AA1	RESIDENT NAME	THOMAS B ANTHONY		
		a.(First) b.(Middle Initial) c.(Last) d.(Jr/Sr))	
Prior AA2	GENDER	1. Male 2. Female	1	
Prior AA3	BIRTHDATE	08 Month Day Year		
Prior AA5a	SOCIAL Security	a. Social Security Number 0007-02-7907		
Prior A6 OR D1.8	REASON FOR ASSESSMENT	ASSESSMENT 1. Admission assessment 2. Annual assessment 3. Significant change in status assessment 4. Semi-Annual 5. Other DISCHARGE TRACKING 6. Discharged 7. Discharged prior to completing initial assessment		
	PRIOR DATE	PRIOR DATE (Complete one only) Complete Prior A5 if Primary Reason (Prior A6) equals 1,2,3,4 or 5 Complete Prior D3.2 if Primary Reason (Prior D1.8) equals 6 or 7		
Prior A5	ASSESSMENT DATE	a. Last day of MDS observation period 08 Month Day Year		
Prior D3.2	DISCHARGE Date	Date of Discharge		

CORRECTION SECTION:

COMPLETE THIS SECTION TO EXPLAIN THE CORRECT REQUEST

AT1.	CORRECTION SEQUENCE NUMBER	(Enter total number of correction for this record, including the present one)	01
AT2.	ACTION Requested	 MODIFY record in error (Attach and submit a COMPLETE assessment or tracking form. Do NOT submit the corrected items ONLY. Proceed to item AT3 below). INACTIVATE record in error. (DO NOT submit an assessment or tracking form. Submit the correction request only. Skip to item AT4). 	1
AT3.	REASONS FOR Modification	If AT2=1, check at least one of the following reasons; check all that apply, then skip to AT5) a. Transcription error b. Data entry error c. Software product error d. Item coding error e. Other error If "Other" checked, please specify:	a. b. X c. d. e.
AT4.	REASONS FOR INACTIVATION	 (If AT2=2, check at least one of the following reasons; check all that apply.) a. Test record submitted as production record b. Event did not occur c. Inadvertent submission of non-required record d. Other reason requiring inactivation If "Other" checked, please specify: 	a. b. c. d.

MDS-RCA COORDINATOR SIGNATURE AND DATE COMPLETION

AT5.	INDIVIDUAL NAME	NANCY	SMITH	RCA DIRECTOR
		a.(First)	b.(Last)	c.(Title)
	SIGNATURE			
AT6.	CORRECTION DATE	08 Month	29 Day	2 0 0 4 Year

MINIMUM DATA SET (MDS)[©] RESIDENTIAL CARE ASSESSMENT (RCA)

BASIC ASSESSMENT TRACKING FORM

GENERAL INSTRUCTIONS:

Complete this form for all assessments and discharges.

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	Thomas B Anthony
		a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER	X 1. Male 2. Female
3.	BIRTHDATE	0 8 - 1 3 - 1 9 0 8 Month Day Year
4.	RACE/ ETHNICITY (Check only one.)	□ 1. American Indian/Alaskan Native □ 4. Hispanic □ 2. Asian/Pacific Islander X 5. White, not of Hispanic origin □ 3. Black, not of Hispanic origin □ 6. Other
5.	SOCIAL SECURITY and MEDICARE NUMBERS (C in 1 st 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
6.	FACILITY NAME AND PROVIDER NO.	a. Facility Name MCBVI b. Provider No. 9
7.	MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient]
8.	SIGNATURE(S)	OF PERSON(S) COMPLETING FACE SHEET:
Ň	ancy Sm	hith RCA Diffectory Affections 8/30/2004
b.		Date
C.	DATE Completed	Record date background information was completed.

MINIMUM DATA SET (MDS)[®] RESIDENTIAL CARE ASSESSMENT (RCA)

FACE SHEET: BACKGROUND INFORMATION ONLY AT ADMISSION

Resident Name: THOMAS B ANTHONY

Date:_____

Soc. Sec. #___007-02-7907

___ Facility Provider #____999999999

SECTION AB. DEMOGRAPHIC INFORMATION

-		CUSTOMARY ROUTINE
1	CUSTOMARY	(Check all that apply. If all information

1.	DATE OF ENTRY	Date the stay began. (Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date.)								
		0 8 2 7 1 9 9 3 Month Day Year								
2.	ADMITTED FROM (AT ENTRY) (Check only one.)									
3.	LIVED ALONE (PRIOR TO ENTRY) (Check only one.)	X 0. No 1. Yes 2. In other facility								
4.	Prior Primary Residence	Provide town, state, zip code for Resident's primary residence prior to admission BERWICK Town State Zip Code								
5.	RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	 (Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above) a. Prior stay at this home b. Nursing home X c. Other residential facility—board and care home, assisted living, group home d. MH/psychiatric hospital e. MR/DD facility f. NONE OF ABOVE 								
6.	LIFETIME Occupation	Put a "/" between two occupations. F L O W E R G R O W E R								
7.	EDUCATION (Highest Level Completed) (Check only one.)	1. No schooling 5. Technical or trade school 2. 8th grade or less X 6. Some college 3. 9–11 grades 7. Bachelor's degree 4. High school 8. Graduate degree								
8.	PRIMARY LANGUAGE (Check only one.)	X 0. English 2. French 1. Spanish 3. Other (specify)								
9.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of the following? a. Mental retardation X 0. No 1. Yes b. Mental illness X 0. No 1. Yes c. Developmental disability X 0. No 1. Yes								
10.	CONDITIONS RELATED TO MR/DD STATUS	(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely) X a. Not applicable—no MR/DD (<i>Skip to AB11</i>) MR/DD with organic condition b. Down's syndrome e. Cerebral palsy c. Autism f. Other organic condition related to MR/DD d. Epilepsy 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 1. Yes b. Dementia other than Alzheimer's disease 0. No X 1. Yes								

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

SECTION AD. FACE SHEET SIGNATURES and DATES

1. SI	1. SIGNATURE(S) OF PERSON(S) COMPLETING FACE SHEET:										
a. Sig	natures NANCY	SMITH	Title RCA	DIRECTOR	Sections ALL	Date 8/30/1993					
b.						Date					
2.	DATE Completed	Record of 0 Mor	8 –	round information 3 0 - 1 Day	was completed. 9 9 3 Year						

CONFIDENTIAL MINIMUM DATA SET (MDS)[®] RESIDENTIAL CARE ASSESSMENT (RCA)

(STATUS IN LAST 7 DAYS UNLESS OTHERWISE NOTED)

1. 2.	CTION A. I	DENTIFICATION and BACKGROUND INFORMATION			COMMUNICATION/HEARING PATTERNS
2.	RESIDENT	THOMAS B ANTHONY] 1.	HEARING	(With hearing appliance, if used)
2.	NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)	_	(Check only one.)	X 0. HEARS ADEQUATELY—normal talk, TV, phone
	SOCIAL SECURITY and	a. Social Security Number			1. MINIMAL DIFFICULTY when not in quiet setting
	MEDICARE	0 0 7 0 2 7 9 0 7			2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly
	(C in 1 st box if	b. Medicare number (or comparable railroad insurance number)			3. HIGHLY IMPAIRED – absence of useful hearing
	no med. no.)	0 0 7 0 2 7 9 0 7 - A	2.	COMMUNICA- TION DEVICES/	(Check all that apply during last 7 days.)
3.		a. Facility Name		TECHNIQUES	a. Hearing aid, present and used
	NAME AND	b. Provider No.			b. Hearing aid, present and not used regularly
	PROVIDER NO.				C. Other receptive communication techniques used (e.g., lip reading) X d. NONE OF ABOVE
		9 9 9 9 9 9 9 9 9 9	3.	MAKING SELF	(Expressing information content—however able)
4.	MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient]	0.	UNDERSTOOD	X 0. UNDERSTOOD
	NO.	4 4 0 2 7 6 9 1 A		(Check only one.)	1. USUALLY UNDERSTOOD—difficulty finding words or
5.	ASSESSMENT	Last day of observation period	-		finishing thoughts
5.	DATE				2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests
		Month Day Year			3. RARELY/NEVER UNDERSTOOD
6.	REASON FOR	(Check primary reason for assessment)	4.	ABILITY TO	(Understanding information content—however able)
	ASSESSMENT	1. Admission assessment 4. Semi-Annual		UNDERSTAND OTHERS	X 0. UNDERSTANDS
		X 2. Annual assessment 5. Other (specify)		(Check only one.)	1. USUALLY UNDERSTANDS—may miss some part / intent of
_	MADITAL	Significant change in status assessment	-		message 2. SOMETIMES UNDERSTANDS—responds adequately to simple,
7.	MARITAL Status	1. Never married X 3. Widowed 5. Divorced			direct communication
	(Check only one.)	2. Married 4. Separated			3. RARELY/NEVER UNDERSTANDS
8.	CURRENT PAYMENT	(Billing Office to indicate; check all that apply in last 30 days or since last admission if less than 30 days)	5.	COMMUNICA-	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
	SOURCES FOR	X a. MaineCare 🗌 e. Private pay		TION (Check only one.)	180 days.
	STAY	X b. SSI f. Private insurance		(<i>, , ,</i>	0. No change 1. Improved X 2. Declined
		C. VA (including co-payment) X d. Social Security g. SSDI			
		X d. Social Security			VISION PATTERNS
Э.	RESPONSI-	(Check all that apply)	1.	VISION	(Ability to see in adequate light and with glasses if used)
	BILITY/ Legal	a. Legal guardian X e. Family member responsible		(Check only one.)	O. ADEQUATE—sees fine detail, including regular print in newspapers/books
	GUARDIAN	b. Other legal oversight X f. Self			I. IMPAIRED—sees large print, but not regular print in newspapers/
		c. Durable power of attorney/health care h. Representative Payee			books
		□ d. Durable power of □ i. NONE OF ABOVE			ODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects
_		attorney/financial Does resident have any of the <u>fol</u> lowing advanced directives in place?	-		X 3. <i>HIGHLY IMPAIRED</i> —object identification in question, but eyes
0.	ADVANCED DIRECTIVES	a. Living Will 0 . No X 1 . Yes			appear to follow objects
		b. Do not resuscitate (DNR) X 0. No			4. SEVERELY IMPAIRED—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects
		c. Do not hospitalize X 0. No 1. Yes	2.	VISUAL	a. Glasses, contact lenses 0. No X 1. Yes
		d. Organ donation Image: 0 No X 1. Yes e. Other X 0. No Image: 1 Yes		APPLIANCES	
					b. Artificial eye X 0. No 🗆 1. Yes
	1 1	(If "yes," specify)			b . Artificial eye X 0 . No 1 . Yes
		(If "yes," specify)		CTION E. I	MOOD AND BEHAVIOR PATTERNS
ε	CTION B. (SE		
	CTION B. (MEMORY	(If "yes," specify) COGNITIVE PATTERNS (Recall of what was learned or known)		CTION E. I INDICATORS OF DEPRESSION,	MOOD AND BEHAVIOR PATTERNS (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
		(If "yes," specify) COGNITIVE PATTERNS (Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes		CTION E. I	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause)
		(If "yes," specify) COGNITIVE PATTERNS (Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK X 1. Memory problem		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	 MOOD AND BEHAVIOR PATTERNS (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)
		(If "yes," specify) COGNITIVE PATTERNS (Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK X 1. Memory problem b. Long-term memory OK—seems/appears to recall long past		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS 0 a. Resident made negative statements—e.g., "Nothing matters;
Ι.	MEMORY	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS 0. a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so
1.	MEMORY MEMORY/ RECALL	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS 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.	MEMORY MEMORY/	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS 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.	MEMORY MEMORY/ RECALL	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	MOOD AND BEHAVIOR PATTERNS (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 up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS 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")
2.	MEMORY MEMORY/ RECALL ABILITY COGNITIVE	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS 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
2.	MEMORY MEMORY/ RECALL ABILITY COGNITIVE SKILLS FOR	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS 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
2.	MEMORY/ RECALL ABILITY COGNITIVE SKILLS FOR DAILY DECISION-	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS 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, ange at placement in facility; anger at care received 0 e. Self deprecation—e.g., "I am nothing; I am of no use to anyone"
2.	MEMORY/ RECALL ABILITY COGNITIVE SKILLS FOR DAILY DECISION- MAKING	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS 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 or being abandoned, left alone, being with others
2.	MEMORY/ RECALL ABILITY COGNITIVE SKILLS FOR DAILY DECISION-	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS 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, ange 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 happer
-	MEMORY/ RECALL ABILITY COGNITIVE SKILLS FOR DAILY DECISION- MAKING (Check only one.)	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	 MOOD AND BEHAVIOR PATTERNS (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 daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die." b. Repetitive questions—e.g., "Where do I go; What do I do?" C. Repetitive verbalizations—e.g., calling out for help, ("God help me") d. Persistent anger with self or others—e.g., easily annoyed, ange at placement in facility; anger at care received e. Self deprecation—e.g.,"I am nothing; I am of no use to anyone" f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack
1.	MEMORY MEMORY/ RECALL ABILITY COGNITIVE SKILLS FOR DAILY DECISION- MAKING (Check only one.) COGNITIVE STATUS	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS 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, ange 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 happer
1. 2. 3.	MEMORY MEMORY/ RECALL ABILITY COGNITIVE SKILLS FOR DAILY DECISION- MAKING (Check only one.) COGNITIVE	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	 MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die." 0. B. Repetitive questions—e.g., "Where do I go; What do I do?" c. Repetitive verbalizations—e.g., calling out for help, ("God help me") d. Persistent anger with self or others—e.g., easily annoyed, ange at placement in facility; anger at care received o. Self deprecation—e.g., "I am nothing; I am of no use to anyone" f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happer—e.g., believes he or she is about to die, have a heart attack h. Repetitive health complaints—e.g., persistently seeks medical
1.	MEMORY MEMORY/ RECALL ABILITY COGNITIVE SKILLS FOR DAILY DECISION- MAKING (Check only one.) COGNITIVE STATUS	(If "yes," specify)		CTION E. I INDICATORS OF DEPRESSION, ANXIETY,	 MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days 1. This type exhibited up to 5 days a week 2. This type exhibited daily or almost daily (6, 7 days/week) VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die." b. Repetitive questions—e.g., "Where do I go; What do I do?" c. Repetitive verbalizations—e.g., calling out for help, ("God help me") d. Persistent anger with self or others—e.g., easily annoyed, ange at placement in facility; anger at care received e. Self deprecation—e.g.,"I am nothing; I am of no use to anyone" f. Expressions of what appear to be unrealistic fears—e.g., fear or being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happer —e.g., believes he or she is about to die, have a heart attack h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions

CONFIDENTIAL 08/13/2004

Date:

007-02-7907 Soc. Sec. #

SECTION E MOOD and REHAVIOR PATTERNS (cont.)

1.	INDICATORS OF Depression.	(CODE: Record the appropriate code for the frequency of the symp in last 30 days, irrespective of the assumed cause)	tom(s	s) obs	erved	
	ANXIETY, SAD MOOD	 Not exhibited in last 30 days This type exhibited up to 5 days a week This type exhibited daily or almost daily (6, 7 days/v 	veek)			
		SLEEP-CYCLE ISSUES				-
		j. Unpleasant mood in morning				
		k. Insomnia/change in usual sleep pattern				
		SAD, APATHETIC, ANXIOUS APPEARANCE				
		0 I. Sad, pained, worried facial expressions—e.g., fu	urrow	ed br	OWS	
		III. Crying, teanuness	and .			
		restlessness, fidgeting, picking	and v	vringi	ng,	
		LOSS OF INTEREST 0 o. Withdrawal from activities of interest—e.g., no ir standing activities or being with family/friends	iteres	st in Ic	ong	
		 p. Reduced social interaction 				
		INDICATORS OF MANIA				
		q. Inflated self-worth, exaggerated self-opinion; infl about one's own ability, etc.	ated	belief		
		r. Excited behavior, motor excitation (e.g., heighter activity; excited, loud or pressured speech; incre				
2.	MOOD Persistence	Check if one or more indicators of depressed, sad or anxiou (above) were not easily altered by attempts to "cheer up", or reassure the resident over last 7 days .	is ma consc	ood ble, or		
	(Check only one.)	X 0. No mood indicators				
		 Indicators present, easily altered 				
		2. Indicators present, not easily altered				
3.	MOOD	Resident's current mood status compared to resident's statu	s 180) day	s ago	
	(Check only one.)	(or since admission if less than 180 days): X 0. No change 1. Improved 2. Dec	linod			
4		X 0. No change 1. Improved 2. Dec (COLUMN A CODES: Record the appropriate (COLUMN B		S.		_
4.	BEHAVIORAL Symptoms	code for the frequency of the symptom <u>Alterability</u> of	f beha	vioral		
		<u>in last 7 days)</u> symptoms <u>in</u>			-	
		 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in 1. Behavior r 				•
		last 7 days	A	B	C	
		 Behavior of this type occurred 4 to 6 days but less than daily Behavior of this type occurred daily 	νcγ	Γ	ORY	
		(COLUMN C CODES: <u>History of this behavior in the last 6 months</u>)	FREQUENCY	ALTERABILITY	HISTC	
		0. No 1. Yes	Ë	ALTE		
a.	WANDERING needs or safe	a (moved with no rational purpose, seemingly oblivious to ty)	0	0	0	
b.	threatened, so	BUSIVE BEHAVIORAL SYMPTOMS (others were creamed at, cursed at)	0	0	0	
c.		ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, check, sexually abused, gross physical assault)	0	0	0	
d.		APPROPRIATE/DISRUPTIVE BEHAVIORAL	-	-	\square	
u.	SYMPTOMS public, smeare	(made disruptive sounds, sexual behavior, disrobing in ed/threw food/feces, hoarding, rummaged through others' ealing, self-abusive acts, substance abuse, self-mutilation)	0	0	0	
e.	RESISTS CA assistance, or	RE (resisted taking medications/ injections, ADL eating)	0	0	0	
f.	invaded)	G BEHAVIOR (made others feel unsafe, at risk, privacy	0	0	0	
g.	ELOPEMENT	-	1	0	0	
h.	Dangerous no	on-violent behavior (e.g., falling asleep while smoking)	2	1	1	
i.	Ū	plent behavior	0	0	0	
j.	FIRE SETTIN	-	0	0	0	
5.	SUICIDAL Ideation	Resident demonstrated suicidal thoughts or actions in the lat X 0. No I 1. Yes	st 30) day	s:	
6.	SLEEP PROBLEMS	Check all present on 2 or more days during last 7 days a. Inability to awaken when desired d. Interrupte X b. Difficulty falling asleep e. NONE OF				
		c. Restless or non-restful sleep				
7.	INSIGHT INTO MENTAL HEALTH	Resident has insight about his/her mental problem X 0. No 1. Yes 2. No mental here	alth p	oroble	ems	
8.	BEHAVIORS	Resident's current behavior status compared to resident's sta days ago (or since admission if less than 180 days):	tus 1	80		
	(Check only one.)	X 0. No change 1. Improved 2. D	ecline	ed		

SECTION F. PSYCHOSOCIAL WELL-BEING X a. At ease interacting with others SENSE OF X b. At ease doing planned or structured activities INVOLVEMENT X c. At ease doing self-initiated activities (Check all that Establishes own goals apply) х e. Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) f. Accepts invitations into most group activities **g.** NONE OF ABOVE UNSETTLED 2. a. Covert/open conflict with or repeated criticism of staff **RELATION**b. Unhappy with roommate SHIPS c. Unhappy with residents other than roommate (Check all that d. Openly expresses conflict/anger with family/friends apply) e. Absence of personal contact with family/friends f. Recent loss of close family member/friend **g.** Does not adjust easily to change in routines X h. NONE OF ABOVE Events in past 2 years 3. LIFE EVENTS HISTORY X a. Serious accident or physical illness **b.** Health concerns for other person Х c. Death of family member or close friend (Check all that apply.) d. Trouble with the law e. Robbed/physically attacked **f.** Conflict laden or severed relationship g. Loss of income leading to change in lifestyle h. Sexual assault/abuse i. Child custody issues X j. Change in marital/partner status k. Review hearings (e.g., forensic, certification, capacity hearing) □ I. NONE OF ABOVE ECTION G. PHYSICAL FUNCTIONING (A) ADL SELF-PERFORMANCE 0. INDEPENDENT-No help or oversight -OR- Help/oversight provided only 1 or 2 times during last 7 days 1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days -OR- Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days 2. LIMITED ASSISTANCE-Resident highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times Limited assistance (3 or more times,) plus weight-bearing support provided 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 В A self-performance classification. SELF-PERFORMANCE 0. No setup or physical help from staff 1. Setup help only SUPPORT 2. One-person physical assist 3. Two+ persons physical assist 8. Activity did not occur during entire 7 days BED MOBILITY- How resident moves to and from lying position, turns side to 0 0 side, and positions body while in bed TRANSFER - How resident moves between surfaces-to/from: bed, chair, n 0 wheelchair, standing position (EXCLUDE to/from bath/toilet) 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, 0 how resident moves to and from distant areas on the floor. If in wheelchair, self-0 sufficiency once in chair DRESSING - How resident puts on, fastens, and takes off all items of street 2 2 clothing, including donning/removing prosthesis EATING - How resident eats and drinks (regardless of skill). Includes intake of 0 0 nourishment by other means (e.g., tube feeding, total parenteral nutrition) TOILET USE - How resident uses the toilet room (or commode, bed- pan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or 0 catheter, adjusts clothes

Res	ident Name: TI	HOMAS B ANTHONY Date: 08-13-20	004	Soc.	Sec. #0	007-02-7907	_ Facility	Provider #999999999	
		HYSICAL FUNCTIONING (cont.)		SE	CTION G.	PHYSICAL FUNCTION	ING (co	ont.)	
2.	BATHING Self- Performance	How resident takes full-body bath/shower, sponge bath, and transfer of tub/shower (EXCLUDE washing of back and hair.) Check for models 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 X 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur during entire 7 days				f. Resident requires or or direction. g. Resident could be more equipment (e.g., can clothing or shoes) h. Resident could perfor IADL activities were being a straight of the straight of t	pre indepe e, walker, j m more ir roken into	rstands no more than a two-step endent if he/she had special plate guard, velcro closings on ndependently if some or all of At o subtasks (task segmentation) endent if he/she received ADL or	DL/
3A.	MODES OF Locomotion	 (Check all that apply during last 7 days) a. Cane/walker/crutch b. Wheeled self c. Other person wheeled X d. NONE OF ABOVE 		7.	NEW DEVICES NEEDED (Check all that apply.)	Resident expresses or gives assistive devices a. Eyeglasses b. Hearing aid c. Cane or walker	☐ f.	of needing new or additional Assistive dressing devices (e.g., button hook, velcro closin Dentures	gs)
3B.	MAIN Mode of Locomotion	Was wheelchair the primary mode of locomotion during the last 7 da X 0. No	ays?			 d. Wheelchair e. Assistive feeding devices (e.g., plate 	□ h.	Other (specify)	
3C.	BEDFAST/ Chairfast	 (Check if health condition keeps resident in his/her room 22+ hours in last 7 days) a. Bedfast all or most of time b. Chairfast all or most of the time X c. NONE OF ABOVE 	per day	8.	SELF- Performance in Iadls	guard, stabilized built Resident's current IADL statu days ago (or since admission	up utensi s or abiliti	l) ies compared to resident's statu an 180 days):	s 180
4.	SELF- PERFORMANCE IN ADLs (Check only one.)	Resident's current ADL status or abilities compared to resident's status ago (or since admission if less than 180 days): 0. No change 1. Improved X 2. Declined	tus 180	SE(CONTINEN (Cade for res 0. CONTIN ostomy d	levice that does not leak urine	ORIES L SHIFTS des use o or stool)) of indwelling urinary catheter o	
5A	. IADL SELF- PERFOR- Mance	F- Code for level of independence in the last 30 days based on resident's involvement in the activity.			BOWEL, 2. OCCASI daily; BO 3. FREQUE some cor 4. INCONT	LLY CONTINENT—BLADDER, Incontinent episodes once a week or L, less than weekly SIONALLY INCONTINENT—BLADDER, 2 or more times a week bu OWEL, once a week UENTLY INCONTINENT—BLADDER, tended to be incontinent daily ontrol present (e.g. on day shift); BOWEL, 2-3 times a week ITINENT—Had inadequate control BLADDER, multiple daily episodes; E Imost all) of the time Control of bowel movement, with appliance or bowel continence programs, if employed			ot
		8. Activity did not occur in the last 30 days.	SELF- PERFORMANCE	b. 2.	BLADDER CONTINENCE BOWEL ELIMINATION	Bowel elimination pattern	loyed	n appliances (e.g. foley) or Diarrhea Fecal Impaction	2 <u>c.</u> d.
		 Resident arranged for shopping for clothing, snacks, other incidentals. 	2		PATTERN	movement every three days Constipation	a. X b.	Resident is Independent	e. f.
		 B. Resident shopped for clothing, snacks, or other incidentals. 	1	3.	APPLIANCES and	Any scheduled toileting plan	a.X b.	Did not use toilet room/ commode/urinal	f.
		c. Resident arranged for suitable transportation to get to	2		PROGRAMS	Bladder retraining program External (condom) catheter	с.	Pads/briefs used	g.
		appointments, outings, necessary engagements. d. Resident managed finances including banking,	2			Indwelling catheter	d.	Enemas/irrigation	h.
		handling checkbook, or paying bills.	2			Intermittent catheter	e.	Ostomy present	i.
		e. Resident managed cash, personal needs allowance.f. Resident prepared snacks, light meals.	0 8	4.	USE OF	Resident's management of	ncontiner	NONE OF ABOVE nce supplies (pads, briefs, oston	j. ny,
		g. Resident used phone.	1		INCONTINENO SUPPLIES	E catheter) in <u>last 14 days.</u>			
		 Resident did light housework such as making own bed, dusting, or taking care of belongings. 	2		(Check only one.)		and able t	o manage incontinence supplies	S
		i. Resident sorted, folded, or washed own laundry.	2			2. Resident incontinent incontinence supplie		ives assistance with managing	
5B.	TRANSPOR- TATION	Check all that apply for level of independence in the last 30 days bas on resident's involvement in the activity.	sea					not use incontinence supplies.	
		 a. Resident drove car or used public transportation independen get to medical, dental appointments, necessary engagement other activities. b. Resident rode to destination with staff, family, others (in car, v 	s, or	5.	CHANGES IN URINARY CONTINENCE	days ago (or since last asse			
		public transportation) but was not accompanied to medical,		SE		IAGNOSES			<u> </u>
		 dental appointments, necessary engagements, or other activ X c. Resident rode to destination with staff, family, others (in car, va public transportation) and <u>was accompanied</u> to medical, der appointments, necessary engagements, or other activities. 	an,	Che and	ck only those behavior statu	diagnoses that have a relationsl is, medical treatments, nurse m ie apply, CHECK item xx. <i>NON</i>	onitoring, E OF ABC		
6.	ADL AND IADL FUNCTIONAL REHABILI- TATION OR IMPROVE- MENT POTENTIAL (Check all that apply.)	 d. Activity did not occur. a. Resident believes he/she is capable of increased independent 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 morning evenings e. Resident requires or only understands a one-step direction. (continued in next column) 		1.	DIAGNOSES	ENDOCRINE/METABOLIC/ NUTRITIONAL a. Diabetes mellitus b. Hyperthyroidism c. Hypothyroidism		 ART/CIRCULATION d. Arteriosclerotic heart disea (ASHD) e. Cardiac dysrhythmia f. Congestive heart failure g. Deep vein thrombosis h. Hypertension i. Hypotension j. Peripheral vascular disea k. Other cardiovascular disea k. Other cardiovascular disea 	se

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

Roci	dent Name:	THOMAS B ANTHONY	08/13/2004 Date:	Soc. S		02-7907	999999999 Facility Provider #)
	_	NOSES (cont.)	Date	-		LTH CONDITIONS AND P	POSSIBLE MEDICATION SIDE EFFECTS	S (cont.)
		MUSCULOSKELETAL I. Arthritis M. Hip fracture N. Missing limb (e.g., amputation) O. Osteoporosis P. Pathological bone fracture	ff. Manic depressive (Bipolar) gg. Schizophrenia PULMONARY hh. Asthma ii. Emphysema/COPD SENSORY	5.	PAIN INTERFERES PAIN MANAGE-	During the last 7 days, h	 a wow much of the time did pain interfere with s visiting with friends, going out, and so on a so in a so in	n resident's
		NEUROLOGICAL 	jj. Cataracts kk. Diabetic retinopathy II. Glaucoma	7.	ACCIDENTS	 2. Treated, full cont a. Fell in past 30 da 	,	
		disease r. Aphasia s. Cerebral palsy	X mm. Macular degeneration OTHER In n. Allergies (specify)		(Check all that apply)	b. Fell in past 31-13 c. Hip fracture in last	80 days X e. NONE OF ABOVE	oo uuyo
		accident (stroke) U. Dementia other than Alzheimer's disease V. Hemiplegia/ hemiparesis W. Multiple sclerosis X. Paraplegia	 oo. Anemia pp. Cancer qq. Renal failure rr. Tuberculosis-TB ss. HIV tt. Mental retardation(e.g., Down's Syndrome, Autism, or other organic condition related to 	8.	DANGER OF FALL (Check all that apply)	c. Limits activity be	olems when standing ecause resident or family fearful of resident ion from seated to standing	t falling
		y. Parkinson's disease	Mental Retardation or Developmental disability (MR/	SEC	TION K. ORA	L/NUTRITIONAL STATUS	S	
		z. Quadriplegia aa. Seizure disorder bb. Transient ischemic attack (TIA)	DD) uu. Substance abuse (alcohol or drug) v. Other psychiatric diagnosis (e.g., paranoia, phobias,	1.	ORAL PROBLEMS (Check all that apply)	 a. Mouth is "dry"wh X b. Chewing Problem X c. Swallowing Probl 	m e. NONE OF AE	BOVE
		cc. Traumatic brain injury PSYCHIATRIC/MOOD dd. Anxiety disorder	ersonality disorder) www. Explicit terminal prognosis xx. NONE OF ABOVE	2.	HEIGHT AND WEIGHT	measure in last 30 days ; me practice–e.g., in a.m. after ve	es and (b.) weight in pounds. Base weight on me easure weight consistently in accord with standa voiding, before meal, with shoes off, and in night HT (in) 67 b WT (lb) 1	ard facility
		ee. Depression		3.	WEIGHT		HT (in.) 6 7 b. WT (lb.) 1 loss–5% or more in last 30 days; or 10%	
2. SEC	OTHER CURRENT DIAGNOSIS AND ICD-9 CODES TION J. HEAL	a b c TH CONDITIONS AND POSSIBI		0.	CHANGE	more in last 180 day X 0. No	/s 1. Yes gain–5% or more in last 30 days; or 10%	
1.	PROBLEM CONDITIONS	 (Check all problems present in last a. Inability to lie flat due to shortness of breath b. Shortness of breath c. Edema d. Dizziness/vertigo e. Delusions f. Hallucinations 	7 days unless other time frame is indicated)	4.	NUTRI- TIONAL PROBLEMS OR AP- PROACHES (Check all that apply)	 a. Complains about of many foods b. Regular or repeti complaints of hu X c. Leaves 25% of fo uneaten at most d. Therapeutic diet e. Mechanically alta pureed) diet 	g. Eating disorders itive h. Food allergies inger (specify) bod i. Restrictions immeals (specify) i. NONE OF ABOVE	
		g. Hostility	o. Other (specify)	SEC	TION L. ORA	L/DENTAL STATUS		
2.	EXTRA- Pyramidal Signs and Symptoms	 need for movement b. Dyskinesia–chewing, pu irregular movements of I c. Tremor–regular rhythmic mouth, or tongue DECREASE IN MOTOR ACTIVITY 	X p. NONE OF ABOVE uring last 3 days rts subjective feeling of restlessness or uckering movements of mouth; abnormal lips; or rocking or writhing of trunk c movements of the fingers, limbs, head, exion and extension of muscles (e.g.,	1.	ORAL STATUS AND DISEASE PREVENTION (check all that apply)	(or partial plates) C. Broken, loose or d. Inflamed gums (ulcers or rashes e. Daily cleaning of staff	I teeth lost-does not have or does not use) r carious teeth (gingiva); swollen or bleeding gums; oral at f teeth/dentures or daily mouth care-by res iculty brushing teeth or dentures	bscesses;
		continuous or cogwheel		SEC	TION M. SKI			
		usually with a decrease f. Bradykinesis–decrease body movement or <i>pove</i> MUSCLE CONTRACTIONS	ction in speed and stride length of gait, in pendular arm movement in spontaneous movements (e.g., reduced <i>erty of</i> facial expression, gestures, speech) tonicity (e.g., muscle spasms or stiffness,	1.	SKIN PROBLEMS (Check all that apply)		rd degree) f. Other (specify)	_
		protruding tongue, upwa Xh. NONE OF ABOVE	ard deviation of the eyes)	2.	ULCERS	Record the number of ulce If none present at a stage,	ers at each ulcer stage-regardless of cause , record "0" (zero). Code all that apply during	
3.	PAIN Symptoms	(Code the highest level of resident's			(Due to any cause)	last 7 days. Code 9=9 or n	more) Requires full body exam.	Nun at Si
			(If no pain, code 0 and skip to J7)			the skin) that does not dis	rea of skin redness (without a break in sappear when pressure is relieved. ness loss of skin layers that presents	0
4.	PAIN SITE	(If pain is present in the last 7 days) a. Back pain	f. Incisional pain			clinically as an abrasion, t	blister, or shallow crater.	0
		 b. Bone pain c. Chest pain while doing 	 g. Joint pain (other than hip) h. Soft tissue pain (e.g., lesion, 				s of skin is lost, exposing the subcutane- a deep crater with or without sue.	0

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

muscle)

i. Stomach pain

j. Other (specify)

c. Chest pain while doing usual activities

d. Headache

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d. Stage 4. A full thickness of skin and subcutaneous tissue is lost,

exposing muscle or bone.

0

Re	esident Name:	THOMAS B ANTHONY 08-13-2004 Date:	Soc.	007-0 Sec. #	02-7907 99999999 Facility Provider #	Э		
SE	ECTION M. SKIN		SEC	TION O. MED	ICATIONS (cont.)			
;	3. FOOT PROBLEMS	 a. Resident or someone else inspects resident's feet on a regular basis? O. No X 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? 	4A 4B	DAYS RECEIVED THE FOLLOWING MEDICATION PRN	(Record the number of DAYS during the last 7 days; enter "0" used. Note-enter "1" for long-acting meds used less than weekl 0 a. Antipsychotic 0d. Hypnotic 0 0b. Antianxiety _0e. Diuretic c. Antidepressant _0f. Aricept Does resident have a prescription for any PRN medication for any	y) g. Insi		
SE		UITY PURSUIT PATTERNS		MEDICATIONS		menta	Ι,	
	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 X c. Evening	5.	SELF- ADMINSTERED MEDICATIONS (Check all that apply.)	Did resident self-administer any of the following in the last 7 da a. Insulin e. Glucosan b. Oxygen f. Over-the-counter Mee c. Nebulizers g. Other (specify) d. Nitropatch X h. NONE OF ABOVE	-		
	2. AVERAGE TIME INVOLVED IN ACTIVITIES (Check only one.) 3. PREFERBED	(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 X 3. Little-less than 1/3 of time 4. None	6.	MEDICATION PREPARATION ADMINISTRA- TION	Did resident prepare and administer his/her own medications in (Check only one.) 0. No Meds X 1. Resident prepared and administrated NONE of his/her own r 2. Resident prepared and administrated SOME of his/her own r 3. Resident prepared and administrated ALL of his/her own me	nedicati nedicati	ions. tions.	
	3. PREFERRED ACTIVITY Settings	(Check all settings in which activities are preferred) X a. Own room X b. Day/activity room X b. Day/activity room X c. Outside facility (e.g., in yard)	7.	MEDICATION COMPLIANCE (Check one)	Resident's level of compliance with medications prescribed by a psychiatrist during last 30 days: 0. No Meds X 1. Always compliant	physic	;ian/	
4	4. GENERAL ACTIVITY PREFER- ENCES (Adapted to	(Check all PREFERENCES whether or not activity is currently available to resident) a. Cards/other games X k. Gardening or plants b. Crafts/arts X I. Talking or conversing X c. Exercise/sports X m. Helping others			 Always compliant 2. Always compliant with reminder, verbal prompts 3. Compliant some of the time (80% of time or more often) some medications 4. Rarely or never compliant 	<u>or</u> with	١	
	resident's current abilities)	X d. Dancing X n. Doing chores around the house/facility X e. Music house/facility X f. Reading/writing o. Cooking/baking	8.	MISUSE OF Medication	Misuse of prescription or over-the-counter medications in the last (e.g., resident uses more or less than the directed dose, is using for a purpose other than intended) \Box 0. No X 1.	g medic		
		g. Spiritual/religious activity p. Computer activities	SEC	TION P. SPEC	CIAL TREATMENTS AND PROCEDURES			
		X h. Trips/shopping X q. Volunteering X i. Walking/wheeling outdoors r. Other (specify)	1.	SPECIAL TREATMENTS, PROCE- DURES,	a. SPECIAL CARE-Check treatments or programs received during days [Note-count only post admission treatments] TREATMEMTS a. Chemotherapy or i. Training in skills requi			'n
	5. PREFERRED ACTIVITY SIZE	(Check all that apply) a. Individual c. Larger group b. Small group X d. No preference		AND PROGRAMS	a. Chemotherapy or radiation i. Training in skiis required to the community (e.g. medications, house w shopping, transportations) b. Oxygen therapy c. Dialysis j. Case management	g., takin vork,	ıg	
	6. PREFER- ENCES IN DAILY ROUTINE	 a. Resident prefers change in type of activity b. Resident prefers change in extent of involvement in activities (e.g., more or less) 			PROGRAMS , , Laboration of the second		ment	t
	(Check all that apply)	 c. Resident prefers change in location of activities d. Resident prefers activity at different time of day X e. Resident prefers stability in daily routine f. NONE OF ABOVE 			Special care unit X n. Transportation X f. Hospice care o. Psychological rehabil X g. Home health p. Formal education X h. Home care q. NONE OF ABOVE	itation		
7	7. INTERACTION WITH FAMILY AND FRIENDS	last 30 days? (check only one)			b. THERAPIES-Record the number of days each of the following the administered (for at least 15 minutes a day) in the last 7 calendar 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	r days (Was (Enter (E) SITE (C)	
		X 3. 1-3 times/month 6. Daily			Check C if therapy was received out-of-home or facility		ON SI	CFT 0
		b. How often has resident talked by telephone with family and friends in the last 30 days? (check only one)			a. Speech-language pathology and auditory services	0	+	
		1. No family or friends outside X 4. Once a week			b. Occupational therapy c. Physical therapy	0	+	_
		facility 5. 2 or 3 times a week but not			d. Respiratory therapy	0	_	_
		2. None daily 3. 1-3 times/month 6. Daily			e. Psychological therapy (by any licensed mental health professional)	0		
-	8. VOTING	Is resident registered to vote? X 0. No I. Yes	2.	INTER-	(Check all interventions or strategies used in the last 7 days unle. specified-no matter where received)	ss othe	r tim	e
	9. SOCIAL ACTIVITES (Check only one.)	Resident's current level of participation in social, religious or other personal activities compared to resident's status 180 days ago (since admission if less than 180 days): X 0. No change 1. Improved 2. Declined		VENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	a. Special behavior symptom evaluation program b. Special behavior	terns-e	•	
SF	ECTION O. MED	ICATIONS			management program X f. Reorientation-e.g.,	•		
	1. NUMBER OF MEDICATIONS	(Record the number of different medications used in the last 7 days;			c. Evaluation by a licensed mental health specialist in h. Crisis intervention i	n facilit	-	
:	2. NEW MEDICATIONS	(Resident currently receiving medicatons that were initiated during the last 90 days)			last 90 days i. Crisis stabilization d. Group therapy 90 days e. Resident-specific j. Other (specify)	unit in la	ast	
;	3. INJECTIONS	(Record the number of DAYS injections of any type received during the last 30 days ; enter "0" if none used)			deliberate changes in the k. NONE OF ABOVE			

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 Facility Provi

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Res	ident Name:	THOMAS B ANTHONY Date: 08/13/2004		Soc. S	ec. #	07-02-7907	_ Facility Provider #	1999
SEC	TION P. SPEC	IAL TREATMENTS AND PROCEDURES (cont.)		SEC	TION Q. SER	/ICE PLANNING		
3.	NEED FOR ON-GOING MONITORING REHABILITA-	(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 RECORD THE number of days each of the following rehabilitation or restorative	'n	1.	RESIDENT GOALS (Check all areas in which resident has self-identified goals)	a. Health promotion/ X b. Social involvement c. Activities/hobbies/ X d. Rehabilitation–skille e. Maintaining physic f. Participation in the g. Other (specify) h. No goals	/making friends 'adult learning ed cal or cognitive function e community	
	TION/ Restorative Care	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.)		2.	CONFLICT	 a. Any disagreement be service plan? b. Any disagreement be 	etween resident and family about g (0. No	
		TRAINING/SKILL PRACTICE IN: 0 d. Bed mobility 0 i. Amputation/prosthesis care		SEC	TION R. DISCI	HARGE POTENTIAL		
		0 e. Transfer 0 j. Communication 0 f. Walking 0 k. Time management 0 g. Dressing or grooming 0 I. Other (specify)		1.	DISCHARGE Potential	🛛 🗶 0. No 🗌 1. Ye	support person who is positive tow	
5.	SKILL Training	0 h. Eating or swallowing Record the number of days, in the last 30 days that each of the following IADL were performed with assistance from staff as a skill training activity identified in the resident's service plan. 0 a. Meal Preparation (snacks, 0 h. Arranges Shopping	5				ficiency changed compared to 6 m	
		light meals) (makes list, acquires		SEC	TION S. ASSE	SSMENT INFORMATION		
		0 c Light Housework (makes 0 i. Shopping (for groceries,		1.	PARTICIPA- Tion	a. Resident: 0.	No X 1.Yes	
		own bed, takes care of incidentals)			IN I	b. Family: X 0. N	lo 🗌 1. Yes 🗌 2. No Family	
		d. Laundry (sorts, folds, or j. Transportation (travel by			MENT	c. Other Non-Staff: X 0. N	lo 🗌 1. Yes 🗌 2. None	
		0 e. Managing Incontinence values in teams to get to medical appointments or other necessary		2.	SIGNATURES NANCY	SOF PERSONS COMPLET SMITH RCA	ING THE ASSESSMENT: COORINATOR	
		Supplies (pads, briefs, engagements)			a. Signature	e of Assessment Coordinator	r (sign on line above)	
		f. Managing Cash (handles			b. Date Ass	essment Coordinator signed	l as complete $0 8 - 18 -$	2 0 0 4
		0 g. Managing Finances (banking, handling checkbook, or paying bills) 0 I. Other (specify)			c . Other Sign	atures Title	Sections	Year Date
6.	ADHERENCE WITH	In the last 6 months, compliant all or most of the time with special treatments, therapies and programs:			d.			Date
	TREATMENTS/ THERAPIES/	X0. Always compliantImage: Image: Imag			e.			Date
	PROGRAMS	1. Compliant 80% of time 8. Unknown 2. Compliant less than 80% of the time		3.	CASE MIX GROUP]	Date
7.	GENERAL HOSPITAL	Record number of times resident was admitted to an acute care hospital with an overnight stay in last 6 months (or since last 0	0	SEC	TION T. Preve	ntive Health/Health Behavi	ors	
	STAY(S)	assessment if less than 6 months.) (Enter "0" if no hospital admissions)	Ū		PREVENTIVE		the resident received during the pa	st 12 months)
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)	1		HEATH	X a. Blood pressure mor b. Hearing assessme	nt h. Pap smear	0
9.	PHYSICIAN VISITS	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)	5			 c. Vision test d. Dental visit X e. Influenza vaccine 	☐ i. PSA or rectal ex ☐ j. Other (<i>specify</i>)	.am
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))			f. Pneumococcal vac (ANY time)	cine	
11.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission if less than 90 days)? 0. No 1. Yes		P11 =)			
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))					

Facility Provider #_____

SECTION U. MEDICATIONS LIST

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

1. List the medication name and the dosage

2. RA (Route of Administration). Use the appropriate code from the following list:

1 = by mouth (PO)	3 = intramuscular (IM)	5 = subcutaneous (SubQ)	7 = topical	9 = enteral tube
2 = sublingual (SL)	4 = intravenous (IV)	6 = rectally	8 = inhalation	10 = other
0 ()		,		

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

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

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

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

1. Medication Name and Dosage	2. RA	3. Freq	4. PRN-n	5. NDC Codes
EXAMPLE: Coumadin 2.5 mg Digoxin 0.125 mg Humulin R 25 Units Robitussin 15cc	1 1 5 1	1W 1D 1D PR	2	
ACELAMINOPHEN 325 MG	01	PR	00	0 0 8 7 1 1 2 9 4 0 0
LOTRISONE CR	07	PR	02	0 0 0 8 5 0 9 2 4 0 2

MINIMUM DATA SET (MDS)[©] RESIDENTIAL CARE ASSESSMENT (RCA)

BASIC ASSESSMENT TRACKING FORM

GENERAL INSTRUCTIONS:

Complete this form for all assessments and discharges.

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	Bertha D Brown
		a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER	I. Male X 2. Female
3.	BIRTHDATE	$ \underbrace{0 3}_{\text{Month}} - \underbrace{0 7}_{\text{Day}} - \underbrace{1 9 7 5}_{\text{Year}} $
4.	RACE/ ETHNICITY (Check only one.)	□ 1. American Indian/Alaskan Native □ 4. Hispanic □ 2. Asian/Pacific Islander X 5. White, not of Hispanic origin □ 3. Black, not of Hispanic origin □ 6. Other
5.	SOCIAL SECURITY and MEDICARE NUMBERS (C in 1 st box if no med. no.)	a. Social Security Number 5 2 9 7 5 8 4 8 6 b. Medicare number (or comparable railroad insurance number)
6.	FACILITY NAME AND PROVIDER NO.	a. Facility Name MCBVI b. Provider No. 9 9 9 9 9 9 9 9
7.	MAINECARE No.	[Record a "+" if pending, "N" if not a MaineCare recipient]
8.	SIGNATURE(S)	OF PERSON(S) COMPLETING FACE SHEET:
a. C	vancy Sr	nith RCA ^T Director Ålf ^{tions} 7/15/2004
b.		Date
C.	DATE Completed	Record date background information was completed. 0 7 1 5 Anoth Day Year

MINIMUM DATA SET (MDS)[©] RESIDENTIAL CARE ASSESSMENT (RCA)

FACE SHEET: BACKGROUND INFORMATION ONLY AT ADMISSION

Res	ident Name:	Bertha D. Brown Date	7/13/2004		Soc. Sec.	#: 529-75-8486 Facility Provider #: 9999999999
SE	CTION AB.	DEMOGRAPHIC INFORMATION		SE	CTION AC.	CUSTOMARY ROUTINE
1.	DATE Of Entry	Date the stay began. (Note — Does not include readmission if record time of temporary discharge to hospital, etc. In such cases, use prior $ \begin{array}{c c} 0 & 7 \\ \hline 0 & 3 \\ \hline 0 & 7 \end{array} - \begin{array}{c c} 0 & 3 \\ \hline 0 & 7 \end{array} - \begin{array}{c c} 1 & 9 & 9 & 4 \\ \hline 0 & 2 & Year \end{array} $		1.	CUSTOMARY ROUTINE (In year prior to DATE OF ENTRY	(Check all that apply. If all information UNKNOWN, check last box [z] only.) CYCLE OF DAILY EVENTS a. Stayed up late at night (e.g., after 9 pm) b. Napped regularly during day (at least 1 hour)
2.	ADMITTED FROM (AT ENTRY) (Check only one.)	X 1. Private home/apt. 2. Other board and care/assisted living/group home 3. Nursing home 4. Acute care hospital 5. Psychiatric hospital 6. MR/DD facility 7. Rehabilitation hospital 8. Other (specify)			to this home, or year last in community if now being admitted from another home, nursing home, or hospital)	 X c. Went out 1+ days a week X d. Stayed busy with hobbies, reading, or a fixed daily routine e. Spent most of time alone or watching TV X f. Moved independently indoors (with appliances, if used) g. Used tobacco products at least daily h. NONE OF ABOVE EATING PATTERNS i. Distinct food preferences
3.	LIVED ALONE (PRIOR TO ENTRY) (Check only one.)	X 0. No □ 1. Yes □ 2. In other facility				 □ j. Ate between meals all or most days □ k. Used alcoholic beverage(s) at least weekly X I. NONE OF ABOVE
4.	PRIOR PRIMARY RESIDENCE	Maine Maine Town State	0 7 5 p Code			ADL PATTERNS m. In bedclothes much of day n. Wakened to toilet all or most nights X o. Had irregular bowel movement pattern
5.	RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	 (Check all settings resident lived in during 5 years prior to date of entigiven in item AB1 above) X a. Prior stay at this home b. Nursing home c. Other residential facility—board and care home, assisting or phome d. MH/psychiatric hospital e. MR/DD facility f. NONE OF ABOVE 				X p. Shower for bathing q. Sponge bath r. Bathed in PM s. NONE OF ABOVE INVOLVEMENT PATTERNS X t. Daily contact with relatives/close friends u. Usually attended church, temple, synagogue (etc.) X v. Found strength in faith X w. Daily animal companion/presence
6.	LIFETIME Occupation	Put a "/" between two occupations. S t u d e n t i				x. Involved in group activities y. NONE OF ABOVE z. UNKNOWN—Resident/family unable to provide information
7.	EDUCATION (Highest Level Completed) (Check only one.)	□ 1. No schooling X 5. Technical or trade so □ 2. 8th grade or less □ 6. Some college □ 3. 9-11 grades □ 7. Bachelor's degree □ 4. High school ■ 8. Graduate degree	chool	SE	CTION AD.	FACE SHEET SIGNATURES and DATES
8.	PRIMARY LANGUAGE (Check only one.)	X 0. English 2. French 1. Spanish 3. Other (specify)		a. S	Signatures	DF PERSON(S) COMPLETING FACE SHEET: Title Sections Date MITH RCA DIRECTOR ALL 07/15/1994
9.	MENTAL Health History	Does resident's RECORD indicate any history of the following? a. Mental retardation X. 0. No 1. Ye b. Mental illness X 0. No 1. Ye c. Developmental disability X 0. No 1. Ye	/es	b. 2.	DATE COMPLETED	Date Record date background information was completed. 0 7 1 5 1 9 9
10.	CONDITIONS RELATED TO MR/DD STATUS	(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely) X a. Not applicable—no MR/DD (Skip to AB11) MR/DD with organic condition b. Down's syndrome e. Cerebral palsy C Autism f. Other organic condition regulation d. Epilepsy g. MR/DD with no organic condition	elated to MR/DD			Month Day Year
11.	alzheimer Dementia History	Does resident's RECORD indicate any history of the following?a. Alzheimer's diseaseXb. Dementia other than Alzheimer's diseaseX0. No	□ 1. Yes □ 1. Yes			

CONFIDENTIAL MINIMUM DATA SET (MDS)[®] RESIDENTIAL CARE ASSESSMENT (RCA)

(STATUS IN LAST 7 DAYS UNLESS OTHERWISE NOTED)

SE				CTION C.	COMMUNICATION/HEARING PATTERNS							
S⊑ 1.	RESIDENT	Bertha D Brown	1.	HEARING	(With hearing appliance, if used)							
	NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)		(Check only one.)	X 0. HEARS ADEQUATELY—normal talk, TV, phone							
2.	SOCIAL	a. Social Security Number			1. <i>MINIMAL DIFFICULTY</i> when not in quiet setting							
-	SECURITY and MEDICARE	5 2 9 - 7 5 - 8 4 8 6			2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust							
	NUMBERS	b. Medicare number (or comparable railroad insurance number)			tonal quality and speak distinctly 3. <i>HIGHLY IMPAIRED</i> –absence of useful hearing							
	(C in 1 st box if no med. no.)				5							
	no meu. no.)		2.	COMMUNICA- TION DEVICES/	(Check all that apply during last 7 days.)							
3.	FACILITY	a. Facility Name MCBVI		TECHNIQUES	a. Hearing aid, present and used							
	AND	b. Provider No.			 b. Hearing aid, present and not used regularly c. Other receptive communication techniques used (e.g., lip reading) 							
	PROVIDER NO.				X d. NONE OF ABOVE							
		9 9 9 9 9 9 9 9 9 9	3.	MAKING SELF	(Expressing information content—however able)							
4.	MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient]	0.	UNDERSTOOD								
	NU.	0 4 2 3 2 7 9 1 A		(Check only one.)	X 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or							
-	100500105117				finishing thoughts							
5.	ASSESSMENT DATE	Last day of observation period $\begin{array}{c ccccccccccccccccccccccccccccccccccc$			2. SOMETIMES UNDERSTOOD—ability is limited to making							
					concrete requests 3. RARELY/NEVER UNDERSTOOD							
-		Month Day Year (Check primary reason for assessment)			(Understanding information content—however able)							
6.	REASON FOR ASSESSMENT		4.	ABILITY TO UNDERSTAND								
		X 2. Annual assessment 5. Other (specify)		OTHERS	X 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part / intent of							
		3. Significant change in status assessment		(Check only one.)	message							
7.	MARITAL	X 1. Never married 3. Widowed 5. Divorced			2. SOMETIMES UNDERSTANDS—responds adequately to simple,							
	STATUS (Check only one.)	2. Married 4. Separated			direct communication 3. RARELY/NEVER UNDERSTANDS							
8.	CURRENT	(Billing Office to indicate; check all that apply in last 30 days or since last admission if less than 30 days)	5.	0000000000								
	PAYMENT		5.	COMMUNICA- TION	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							
	SOURCES FOR STAY	c. Thirdle pay		(Check only one.)	180 days.							
		X b. SSI f. Private insurance C. VA (including co-payment)			X 0. No change . 1. Improved . 2. Declined							
		C. VA (including co-payment) d. Social Security g. SSDI	SE		VISION PATTERNS							
		h. Other <i>(specify)</i>	_		(Ability to see in adequate light and with glasses if used)							
9.	RESPONSI-	(Check all that apply)	1.									
	BILITY/ Legal	a. Legal guardian e. Family member responsible		(Check only one.)	O. ADEQUATE—sees fine detail, including regular print in newspapers/books							
	GUARDIAN	b. Other legal oversight X f. Self			I. IMPAIRED—sees large print, but not regular print in newspapers/							
		C. Durable power of g. Legal Conservator attorney/health care h. Representative Payee			books							
		d. Durable power of i. NONE OF ABOVE			2. MODERATELY IMPAIRED—limited vision; not able to see							
		attorney/financial			newspaper headlines, but can identify objects 3. <i>HIGHLY IMPAIRED</i> —object identification in guestion, but eyes							
10.	ADVANCED	Does resident have any of the following advanced directives in place? a. Living Will X 0. No 1. Yes			appear to follow objects							
	DIRECTIVES	b. Do not resuscitate (DNR) X 0. No			X 4. SEVERELY IMPAIRED—no vision or sees only light, colors, or							
		c. Do not hospitalize X 0. No 1. Yes	2. VISUAL		shapes; eyes do not appear to follow objects							
		d. Organ donation X 0. No I. Yes		VISUAL Appliances	a. Glasses, contact lenses X 0. No 🗆 1. Yes							
		e. Other X 0. No I 1. Yes			b. Artificial eye X 0. No 🗆 1. Yes							
		(If "yes," specify)	SE	CTION E. I	MOOD AND BEHAVIOR PATTERNS							
SF	CTION B	COGNITIVE PATTERNS	1.	INDICATORS	(CODE: Record the appropriate code for the frequency of the symptom(s)							
_		(Recall of what was learned or known)		OF DEPRESSION,	observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days							
1.	MEMORY	a. Short-term memory OK—seems/appears to recall after 5 minutes		ANXIETY,	 This type exhibited up to 5 days a week 							
		X 0. Memory OK I. Memory problem		SAD MOOD	2. This type exhibited daily or almost daily (6, 7 days/week)							
		b. Long-term memory OK—seems/appears to recall long past			VERBAL EXPRESSIONS OF DISTRESS							
		X 0. Memory OK I. Memory problem			<u>0</u> a. Resident made negative statements—e.g., "Nothing matters;							
2.	MEMORY/	(Check all that resident was normally able to recall during last 7 days)			Would rather be dead; What's the use; Regrets having lived so long; Let me die."							
1	RECALL	Xa.Current seasonXd.That he/she is in a facility/home			0 b. Repetitive questions—e.g., "Where do I go; What do I do?"							
	ABILITY	X b. Location of own room e. NONE OF ABOVE are recalled			c. Repetitive verbalizations—e.g., calling out for help,							
		X c. Staff names/faces			("God help me")							
3.	COGNITIVE	(Made decisions regarding tasks of daily life)			0_ d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in facility; anger at care received							
	SKILLS FOR DAILY	X 0. INDEPENDENT—decisions consistent/reasonable			e. Self deprecation—e.g.,"I am nothing; I am of no use to anyone"							
	DECISION-	1. MODIFIED INDEPENDENCE—some difficulty in new situations only			f. Expressions of what appear to be unrealistic fears—e.g., fear of							
	MAKING	2. MODERATELY IMPAIRED—decisions poor; cues/			being abandoned, left alone, being with others							
	(Check only one.)	supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions			0 g. Recurrent statements that something terrible is about to happen							
-	COONTRAC	-			-e.g., believes he or she is about to die, have a heart attack							
4.	COGNITIVE Status	Resident's cognitive status or abilities now compared to resident's status 180 days ago (or since admission if less than 180 days).			0_ h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions							
	(Check only one.)	X 0. No change										
		1. Improved			0_ i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding							
		2. Declined			schedules, meals, laundry, clothing, relationship issues							
			1	1	(continued next page)							

CONFIDENTIAL 7/13/2004 Date:___

Soc. Sec. #_

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1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	 (CODE: Record the appropriate code for the frequency of the symptoning 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/w SLEEP-CYCLE ISSUES 	veek) furrow	ved b	prows	2.	SENSE OF INITIATIVE/ INVOLVEMENT (Check all that apply) UNSETTLED RELATION- SHIPS (Check all that apply)	 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 frier involved in group activities; responds positively to new activ assists at religious services) X f. Accepts invitations into most group activities g. NONE OF ABOVE a. Covert/open conflict with or repeated criticism of staff b. Unhappy with roommate c. Unhappy with residents other than roommate X d. Openly expresses conflict/anger with family/friends 	
		LOSS OF INTEREST00. Withdrawal from activities of interest—e.g., no i0 p. Reduced social interaction	nteres	st in I	long			 e. Absence of personal contact with family/friends f. Recent loss of close family member/friend g. Does not adjust easily to change in routines h. NONE OF ABOVE 	
		INDICATORS OF MANIA 2q. Inflated self-worth, exaggerated self-opinion; inf about one's own ability, etc. 2r. Excited behavior, motor excitation (e.g., heighte activity; excited, loud or pressured speech; increativity; excited, loud or pressured speech; increativity;	ened p	ohysi	ical	3.	LIFE- EVENTS HISTORY (Check all	Events in past 2 years a. Serious accident or physical illness b. Health concerns for other person c. Death of family member or close friend d. Trouble with the law	
	MOOD PERSISTENCE (Check only one.)	Check if one or more indicators of depressed, sad or anxiou (above) were not easily altered by attempts to "cheer up", or reassure the resident over last 7 days . X 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	s mod	od			that apply.)	 e. Robbed/physically attacked X f. Conflict laden or severed relationship g. Loss of income leading to change in lifestyle h. Sexual assault/abuse i. Child custody issues 	
3.	MOOD (Check only one.)	Resident's current mood status compared to resident's status (or since admission if less than 180 days): X 0. No change 1. Improved 2. Decli	ined		s ago			j. Change in marital/partner status k. Review hearings (e.g., forensic, certification, capacity hearin l. NONE OF ABOVE PHYSICAL FUNCTIONING	ng)
4.	BEHAVIORAL Symptoms	(COLUMN A CODES: Record the appropriate code for the frequency of the symptom in	<i>behav</i> <i>last 7</i> it or ea	<i>rioral <mark>7 days</mark></i> asily a	<u>s</u>) alterec	1.	 (A) ADL SELI <i>INDEPENDE</i> during last <i>SUPERVISIC</i> days — OR times durin <i>LIMITED AS</i> maneuverin 	F-PERFORMANCE EN7—No help or oversight —OR— Help/oversight provided only 1 or 2 tin 7 days ION—Oversight, encouragement or cueing provided 3 or more times durin R— Supervision (3 or more times) plus physical assistance provided only ng last 7 days SISTANCE—Resident highly involved in activity; received physical help in ing of limbs or other non-weight bearing assistance 3 or more times —OF	ng last 1 or 2 guideo R—
	WANDERING needs or safet	(moved with no rational purpose, seemingly oblivious to (y)	0	0	0		3. EXTENSIVE	sistance (3 or more times,) plus weight-bearing support provided 1 or 2 ti ASSISTANCE —While resident performed part of activity, over last 7-day per owing type(s) provided 3 or more times:	
		BUSIVE BEHAVIORAL SYMPTOMS (others were reamed at, cursed at)	0	0	0			-bearing support ff performance during part (but not all) of last 7 days	
		ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, ched, sexually abused, gross physical assault)	0	0	0			ENDENCE—Full staff performance of activity during last 7 days IND NOT OCCUR DURING LAST 7 DAYS	
	SYMPTOMS public, smeare	APPROPRIATE/DISRUPTIVE BEHAVIORAL (made disruptive sounds, sexual behavior, disrobing in sd/threw food/feces, hoarding, rummaged through others' ealing, self-abusive acts, substance abuse, self-mutilation)	0	0	0		HOUR PERIC		A
e.	0.0	RE (resisted taking medications/ injections, ADL	0	0	0		1. Setup he	ip or physical help from staff ielp only irson physical assist	SELF- PERFORMANCE
	INTIMIDATIN(invaded)	G BEHAVIOR (made others feel unsafe, at risk, privacy	0	0	0			ersons physical assist did not occur during entire 7 days	PERFO
-	ELOPEMENT		0	0	0	a.		TY – How resident moves to and from lying position, turns side to itions body while in bed	0
	Dangerous no Dangerous vio	n-violent behavior (e.g., falling asleep while smoking) blent behavior	-	0	0	b.		- How resident moves between surfaces—to/from: bed, chair, tanding position (EXCLUDE to/from bath/toilet)	0
j. 5.	FIRE SETTIN SUICIDAL IDEATION	G Resident demonstrated suicidal thoughts or actions in the las X 0. No I 1. Yes	÷	0 days	0 s:	C.	LOCOMOTIO areas set asid	DN – How resident moves to and returns from other locations (e.g., de for dining, activities, or treatments). If facility has only one floor, moves to and from distant areas on the floor. If in wheelchair, self-	0
6.	SLEEP PROBLEMS	Check all present on 2 or more days during last 7 days a. Inability to awaken when desired d. Interrupted				d.		- How resident puts on, fastens, and takes off all items of street uding donning/removing prosthesis	0
0.	THODLEWIS	X b. Difficulty falling asleep					nourishment b	by resident eats and drinks (regardless of skill). Includes intake of by other means (e.g., tube feeding, total parenteral nutrition)	0
0.						f.			
7.	INSIGHT INTO Mental	c. Restless or non-restful sleep Resident has insight about his/her mental problem X 0. No 1. Yes 2. No mental hea	lth pro	obler	ms		urinal); transfe catheter, adjus	 How resident uses the toilet room (or commode, bed- pan, er on/off toilet, cleanses, changes pad, manages ostomy or sts clothes HYGIENE – How resident maintains personal hygiene, including 	0
	INTO Mental Health Behaviors	c. Restless or non-restful sleep Resident has insight about his/her mental problem			ms	g.	urinal); transfe catheter, adjust PERSONAL F combing hair,	er on/off toilet, cleanses, changes pad, manages ostomy or sts clothes HYGIENE – How resident maintains personal hygiene, including brushing teeth, shaving, applying makeup, washing/drying face, erineum (EXCLUDE baths and showers)	0 0 0

SELF-PERFORMANCE SUPPORT

> 0 0

0 0

0 0

0 0

0 0

0 0

Res	ident Name:	_Bertha Brown Date:_7-13-2004		Soc	. Sec. #52	9-75-8486 Facility Provider #_9999999999
SE	CTION G. P	HYSICAL FUNCTIONING (cont.)		SE	CTION G.	PHYSICAL FUNCTIONING (cont.)
2.	BATHING SELF- Performance	 X 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 	s in/out <u>s</u> t			 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
3A.	MODES OF Locomotion	(Check all that apply during last 7 days) a. Cane/walker/crutch b. Wheeled self c. Other person wheeled X d. 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 b. Hearing aid (e.g., button hook, velcro closings) c. Cane or walker g. Dentures
3B.	MAIN Mode of Locomotion	Was wheelchair the primary mode of locomotion during the last 7 day X 0. No 1. Yes	ys?			d. Wheelchair h. Other (specify) e. Assistive feeding devices (e.g., plate X i. NONE OF ABOVE
3C.	BEDFAST/ Chairfast	(Check if health condition keeps resident in his/her room 22+ hours p in last 7 days)	oer day			guard, stabilized built-up utensil)
		 a. Bedfast all or most of time b. Chairfast all or most of the time X c. NONE OF ABOVE 		8.	SELF- Performance In Iadls	Resident's current IADL status or abilities compared to resident's status 180 days ago (or since admission if less than 180 days): X 0. No change 1. Improved 2. Declined
4.	SELF-	Resident's current ADL status or abilities compared to resident's stat	us 180	SE	CTION H.	CONTINENCE IN LAST 14 DAYS
	PERFORMANCE IN ADLs (Check only one.) (Check only			1.	(Code for res 0. CONTIN	CE SELF-CONTROL CATEGORIES <i>ident's PERFORMANCE OVER ALL SHIFTS)</i> <i>ENT</i> —Complete control (includes use of indwelling urinary catheter or evice that does not leak urine or stool)
5A.	IADL SELF- PERFOR- MANCE	 Code for level of independence in the last 30 days based on residen involvement in the activity. SELF-PERFORMANCE CODES: INDEPENDENT : (with/without assistive devices)—No help p DONE WITH HELP: Resident involved in activity but help (inc supervision, reminders, and/or physical help) is provided. DONE BY OTHERS: Full performance of the activity is done by others. The resident is involved at all when the activity is performed. 	rovided. Iuding	a.	BOWEL, 2. OCCASI daily; BO 3. FREQUE some cor 4. INCONTI all (or alm	Y CONTINENT—BLADDER, Incontinent episodes once a week or less; less than weekly ONALLY INCONTINENT—BLADDER, 2 or more times a week but not WEL, once a week ENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but throl present (e.g. on day shift); BOWEL, 2-3 times a week NENT—Had inadequate control BLADDER, multiple daily episodes; BOWEL, ost all) of the time Control of bowel movement, with appliance or bowel continence programs, if employed
		 Activity did not occur in the last 30 days. 		b.	BLADDER	Control of urinary bladder function with appliances (e.g. foley) or
		IADL	SELF- PERFORMANCE	2.	CONTINENCE	continence programs, if employed 0 Bowel elimination pattern regular—at least one movement every three days Diarrhea c. A. Fecal Impaction d. Resident is Independent e.
		a. Resident arranged for shopping for clothing, snacks, other incidentals.	0	3.	APPLIANCES	Constipation b. X NONE OF ABOVE f.
		b. Resident shopped for clothing, snacks, or other incidentals.	0	3.	and PROGRAMS	Any scheduled toileting plan a. Did not use toilet room/ commode/urinal f.
		 Resident arranged for suitable transportation to get to appointments, outings, necessary engagements. 	0		FROUNAINS	External (condom) catheter c. Pads/briefs used g.
		d. Resident managed finances including banking, handling checkbook, or paying bills.	0	1		Indwelling catheter d. Enemas/irrigation h. Intermittant entheter e. Ostomy present i.
		e. Resident managed cash, personal needs allowance.	0			Intermittent catheter
		f. Resident prepared snacks, light meals.	0	4.	USE OF INCONTINENC	Resident's management of incontinence supplies (pads, briefs, ostomy, catheter) in last 14 days.
		g. Resident used phone.h. Resident did light housework such as making own bed,	0		SUPPLIES (Check only one.)	X 0. Always continent
		dusting, or taking care of belongings. i. Resident sorted, folded, or washed own laundry.	0			independently. 2. Resident incontinent and receives assistance with managing
5B.	TRANSPOR- Tation	Check all that apply for level of independence in the last 30 days bas on resident's involvement in the activity.				 a. Resident incontinent and does not use incontinence supplies. a. Resident incontinent and does not use incontinence supplies.
		 a. Resident drove car or used public transportation independent get to medical, dental appointments, necessary engagements other activities. X b. Resident rode to destination with staff, family, others (in car, vai public transportation) but was not accompanied to medical, 	s, or	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): X 0. No change 1. Improved 2. Deteriorated
		dental appointments, necessary engagements, or other activit				IAGNOSES
		 X c. Resident rode to destination with staff, family, others (in car, val public transportation) and <u>was accompanied</u> to medical, den appointments, necessary engagements, or other activities. d. Activity did not occur. 		and	l behavior statu	diagnoses that have a relationship to current ADL status, cognitive status, mood is, medical treatments, nurse monitoring, or risk of death. (Do not list inactive le apply, CHECK item xx. NONE OF ABOVE)
6.	ADL AND IADL FUNCTIONAL REHABILI- TATION OR IMPROVE- MENT POTENTIAL (Check all that apply.)	 X a. Resident believes he/she is capable of increased independence at least some ADLs or IADLs. X 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 morning evenings e. Resident requires or only understands a one-step direction. <i>(continued in next column)</i> 		1.	DIAGNOSES	ENDOCRINE/METABOLIC/ NUTRITIONAL HEART/CIRCULATION a. Diabetes mellitus d. Arteriosclerotic heart disease (ASHD) b. Hyperthyroidism e. Cardiac dysrhythmia c. Hypothyroidism f. Congestive heart failure g. Deep vein thrombosis h. Hypertension i. Hypotension j. Peripheral vascular disease k. Other cardiovascular disease k. Other cardiovascular disease

_		Bertha D. Brown	7/13/2004	_	_	529-75-8486	999999999	÷
	sident Name:		Date:		Sec #			
SE	CTION I. DIAGI	NOSES (cont.) MUSCULOSKELETAL I. Arthritis m. Hip fracture n. Missing limb (e.g., amputation) o. Osteoporosis	ff. Manic depressive (Bipolar) gg. Schizophrenia PULMONARY hh. Asthma ii. Emphysema/COPD	SEC		LTH CONDITIONS AND POSSIBLI During the last 7 days, how much normal activities such as visiting w 1. All of the time 2. Some of the time	of the time did pain interfere with	resident's
		p. Pathological bone fracture	SENSORY	6.	PAIN MANAGE- MENT	 1. No pain treatment X 2. Treated, full control 	 3. Treated, partial control 4. Treated, no or minimal of the second second	control
		NEUROLOGICAL q. Alzheimer's disease r. Aphasia s. Cerebral palsy	Kk. Diabetic retinopathy Il. Glaucoma mm. Macular degeneration	7.	ACCIDENTS (Check all that apply)	a. Fell in past 30 days	d. Other fracture in last 18 X e. NONE OF ABOVE	
		 L. Cerebrovascular accident (stroke) U. Dementia other than Alzheimer's disease V. Hemiplegia/ hemiparesis M. Multiple sclerosis x. Paraplegia 	X nn. Allergies (<i>specify</i>) <u>LACTOSE</u> oo. Anemia pp. Cancer qq. Benal failure rr. Tuberculosis-TB ss. HIV tt. Mental retardation(e.g., Down's Syndrome, Autism, or other organic condition related to	8.	DANGER OF FALL (Check all that apply)	a. Has unsteady gait b. Has balance problems wh	- nen standing sident or family fearful of resident t	falling
		y. Parkinson's disease	Mental Retardation or Developmental disability (MR/	SEC	CTION K. ORA	L/NUTRITIONAL STATUS		
		z. Quadriplegia aa. Seizure disorder bb. Transient ischemic attack (TIA)	DD) uu. Substance abuse (alcohol or drug) vv. Other psychiatric diagnosis (e.g., paranoia, phobias,	1.	ORAL PROBLEMS (Check all that apply)	a. Mouth is "dry"when eating b. Chewing Problem c. Swallowing Problem	g a meal 🗌 d. Mouth Pain X e. NONE OF ABC)VE
		Cc. Traumatic brain injury PSYCHIATRIC/MOOD dd. Anxiety disorder	personality disorder) ww. Explicit terminal prognosis xx. NONE OF ABOVE	2.	HEIGHT AND WEIGHT	Record (a.) height in inches and (b.) u measure in last 30 days; measure weig practice-e.g., in a.m. after voiding, before	ght consistently in accord with standau ore meal, with shoes off, and in nightc	rd facility
		ee. Depression			WEIQUT	a. HT (in.)		-
2	. OTHER CURRENT DIAGNOSIS	a	008.45	3.	WEIGHT Change	a. Unintended weight loss–5% more in last 180 days X 0. No 1. Ye:		, or
	AND ICD-9 CODES	b c				b. Unintended weight gain–5% more in last 180 days		or
SEC	CTION J. HEAL	TH CONDITIONS AND POSSIBI	LE MEDICATION SIDE EFFECTS			X 0. No 1. Yes	s	
1	PROBLEM CONDITIONS	 (Check all problems present in last a. Inability to lie flat due to shortness of breath b. Shortness of breath c. Edema d. Dizziness/vertigo e. Delusions f. Hallucinations 	 t7 days unless other time frame is indicated) i. Headache j. Numbness/tingling k. Blurred vision I. Dry mouth m. Excessive salivation or drooling n. Change in normal appetite 	4.	NUTRI- TIONAL PROBLEMS OR AP- PROACHES (Check all that apply)	 a. Complains about the taster of many foods b. Regular or repetitive complaints of hunger c. Leaves 25% of food uneaten at most meals d. Therapeutic diet e. Mechanically altered (or pureed) diet 	 f. Noncompliance with a g. Eating disorders h. Food allergies (specify) i. Restrictions (specify) X j. NONE OF ABOVE 	diet
		g. Hostility	O. Other (specify)	SEC	TION L. ORA	L/DENTAL STATUS		
2	EXTRA- PYRAMIDAL SIGNS AND SYMPTOMS	h. Suspiciousness Check all present at any point d INCREASE IN MOTOR ACTIVITY X a. Akathisia-resident report need for movement b. Dyskinesia-chewing, pu irregular movements of C. Tremor-regular rhythmia mouth, or tongue DECREASE IN MOTOR ACTIVITY	X p. NONE OF ABOVE	1.	ORAL STATUS AND DISEASE PREVENTION (check all that apply)	 a. Has dentures or removable b. Some/all natural teeth lost (or partial plates) c. Broken, loose or carious to d. Inflamed gums (gingiva); sulcers or rashes 	t-does not have or does not use of eeth swollen or bleeding gums; oral ab ntures or daily mouth care-by resi	oscesses;
		continuous or cogwheel		SEC	CTION M. SKI	N CONDITION		
		usually with a decrease f. Bradykinesis–decrease body movement or <i>pove</i> MUSCLE CONTRACTIONS g. Dystonia–muscle hyper	in pendular arm movement in spontaneous movements (e.g., reduced <i>erty of</i> facial expression, gestures, speech) tonicity (e.g., muscle spasms or stiffness, ard deviation of the eyes)	1.	SKIN PROBLEMS (Check all that apply) ULCERS	Any troubling skin conditions or ct a. Abrasions (scrapes) or cu b. Burns (2nd or 3rd degree) c. Bruises X d. Rashes, itchiness, body licc Record the number of ulcers at eacl If none present at a stage, record "0	e Open sores or lesic f. Other (<i>specify</i>) g. NONE OF ABOVE h ulcer stage-regardless of cause.	
3	PAIN	(Code the highest level of resident's	s pain present in the last 7 days) 01		(Due to	last 7 days. Code 9=9 or more) Req		Number at Stage
	SYMPTOMS	On a scale of 1 to 10, where 1 is			any cause)	a. Stage 1. A persistent area of skir the skin) that does not disappear w	hen pressure is relieved.	ਟ ਢ 1
4	PAIN SITE	(If pain is present in the last 7 days) a. Back pain	s)			b. Stage 2. A partial thickness loss of clinically as an abrasion, blister, or s	shallow crater.	0
		 b. Bone pain c. Chest pain while doing 	 g. Joint pain (other than hip) h. Soft tissue pain (e.g., lesion, 			c. Stage 3. A full thickness of skin is ous tissues–presents as a deep cra undermining adjacent tissue.		0
		usual activities X d. Headache	muscle)			d. Stage 4. A full thickness of skin a exposing muscle or bone.	ind subcutaneous tissue is lost,	0
		🗌 e. Hip pain	j. Other (specify)	L	1			

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

		CONF	DENTI	AL			
Re	sident Name:	Bertha D. Brown 7/13/2004 Date:	Soc.	5 Sec #	529-75-8486 999999999 Facility Provider #		
SE	ECTION M. SKI				DICATIONS (cont.)		
	3. FOOT PROBLEMS	 a. Resident or someone else inspects resident's feet on a regular basis? X 0. No	4A 4B	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) 0a. Antipsychotic _0d. Hypnotic _0g. 0b. Antianxiety _0e. Diuretic g. 0c. Antidepressant f. Aricept	Ins	ulin
				MEDICATIONS	emotional or nervous condition, or behavioral problem?		
	TINAE						
	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: X a. Morning d. Night (Bedtime to A.M.) X b. Afternoon X c. Evening	5.	SELF- ADMINSTERED MEDICATIONS (Check all that apply.)	a. Insulin a. Insulin b. Oxygen X f. Over-the-counter Meds		_
2	2. AVERAGE TIME INVOLVED IN	(When awake and not receiving treatments or ADL care) 1. Most-more than 2/3 of time	6.	MEDICATION Preparation Administra-		day	ys?
	ACTIVITIES (Check only one.)	 X 2. Some-from 1/3 to 2/3 of time ☐ 3. Little-less than 1/3 of time ☐ 4. None 		TION	 0. No Meds 1. Resident prepared and administrated <u>NONE</u> of his/her own medica 2. Resident prepared and administrated <u>SOME</u> of his/her own medication X 3. Resident prepared and administrated <u>ALL</u> of his/her own medication 	atior	ns.
3	3. PREFERRED	(Check all settings in which activities are preferred)	7.				
	ACTIVITY Settings	X a. Own room X d. Away from facility b. Day/activity room e. NONE OF ABOVE		MEDICATION	Resident's level of compliance with medications prescribed by a phys psychiatrist during last 30 days: 0. No Meds	icia	.n/
		X c. Outside facility (e.g., in yard)		(Check one)	X 1. Always compliant		
4	4. GENERAL ACTIVITY PREFER- ENCES	(Check all PREFERENCES whether or not activity is currently available to resident) X a. Cards/other games K Gardening or plants X b. Crafts/arts I. Talking or conversing X c. Exercise/sports m. Helping others			 Always compliant with reminder, verbal prompts Compliant some of the time (80% of time or more often) or wis some medications 	ith	
	(Adapted to resident's	X c. Exercise/sports m. Helping others d. Dancing n. Doing chores around the		MISUSE	4. Rarely or never compliant Misuse of prescription or over-the-counter medications in the last 6 m		he
	current	X e. Music house/facility	8.	OF	(e.g., resident uses more or less than the directed dose, is using med		
	abilities)	X f. Reading/writing O. Cooking/baking		MEDICATION	for a purpose other than intended) X 0. No 1. Yes		
		g. Spiritual/religious activity p. Computer activities X h. Trips/shopping g. Volunteering	SE	CTION P. SPEC	CIAL TREATMENTS AND PROCEDURES		
		X h. Trips/shopping q. Volunteering i. Walking/wheeling outdoors r. Other (specify)	1.	SPECIAL TREATMENTS,	a. SPECIAL CARE-Check treatments or programs received during the la days [Note-count only post admission treatments]	ist 1	14
		i. Watching TV □ s. NONE OF ABOVE		PROCE-		a rot	turn
\vdash	5. PREFERRED	(Check all that apply)		DURES, AND	a. Chemotherapy or radiation I raining in skills required to to the community (e.g., taki		.um
	ACTIVITY	a. Individual c. Larger group		PROGRAMS	b. Oxygen therapy medications, house work, shopping, transportation, A		2)
	5121	X b. Small group d. No preference			c. Dialysis j. Case management	DL	5)
	6. ENCES IN	a. Resident prefers change in type of activity			PROGRAMS		
	DAILY	b. Resident prefers change in extent of involvement in activities (e.g., more or less)			program I. Sheltered workshop/emplo	ym	ent
		c. Resident prefers change in location of activities			e. Alzheimer's/dementia		
	(Check all that apply)	d. Resident prefers activity at different time of day			special care unit In. Transportation f. Hospice care O. Psychological rehabilitation	n	
		e. Resident prefers stability in daily routine			g. Home health □ p. Formal education		
\vdash		X f. NONE OF ABOVE			h. Home care X q. NONE OF ABOVE		
7	7. INTERACTION WITH FAMILY				b. THERAPIES—Record the number of days each of the following therapies administered (for at least 15 minutes a day) in the last 7 calendar days		
	AND FRIENDS				0 if none or less than 15 min. a day)		
		facility 5. 2 or 3 times a week but not			(Note-count only post admission therapies) (A) = # of days administered for 15 minutes or more		SITE (C)
		2. None daily X 3. 1-3 times/month 6. Daily			Check B if therapy was received at home or in facility Days	N SITE	E SI
		· · · · · · · · · · · · · · · · · · ·			Check C if therapy was received out-of-home or facility (A)	ō	E O
		b. How often has resident talked by telephone with family and friends in the last 30 days? (check only one)			a. Speech-language pathology and auditory services 0 b. Occupational therapy 0	+	+
		□ 1. No family or friends outside X 4. Once a week			b. Occupational therapy 0 c. Physical therapy 0	+	+
		facility 5. 2 or 3 times a week but not			d. Respiratory therapy 0	+	+
		2. None daily 3. 1-3 times/month 6. Daily			e. Psychological therapy (by any licensed mental health professional) 0	T	
-	8. VOTING	Is resident registered to vote? 0. No X 1. Yes	2		Check all interventions or strategies used in the last 7 days unless oth	ier t	ime
	9. SOCIAL ACTIVITES	Resident's current level of participation in social, religious or other personal		VENTION PROGRAMS	specified-no matter where received) a. Special behavior environment to address		
	(Check only	activities compared to resident's status 180 days ago (since admission if less than 180 days):		FOR MOOD, BEHAVIOR.	symptom evaluation mood/behavior patterns-		
	one.)	0. No change X 1. Improved 2. Declined		COGNITIVÉ	program providing bureau in which rummage	11 (0	'
			'	LOSS	b. Special behavior management program	ng	
SE	ECTION O. MEE	(Becard the number of different mediactions used in the last 7 days)			c. Evaluation by a licensed g. Validation/Redirection		
	MEDICATION				mental health specialist in L h. Crisis intervention in facil		
1	2. NEW	(Resident currently receiving medicatons that were initiated during the last 90 days)			last 90 days i. Crisis stabilization unit in d. Group therapy 90 days	las	Τ.
	MEDICATION	X 0. No 🗌 1. Yes			□ u. Group merapy □ u. Group merapy □ e. Resident-specific □ j. Other (specify)		
1	3. INJECTIONS	(Record the number of DAYS injections of any type received during the last 30 days ; enter "0" if none used)			deliberate changes in the X k. NONE OF ABOVE		

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

MDS-RCA ME (Rev 12/03) (RAI © copyright 6/19/95)

			CONFIDENTIA	AL.				
Res	sident Name:	O7/13/200 Bertha D. Brown Date:)4 Soc. Sec	5: # _)	29-75-8486 Facility Pr	rovider #	9999999999	
SE	CTION P. SPEC	IAL TREATMENTS AND PROCEDURES (cont.)	SEC	TION Q. SER	VICE PLANNING			
3.	ON-GOING MONITORING REHABILITA-	(Code for person responsible for monitoring) 0. No monitoring required 2. RCF Other Staff 1. RCF nurse 3. Home health nurse a. Acute physical or psychiatric condition - not chronic b. New treatment/med RECORD THE number of days each of the following rehabilitation or restorative		RESIDENT GOALS (Check all areas in which: resident has self-identified goals)	X d. Rehabilitation-skilled	king friends learning cognitive function mmunity		
	TION/ Restorative Care	techniques or practices was provided to the resident for more than or equal to minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.)	2.	CONFLICT	 a. Any disagreement betwee service plan? b. Any disagreement betwee 	0. No X 1. Yes	0	
5.	SKILL TRAINING	o e. Transfer o j. Communication 0 f. Walking o k. Time management 0 g. Dressing or grooming o l. Other (specify) 0 h. Eating or swallowing Record the number of days, in the last 30 days that each of the following were performed with assistance from staff as a skill training activity identified the resident's spring alago.		DISCHARGE POTENTIAL	 a. Does resident of X1. Yes b. Does resident have a supp discharge? 0. No c. Has resident's self-sufficier since admission, if less that the support of the sup	X 1. Yes ncy changed compared to 6 an 6 months?	towards	
		<u>0</u> a. Meal Preparation (snacks, <u>0</u> h. Arranges Shopping light meals) (makes list, acquires	S					
		b. Telephone Use help)		1	ESSMENT INFORMATION			
		own bed, takes care of incidentals)		TION	a. Resident: 0. No b. Family: X 0. No	X 1. Yes 2. No Fam	nilv	
		0 belongings) 0 j. Transportation (trave		ASSESS- MENT	c. Other Non-Staff: X 0. No			
		0 washes own laundry 0 washes own laundry 1 e. Managing Incontinence Supplies (pads, briefs, ostomy, catheter) o 1 f. Managing Cash (handles cash, makes purchases) o 2 g. Managing Finances (banking, handling checkbook, or paying bills) 0	nts or 2. ra-	SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT: a. Signature of Assessment Coordinator (sign on line above) b. Date Assessment Coordinator signed as complete				
6.	WITH	In the last 6 months, compliant all or most of the time with special treatm therapies and programs:	ents,	d.			Date	
	TREATMENTS/ Therapies/ Programs	X 0. Always compliant 3. No treatments or progra 1. Compliant 80% of time 8. Unknown 2. Compliant less than 80% of the time	ams 3.	e. CASE MIX GROUP			Date	
7.	HOSPITAL	Record number of times resident was admitted to an acute care hospital with an overnight stay in last 6 months (or since last	0 0 SEC		entive Health/Health Behaviors			
	STAY(S)	assessment if less than 6 months.) (Enter "0" if no hospital admissions)		PREVENTIVE	(Check all the procedures the re	esident received during the	past 12 months)	
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)	0 0	HEATH	 X a. Blood pressure monitorir b. Hearing assessment c. Vision test 	ng g. Breast exam h. Pap smear i. PSA or rectal	0	
9.	VISITS	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		 d. Dental visit X e. Influenza vaccine 	X j. Other (specify, LACTOSE		
10	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)	0 1		f. Pneumococcal vaccine (ANY time)			
11.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission if less than 90 days)? 0. No X 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)	0 0					
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)	0 0					

		CONFIDENTIAL					
Bertha D. Brown	07/13/	2004 529-7	5-8486	999999999			
sident Name:	Date:	Soc. Sec. #	Facility	Facility Provider #			
	SECTIO	N U. MEDICATIONS LIST					
List all medications given during the	e last 7 days. Include medications use	d regularly less than weekly as	part of the resident's treatment reg	gimen.			
1. List the medication name and the	e dosage						
2. RA (Route of Administration). U	se the appropriate code from the follow	ving list:					
1 = by mouth (PO)	3 = intramuscular (IM)	5 = subcutaneous (SubQ)	7 = topical	9 = enteral tube			
2 = sublingual (SL)	4 = intravenous (IV)	6 = rectally	8 = inhalation	10 = other			
3. FREQ (Frequency): Use the ap	propriate frequency code to show the n	umber of times per day that the	medication was given.				
PR = (PRN) as necessary	8H = (q8h) every eight hours	5D = five times a da	V				
1H = (qh) every hour	1D = (qd or hs) once daily	1W = (QWeek) once	SVV = IIVE	e times every week times every week			
2H = (q2h) every two hours	2D = (BID) two times daily	2W = twice every we	eek 1M = (QN	Month) once every month			
3H = (q3h) every three hours	(includes every 12 hours)	3W = three times ev	ery week 2M = twic	ce every month			
4H = (q4h) every four hours 6H = (q6h) every six hours	3D = (TID) three times daily 4D = (QID) four times daily	QO = every other da 4W = four times eve					
			O = other	r			

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

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

1. Medication Name and Dosage	2. RA	3. Freq	4. PRN-n	5. NDC Codes								
EXAMPLE: Coumadin 2.5 mg Digoxin 0.125 mg Humulin R 25 Units Robitussin 15cc	1 1 5 1	1W 1D 1D PR	2									
Zestril 40 mg	01	1D		0 0	0	3	8	0	1	3	4	1 0
									1			
								<u> </u>				
									<u> </u>	L	<u> </u>	
					I	1	1	I	1	I		I
								1				
					I	I	I	I	I	I		I
									1	I		
						I	I	1	1	I		
					1	1	1		1	1		
	1		1	1				1	1	1	1	

MINIMUM DATA SET - RESIDENTIAL CARE ASSESSMENT (MDS-RCA)

CORRECTION REQUEST FORM

Use this form:

- 1. To request correction of error(s) in an MDS-RCA assessment record or error(s) in an MDS-RCA Discharge Tracking
- record that has been previously accepted into the State MDS-RCA database; and
- 2. To identify the inaccurate record.

A correction request can be made to either MODIFY or INACTIVATE a record.

TO MODIFY A RECORD IN THE STATE DATABASE:

- 1. Complete a new corrected assessment or discharge tracking form. Include all the items on the form, not just those in need of correction;
- 2. Complete and attach this Correction Request Form to the corrected assessment or discharge tracking form;
- 3. Place a hard copy of the complete assessment and correction form in the Clinical Record;
- 4. Create a new electronic record including the corrected assessment or tracking form AND the Correction Request Form; and
- 5. Electronically submit the new record (as in #3) to the MDS-RCA database at the State.
- TO INACTIVATE A RECORD IN THE STATE DATABASE:
- 1. Complete this correction request form;
- 2. Create an electronic record of the Correction Request Form;
- 3. Place a hard copy of the complete assessment and correction form in the Clinical Record; and
- 4. Electronically submit this Correction Request record to the MDS-RCA database at the State.

PRIOR RECORD SECTION:

THIS SECTION IDENTIFIES THE ASSESSMENT OR TRACKING FORM THAT IS IN ERROR. (In this section, reproduce the information EXACTLY as it appeared in the erroneous record, even if the information is wrong. This information is necessary in order to locate the record in the State database.)

Prior AA1	RESIDENT NAME	Bertha D Brown	
		a.(First) b.(Middle Initial) c.(Last) d.(Jr/Sr)
Prior AA2	GENDER	1. Male 2. Female	2
Prior AA3	BIRTHDATE	0 3 - 0 7 - 1 9 7 5 Month Day Year	
Prior AA5a	SOCIAL Security	a. Social Security Number 5 2 9 7 5 8 4 8	6
Prior A6 OR D1.8	REASON FOR Assessment	ASSESSMENT 1. Admission assessment 2. Annual assessment 3. Significant change in status assessment 4. Semi-Annual 5. Other DISCHARGE TRACKING 6. Discharged 7. Discharged prior to completing initial assessment	2
	PRIOR DATE	PRIOR DATE (Complete one only) Complete Prior A5 if Primary Reason (Prior A6) equals 1,2,3,4 or 5 Complete Prior D3.2 if Primary Reason (Prior D1.8) equals 6 or 7	_
Prior A5	ASSESSMENT DATE	a. Last day of MDS observation period 0 7 1 3 2 0 4 Month Day Year	
Prior D3.2	DISCHARGE Date	Date of Discharge	

CORRECTION SECTION:

COMPLETE THIS SECTION TO EXPLAIN THE CORRECT REQUEST

AT1.	CORRECTION Sequence NUMBER	(Enter total number of correction for this record, including the present one)	01
AT2.	ACTION REQUESTED	 MODIFY record in error (Attach and submit a COMPLETE assessment or tracking form. Do NOT submit the corrected items ONLY. Proceed to item AT3 below). INACTIVE record in error. (Don NOT submit an assessment or tracking form. Submit the correction request only. Skip to item AT4). 	1
AT3.	REASONS FOR Modification	If AT2=1, check at least one of the following reasons; check all that apply, then skip to AT5) a. Transcription error b. Data entry error c. Software product error d. Item coding error e. Other error If "Other checked, please specify:	a. X b. c. d. e.
AT4.	REASONS FOR INACTIVATION	(If At2=2, check at least one of the following reasons; check all that apply.) a. Test record submitted as production record b. Event did not occur c. Inadvertent submission of non-required record d. Other reason requiring inactivation If "Other" checked, please specify:	a. b. c. d.

MDS-RCA COORDINATOR SIGNATURE AND DATE COMPLETION

AT5.	INDIVIDUAL NAME	Nancy Smith		RCA Director				
		a.(First)	b.(Last)	c.(Title)				
	SIGNATURE							
AT6.	CORRECTION DATE	0 8 — Month	0 1 — 2 Day	0 0 4 Year				

MINIMUM DATA SET (MDS)[©] RESIDENTIAL CARE ASSESSMENT (RCA)

BASIC ASSESSMENT TRACKING FORM

GENERAL INSTRUCTIONS:

Complete this form for all assessments and discharges.

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	Bertha D Brown	
		a. (First) b. (Middle Initial) c. (Last) d. (Jr/S	Sr)
2.	GENDER	1. Male X 2. Female	
3.	BIRTHDATE	03-07-1975 Month Day Year	
4.	RACE/ ETHNICITY (Check only one.)	□ 1. American Indian/Alaskan Native □ 4. Hispanic □ 2. Asian/Pacific Islander X 5. White, not of Hispanic origin □ 3. Black, not of Hispanic origin □ 6. Other	
5.	SOCIAL SECURITY and MEDICARE NUMBERS (C in 1 st box if no med. no.)	a. Social Security Number 5 2 9 7 5 - 8 4 9 6 b. Medicare number (or comparable railroad insurance number)	
6.	FACILITY NAME AND PROVIDER NO.	a. Facility Name MCBVI b. Provider No. 9 <th></th>	
7.	MAINECARE No.	[Record a "+" if pending, "N" if not a MaineCare recipient]	
	()	OF PERSON(S) COMPLETING FACE SHEET:	
a . S	Signatures	Title Sections Date	
b.		Date	
C.	DATE Completed	Record date background information was completed. 0 7	

MINIMUM DATA SET (MDS)[©] RESIDENTIAL CARE ASSESSMENT (RCA)

FACE SHEET: BACKGROUND INFORMATION ONLY AT ADMISSION

Res	ident Name:	Bertha D. Brown	Date: 7/13/2004		Soc. Sec.	#:	529-75-8486	Facility	Provider	#: _	999999	9999
SE	CTION AB.	DEMOGRAPHIC INFORMATION		SE	CTION AC.	С	USTOMARY ROUT	NE				
1.	DATE Of Entry	Date the stay began. (Note — Does not include readmission in time of temporary discharge to hospital, etc. In such cases, us 0 7 0 3 1 9 9 4 Month Day Year	f record was closed at se prior admission date.)	1.	CUSTOMARY ROUTINE (In year prior to DATE OF ENTRY	L.	heck all that apply. If <u>all</u> info CLE OF DAILY EVENTS a. Stayed up late at nigh b. Napped regularly duri	t (e.g., afte	r 9 pm)	: last b	ox [z] on	nly.)
2.	ADMITTED FROM (AT ENTRY) (Check only one.)	X 1. Private home/apt. 2. Other board and care/assisted living/group hor 3. Nursing home 4. Acute care hospital 5. Psychiatric hospital 6. MR/DD facility 7. Rehabilitation hospital 8. Other (specify)	ne		to this home, or year last in community if now being admitted from another home, nursing home, or hospital)	X X	 c. Went out 1+ days a we d. Stayed busy with hobb e. Spent most of time ald f. Moved independently i g. Used tobacco product h. NONE OF ABOVE TING PATTERNS i. Distinct food preference 	ies, reading one or watc ndoors (wit ts at least d	ching TV th appliances			
3.	LIVED ALONE (PRIOR TO ENTRY) (Check only one.)	X 0. No Image: Im					j. Ate between meals al k. Used alcoholic bevera I. NONE OF ABOVE	l or most da				
4.	PRIOR PRIMARY RESIDENCE	Provide town, state, zip code for Resident's primary residence prior to admission Sebago Lake Maine Town State	e 0 4 0 7 5 Zip Code				IL PATTERNS M. In bedclothes much of n. Wakened to toilet all o o. Had irregular bowel mo	or most nigh				
5.	RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	 (Check all settings resident lived in during 5 years prior to dat given in item AB1 above) X a. Prior stay at this home b. Nursing home c. Other residential facility—board and care home group home d. MH/psychiatric hospital 					 p. Shower for bathing q. Sponge bath r. Bathed in PM s. NONE OF ABOVE VOLVEMENT PATTERNS t. Daily contact with relation 					
6.	LIFETIME Occupation	□ e. MR/DD facility □ f. NONE OF ABOVE Put a "/" between two occupations. S t u d e n t					 u. Usually attended chur v. Found strength in faith w. Daily animal companio x. Involved in group activ y. NONE OF ABOVE 	n/presence		(etc.)		
7.	EDUCATION (Highest Level Completed) (Check only one.)	1. No schooling X 5. Technical or tr 2. 8th grade or less 6. Some college 3. 9–11 grades 7. Bachelor's de 4. High school 8. Graduate de	e egree	SE	CTION AD.	FA	2. UNKNOWN-Reside				formation	n END
8.	PRIMARY LANGUAGE (Check only one.)	X 0. English 2. French 1. Spanish 3. Other (specified)	fy)		SIGNATURE(S) (Signatures	OF P	PERSON(S) COMPLETING FA Title	CE SHEET:	Sections		Dat	te
9.	Mental Health History	b. Mental illness X 0. No	? 1. Yes 1. Yes 1. Yes	b. 2.	DATE Completed		Record date background in	iformation v	<u> </u>	ed.	Dat	te
10.	CONDITIONS RELATED TO MR/DD STATUS	(Check all conditions that are related to MR/DD status the manifested before age 22, and are likely to continue indefinit. X a. Not applicable—no MR/DD (<i>Skip to AB11</i>) MR/DD with organic condition b. Down's syndrome b. Down's syndrome e. Cerebral palsy c. Autism f. Other organic condition d. Epilepsy g. MR/DD with no organic condition	ely) lition related to MR/DD ganic condition				0 7 — 1 5 Month Day		Year			
	alzheimer Dementia History	Does resident's RECORD indicate any history of the following a. Alzheimer's disease X 0. b. Dementia other than Alzheimer's disease X 0.	No 🗌 1. Yes									

CONFIDENTIAL MINIMUM DATA SET (MDS)[®] RESIDENTIAL CARE ASSESSMENT (RCA)

(STATUS IN LAST 7 DAYS UNLESS OTHERWISE NOTED)

SF		DENTIFICATION and BACKGROUND INFORMATION	SE	CTION C.	COMMUNICATION/HEARING PATTERNS
1.	RESIDENT NAME SOCIAL SECURITY and MEDICARE NUMBERS (C in 1 st box if	Bertha D Brown a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr) a. Social Security Number 5 2 9 7 5 — 8 4 9 6 b. Medicare number (or comparable railroad insurance number)	1.	HEARING (Check only one.)	 (With hearing appliance, if used) X 0. HEARS ADEQUATELY—normal talk, TV, phone 1. MINIMAL DIFFICULTY when not in quiet setting 2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly 3. HIGHLY IMPAIRED –absence of useful hearing
3.	FACILITY NAME AND PROVIDER NO.	C	2.	COMMUNICA- TION DEVICES/ TECHNIQUES	 (Check all that apply during last 7 days.) a. Hearing aid, present and used b. Hearing aid, present and not used regularly c. Other receptive communication techniques used (e.g., lip reading) X d. NONE OF ABOVE
4. 5.	NO.	$\begin{bmatrix} Record a "+" if pending, "N" if not a MaineCare recipient] \\ \hline 0 4 2 3 2 7 9 1 A \\ \hline Last day of observation period \\ \hline 0 7 - 1 3 - 2 0 0 4 \\ \hline \end{bmatrix}$	3.	. MAKING SELF UNDERSTOOD (Check only one.)	 (Expressing information content—however able) X 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY/NEVER UNDERSTOOD
6.	REASON FOR Assessment	Month Day Year (Check primary reason for assessment) 1. 1. Admission assessment 4. X 2. Annual assessment 3. Significant change in status assessment	4.	ABILITY TO UNDERSTAND OTHERS (Check only one.)	(Understanding information content—however able) X 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part / intent of message
7.	MARITAL STATUS (Check only one.)	X 1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated			 SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication RARELY/NEVER UNDERSTANDS
8.	CURRENT PAYMENT SOURCES FOR STAY	X b. SSI f. Private insurance	5.	COMMUNICA- TION (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. X 0. No change 1. Improved 2. Declined
		d. Social Security g. SSDI	SE	CTION D.	VISION PATTERNS
9.	RESPONSI- BILITY/ LEGAL GUARDIAN ADVANCED DIRECTIVES	In the second seco	1.	VISION (Check only one.)	 (Ability to see in adequate light and with glasses if used) 0. ADEQUATE—sees fine detail, including regular print in newspapers/books 1. IMPAIRED—sees large print, but not regular print in newspapers/books 2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects X 4. SEVERELY IMPAIRED—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects
		c. Do not hospitalize X 0. No 1. Yes d. Organ donation X 0. No 1. Yes e. Other X 0. No 1. Yes (If "upped" properties) 2.	VISUAL Appliances	a. Glasses, contact lenses X 0. No □ 1. Yes b. Artificial eye X 0. No □ 1. Yes	
		(If "yes," specify)	_		MOOD AND BEHAVIOR PATTERNS
SE 1.	CTION B.	COGNITIVE PATTERNS (Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes X 0. Memory OK 1. Memory problem	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)
2.	MEMORY/ Recall Ability	b. Long-term memory OK—seems/appears to recall long past X 0. Memory OK 1. Memory problem (<i>Check all that resident was normally able to recall during last 7 days</i>) X a. Current season X d. That he/she is in a facility/home X b. Location of own room e. NONE OF ABOVE are recalled			 VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die." b. Repetitive questions—e.g., "Where do I go; What do I do?"
3.	COGNITIVE SKILLS FOR DAILY DECISION- MAKING (Check only one.)	X c. Staff names/faces (Made decisions regarding tasks of daily life) X 0. INDEPENDENT—decisions consistent/reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues/ supervision required			 _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
4.	COGNITIVE STATUS (Check only one.)	□ 3. SEVERELY IMPAIRED—never/rarely made decisions 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 □ 1. Improved □ 2. Declined			

CONFIDENTIAL 7/13/2004 Date:___

Soc. Sec. #_

529-75-8486

SEC	CTION E. N	IOOD and BEHAVIOR PATTERNS (cont.)					SE	CTION F. PSYCHOSOCIAL WELL-BEING					
1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	in last 30 days irrespective of the assumed cause)						SENSE OF INITIATIVE/ INVOLVEMENT X a. At ease interacting with others (Check all that apply) X b. At ease doing planned or structured activities X c. At ease doing self-initiated 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 friend involved in group activities; responds positively to new activiti assists at religious services) X f. Accepts invitations into most group activities g. NONE OF ABOVE a. Covert/open conflict with or repeated criticism of staff BLATION- SHIPS (Check all that apply) a. Covert/open conflict with or repeated criticism of staff B. Unhappy with residents other than roommate c. Unhappy with residents other than invi/friends B. Absence of personal contact with family/friends f. Recent loss of close family member/friend B. Does not adjust easily to change in routines t. Outines					
		 0 p. Reduced social interaction INDICATORS OF MANIA _0_ q. Inflated self-worth, exaggerated self-opinion; ir about one's own ability, etc. _2_ r. Excited behavior, motor excitation (e.g., height activity; excited, loud or pressured speech; increding the section of th	ened	phys	sical	y)	3.	h. NONE OF ABOVE LIFE- EVENTS HISTORY (Check all that apply.) d. Trouble with the law					
2.	MOOD PERSISTENCE (Check only one.) MOOD	Check if one or more indicators of depressed, sad or anxiou (above) were not easily altered by attempts to "cheer up", or reassure the resident over last 7 days . X 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered Resident's current mood status compared to resident's statu	consc	ole, oi		30	nac appry.		1)				
	(Check only one.)												
4.	BEHAVIORAL Symptoms	(COLUMN A CODES: Record the appropriate code for the frequency of the symptom in last 7 days) (COLUMN B CODES: Alterability of behavioral symptoms in last 7 days) 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 A B C 3. Behavior of this type occurred daily COLUMN C CODES: History of this behavior in the last 6 months) 0. No 1. Yes					1.	 INDEPENDENT—No help or oversight —OR— Help/oversight provided only 1 or 2 time during last 7 days SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during days —OR— Supervision (3 or more times) plus physical assistance provided only 1 times during last 7 days LIMITED ASSISTANCE—Resident highly involved in activity; received physical help in gr maneuvering of limbs or other non-weight bearing assistance 3 or more times —OR— 	i last or 2 uide	2			
a.	WANDERING needs or safe	O. No 1. Yes (moved with no rational purpose, seemingly oblivious to tv)	0	0	0			 Limited assistance (3 or more times,) plus weight-bearing support provided 1 or 2 tim EXTENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day per help of following type(s) provided 3 or more times: 					
b.	VERBALLY A	BUSIVE BEHAVIORAL SYMPTOMS (others were preamed at, cursed at)	0	0		b		Weight-bearing support Weight-bearing support Full staff performance during part (but not all) of last 7 days					
c.	PHYSICALLY	ABUSIVE BEHAVIORAL SYMPTOMS (others were hit,	0	0	0			4. TOTAL DEPENDENCE—Full staff performance of activity during last 7 days					
d.		ched, sexually abused, gross physical assault) APPROPRIATE/DISRUPTIVE BEHAVIORAL				+		8. ACTIVITY DID NOT OCCUR DURING LAST 7 DAYS (B) ADL SUPPORT CODES (CODE for MOST SUPPORT PROVIDED OVER EAC.	H 24	4			
	public, smeare	(made disruptive sounds, sexual behavior, disrobing in ed/threw food/feces, hoarding, rummaged through others' ealing, self-abusive acts, substance abuse, self-mutilation)	0	0	0			HOUR PERIOD) during last 7 days; code regardless of person's					
e.		RE (resisted taking medications/ injections, ADL	0	0	0	1		 0. No setup or physical help from staff 1. Setup help only 2. One-person physical assist 	RIMANC	F			
f.	-	G BEHAVIOR (made others feel unsafe, at risk, privacy	0	0	0			3. Two-persons physical assist 8. Activity did not occur during entire 7 days	PERFORMANCE				
g.	ELOPEMENT	·	0	0	0	<u> </u>		BED MOBILITY – How resident moves to and from lying position, turns side to		(
h.	0	n-violent behavior (e.g., falling asleep while smoking)	0	0	0]		side, and positions body while in bed TRANSFER – How resident moves between surfaces—to/from: bed, chair,	+	_			
i. :	Dangerous vio		0	0	0	┥╿┝		wheelchair, standing position (EXCLUDE to/from bath/toilet)	'	_			
j. 5.	FIRE SETTIN SUICIDAL IDEATION	G Resident demonstrated suicidal thoughts or actions in the la X 0. No I Yes	0 ast 30	0) day	0 s:				0	0			
6.	SLEEP	Check all present on 2 or more days during last 7 days				_	d.	sufficiency once in chair DRESSING – How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis 0	,				
	PROBLEMS	a. Inability to awaken when desired d. Interrupte X b. Difficulty falling asleep e. NONE OF					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			
	INSIGHT	c. Restless or non-restful sleep					f.	TOILET USE – How resident uses the toilet room (or commode, bed- pan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or	b	_			
7.	INTO MENTAL HEALTH	Resident has insight about his/her mental problem X 0. No 1. Yes 2. No mental her	alth p	roble	ms		g.	PERSONAL HYGIENE – How resident maintains personal hygiene, including	0				
8.	BEHAVIORS	Resident's current behavior status compared to resident's sta days ago (or since admission if less than 180 days):	atus 1	80		_		Anads, and perineum (EXCLUDE baths and showers) STAIRS – How resident climbs stairs 0		0			
	(Check only one.)	X 0. No change 1. Improved 2. D	Declin	ed			<i>n</i> .						

0 0

SELF-PERFORMANCE SUPPORT

> 0 0

0 0

0 0

0 0

0 0

Res	ident Name:	_Bertha Brown Date:_7-13-2004		Soc	. Sec. #52	9-75-8486 Facility Provider #_9999999999					
SE	CTION G. P	HYSICAL FUNCTIONING (cont.)		SE	CTION G.	PHYSICAL FUNCTIONING (cont.)					
2.	BATHING Self- Performance	 X 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 	s in/out s <u>t</u>			 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 					
3A.	MODES OF Locomotion	 (Check all that apply during last 7 days) a. Cane/walker/crutch b. Wheeled self c. Other person wheeled X d. 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 b. Hearing aid (e.g., button hook, velcro closings) c. Cane or walker g. Dentures					
3B.	MAIN Mode of Locomotion	Was wheelchair the primary mode of locomotion during the last 7 day X 0. No 1. Yes	ys?			d. Wheelchair h. Other (specify) e. Assistive feeding devices (e.g., plate X i. NONE OF ABOVE					
3C.	BEDFAST/ Chairfast	(Check if health condition keeps resident in his/her room 22+ hours p in last 7 days)	oer day			guard, stabilized built-up utensil)					
		 a. Bedfast all or most of time b. Chairfast all or most of the time X c. NONE OF ABOVE 		8.	SELF- Performance In Iadls	Resident's current IADL status or abilities compared to resident's status 180 days ago (or since admission if less than 180 days): X 0. No change 1. Improved 2. Declined					
4.	SELF- Performance	Resident's current ADL status or abilities compared to resident's state	us 180	SE	CTION H.	CONTINENCE IN LAST 14 DAYS					
	(Check only one.)	 days ago (or since admission if less than 180 days): X 0. No change 1. Improved 2. Declined 			(Code for res 0. CONTIN	E SELF-CONTROL CATEGORIES dent's PERFORMANCE OVER ALL SHIFTS) :NT—Complete control (includes use of indwelling urinary catheter or vice that does not leak urine or stool)					
5A.	IADL SELF- Perfor- Mance	 Code for level of independence in the last 30 days based on residen involvement in the activity. SELF-PERFORMANCE CODES: INDEPENDENT : (with/without assistive devices)—No help pi DONE WITH HELP: Resident involved in activity but help (inc supervision, reminders, and/or physical help) is provided. DONE BY OTHERS: Full performance of the activity is done by others. The resident is involved at all when the activity is performed. 	rovided. Iuding	a.	BOWEL, 2. OCCASI daily; BO 3. FREQUE some cor 4. INCONTI all (or alm	LLY CONTINENT—BLADDER, Incontinent episodes once a week or less; iL, less than weekly SIONALLY INCONTINENT—BLADDER, 2 or more times a week but not BOWEL, once a week UENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but control present (e.g. on day shift); BOWEL, 2-3 times a week ITINENT—Had inadequate control BLADDER, multiple daily episodes; BOWEL, lmost all) of the time Control of bowel movement, with appliance or bowel continence programs, if employed					
		 Activity did not occur in the last 30 days. 		b.	BLADDER	Control of urinary bladder function with appliances (e.g. foley) or					
		IADL	SELF- PERFORMANCE	2.	CONTINENCE	continence programs, if employed 0 Bowel elimination pattern regular—at least one movement every three days Diarrhea Fecal Impaction Resident is Independent c.					
		a. Resident arranged for shopping for clothing, snacks, other incidentals.	0	3.	APPLIANCES	Constipation b. X NONE OF ABOVE f.					
		b. Resident shopped for clothing, snacks, or other incidentals.	0	3.	and	Any scheduled toileting plan a. Did not use toilet room/ Bladder retraining program b. commode/urinal					
		c. Resident arranged for suitable transportation to get to appointments, outings, necessary engagements.	0		FROUNAINS	External (condom) catheter c. Pads/briefs used g.					
		d. Resident managed finances including banking, handling checkbook, or paying bills.	0	1		Indwelling catheter d. Enemas/irrigation h. Intermittant entheter e. Ostorny present i.					
		e. Resident managed cash, personal needs allowance.	0			Intermittent catheter					
		f. Resident prepared snacks, light meals.	0	4.	USE OF INCONTINENC	Resident's management of incontinence supplies (pads, briefs, ostomy, catheter) in last 14 days.					
		g. Resident used phone.h. Resident did light housework such as making own bed,	0		SUPPLIES (Check only one.)	X 0. Always continent					
		dusting, or taking care of belongings. i. Resident sorted, folded, or washed own laundry.	0			independently. 2. Resident incontinent and receives assistance with managing					
5B.	TRANSPOR- Tation	Check all that apply for level of independence in the last 30 days bas on resident's involvement in the activity.				 2. Resident incontinent and does not use incontinence supplies. 3. Resident incontinent and does not use incontinence supplies. 					
		 a. Resident drove car or used public transportation independenti get to medical, dental appointments, necessary engagements other activities. X b. Resident rode to destination with staff, family, others (in car, var public transportation) but was not accompanied to medical, 	, or	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): X 0. No change 1. Improved 2. Deteriorated					
		dental appointments, necessary engagements, or other activit				IAGNOSES					
		 X c. Resident rode to destination with staff, family, others (in car, var public transportation) and <u>was accompanied</u> to medical, den appointments, necessary engagements, or other activities. d. Activity did not occur. 		and	l behavior statu	diagnoses that have a relationship to current ADL status, cognitive status, mood is, medical treatments, nurse monitoring, or risk of death. (Do not list inactive le apply, CHECK item xx. NONE OF ABOVE)					
6.	ADL AND IADL FUNCTIONAL REHABILI- TATION OR IMPROVE- MENT POTENTIAL (Check all that apply.)	 X a. Resident believes he/she is capable of increased independence at least some ADLs or IADLs. X 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 morning evenings e. Resident requires or only understands a one-step direction. <i>(continued in next column)</i> 		1.	DIAGNOSES	ENDOCRINE/METABOLIC/ NUTRITIONAL HEART/CIRCULATION a. Diabetes mellitus d. Arteriosclerotic heart disease (ASHD) b. Hyperthyroidism e. Cardiac dysrhythmia c. Hypothyroidism f. Congestive heart failure g. Deep vein thrombosis h. Hypertension i. Hypotension j. Peripheral vascular disease k. Other cardiovascular disease k. Other cardiovascular disease					

_		Bertha D. Brown	7/13/2004	_	_	529-75-8486	999999999	÷
	sident Name:		Date:		Sec #			
SE	CTION I. DIAGI	MUSCULOSKELETAL U. Arthritis I. Arthritis I. Hip fracture I. Missing limb (e.g., amputation) O. Osteoporosis	ff. Manic depressive (Bipolar) gg. Schizophrenia PULMONARY hh. Asthma ii. Emphysema/COPD	SEC		LTH CONDITIONS AND POSSIBLI During the last 7 days, how much normal activities such as visiting w 1. All of the time 2. Some of the time	of the time did pain interfere with	resident's
		p. Pathological bone fracture	SENSORY	6.	PAIN MANAGE- MENT	 1. No pain treatment X 2. Treated, full control 	 3. Treated, partial control 4. Treated, no or minimal of the second second	control
		NEUROLOGICAL q. Alzheimer's disease r. Aphasia s. Cerebral palsy	Kk. Diabetic retinopathy I. Glaucoma mm. Macular degeneration	7.	ACCIDENTS (Check all that apply)	a. Fell in past 30 days	d. Other fracture in last 18 X e. NONE OF ABOVE	
		L. Cerebrovascular accident (stroke) u. Dementia other than Alzheimer's disease v. Hemiplegia/ hemiparesis w. Multiple sclerosis	oo. Anemia pp. Cancer qq. Renal failure rr. Tuberculosis-TB ss. HIV tt. Mental retardation(e.g., Down's Syndrome, Autism, or other organic condition related to	TB ation(e.g., Down's 	DANGER OF FALL (Check all that apply)	a. Has unsteady gait b. Has balance problems wh	- nen standing sident or family fearful of resident f	falling
		y. Parkinson's	Mental Retardation or Developmental disability (MR/	SEC	CTION K. ORA	L/NUTRITIONAL STATUS		
		Z. Quadriplegia DD) aa. Seizure disorder drug) bb Transient ischemic W. Other	DD) uu. Substance abuse (alcohol or drug) vv. Other psychiatric diagnosis (e.g., paranoia, phobias,	1.	ORAL PROBLEMS (Check all that apply)	a. Mouth is "dry"when eating b. Chewing Problem c. Swallowing Problem	g a meal 🗌 d. Mouth Pain X e. NONE OF ABC)VE
		Cc. Traumatic brain injury PSYCHIATRIC/MOOD dd. Anxiety disorder	personality disorder) www. Explicit terminal prognosis xx. NONE OF ABOVE	2.	HEIGHT AND WEIGHT	Record (a.) height in inches and (b.) a measure in last 30 days; measure weig practice–e.g., in a.m. after voiding, befor a. HT (in.)	ght consistently in accord with standar ore meal, with shoes off, and in nightc.	rd facility
		ee. Depression		3.	WEIGHT	a. Unintended weight loss-5%		
2	. OTHER CURRENT	a	008.45	3.	CHANGE	more in last 180 days	of more in last 50 days, of 10%	, 01
	DIAGNOSIS AND ICD-9 CODES	b c				X 0. No I. Yes b. Unintended weight gain–5% more in last 180 days	or more in last 30 days; or 10%	or
SEC	CTION J. HEAL	TH CONDITIONS AND POSSIBI	LE MEDICATION SIDE EFFECTS			X 0. No 1. Yes		
1	. PROBLEM CONDITIONS	S a. Inability to lie flat due to shortness of breath i. b. Shortness of breath k. c. Edema I. d. Dizziness/vertigo m e. Delusions		 i. Headache j. Numbness/tingling k. Blurred vision l. Dry mouth m. Excessive salivation or drooling 	NUTRI- TIONAL PROBLEMS OR AP- PROACHES (Check all that apply)	 a. Complains about the taster of many foods b. Regular or repetitive complaints of hunger c. Leaves 25% of food uneaten at most meals d. Therapeutic diet e. Mechanically altered (or pureed) diet 	 f. Noncompliance with a g. Eating disorders h. Food allergies (specify) i. Restrictions (specify) X j. NONE OF ABOVE 	
		g. Hostility	O. Other (<i>specify</i>)	SEC	CTION L. ORA	L/DENTAL STATUS		
2	EXTRA- PYRAMIDAL SIGNS AND SYMPTOMS	 need for movement b. Dyskinesia–chewing, puirregular movements of c. Tremor–regular rhythmi mouth, or tongue DECREASE IN MOTOR ACTIVITY 	X p. NONE OF ABOVE	1.	ORAL STATUS AND DISEASE PREVENTION (check all that apply)	(or partial plates) c. Broken, loose or carious to d. Inflamed gums (gingiva); s ulcers or rashes	t-does not have or does not use of eeth swollen or bleeding gums; oral ab ntures or daily mouth care-by resi	oscesses;
		continuous or cogwheel		SEC	CTION M. SKI	N CONDITION		
		 e. Slow shuffling gait-reduction in speed and stride length of gait, usually with a decrease in pendular arm movement f. Bradykinesis-decrease in spontaneous movements (e.g., reduced body movement or <i>poverty of</i> facial expression, gestures, speech) MUSCLE CONTRACTIONS g. Dystonia-muscle hypertonicity (e.g., muscle spasms or stiffness, protruding tongue, upward deviation of the eyes) h. NONE OF ABOVE 	1.	SKIN PROBLEMS (Check all that apply) ULCERS	Any troubling skin conditions or ch a. Abrasions (scrapes) or cu b. Burns (2nd or 3rd degree) c. Bruises X d. Rashes, itchiness, body lice Record the number of ulcers at each f anno properts at each	e Open sores or lesion f. Other (<i>specify</i>) g. NONE OF ABOVE h ulcer stage-regardless of cause.		
3	PAIN	(Code the highest level of resident's	s pain present in the last 7 days) 01		(Due to	If none present at a stage, record "0 last 7 days. Code 9=9 or more) Req		Number at Stage
	SYMPTOMS	On a scale of 1 to 10, where 1 is			any cause)	a. Stage 1. A persistent area of skir the skin) that does not disappear w	n redness (without a break in hen pressure is relieved.	2 te 1
4	PAIN SITE	(If pain is present in the last 7 days				b. Stage 2. A partial thickness loss clinically as an abrasion, blister, or		
		 a. Back pain b. Bone pain 	f. Incisional pain g. Joint pain (other than hip)			c. Stage 3. A full thickness of skin is ous tissues-presents as a deep cra	s lost, exposing the subcutane-	0
		c. Chest pain while doing usual activities	h. Soft tissue pain (e.g., lesion, muscle)			undermining adjacent tissue. d. Stage 4. A full thickness of skin a		0
		X d. Headache	 i. Stomach pain j. Other (specify) 			exposing muscle or bone.		0

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

CONFIDENTIAL								
Re	sident Name:	Bertha D. Brown 7/13/2004 Date:	Soc.	5 Sec #	529-75-8486 9999999999 Facility Provider #			
SE	ECTION M. SKI				DICATIONS (cont.)	_		
	3. FOOT PROBLEMS	 a. Resident or someone else inspects resident's feet on a regular basis? X 0. No	4A 4B	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) 0a. Antipsychotic 0d. Hypnotic 0g. I 0b. Antianxiety 0e. Diuretic 0c. Antidepressant 0f. Arcept	Insu	ulin	
				MEDICATIONS	emotional or nervous condition, or behavioral problem?			
	TINAE		1 -					
	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: X a. Morning d. Night (Bedtime to A.M.) X b. Afternoon X c. Evening	5.	SELF- ADMINSTERED MEDICATIONS (Check all that apply.)	a. Insulin e. Glucosan b. Oxygen X f. Over-the-counter Meds			
2	2. AVERAGE TIME INVOLVED IN	(When awake and not receiving treatments or ADL care) I. Most–more than 2/3 of time	6.	MEDICATION Preparation Administra-	Did resident prepare and administer his/her own medications in last 7 of <i>(Check only one.)</i>	day	rs?	
	ACTIVITIES (Check only one.)	 X 2. Some-from 1/3 to 2/3 of time 3. Little-less than 1/3 of time 4. None 		TION	 0. No Meds 1. Resident prepared and administrated <u>NONE</u> of his/her own medicat 2. Resident prepared and administrated <u>SOME</u> of his/her own medicat X 3. Resident prepared and administrated <u>ALL</u> of his/her own medication 	tion		
13	3. PREFERRED	(Check all settings in which activities are preferred)	7.					
	ACTIVITY Settings	X a. Own room X d. Away from facility b. Day/activity room e. NONE OF ABOVE		MEDICATION	Resident's level of compliance with medications prescribed by a physic psychiatrist during last 30 days: 0. No Meds	ciar	V	
		X c. Outside facility (e.g., in yard)		(Check one)	X 1. Always compliant			
4	4. GENERAL ACTIVITY PREFER- ENCES	(Check all PREFERENCES whether or not activity is currently available to resident) X a. Cards/other games K Gardening or plants X b. Crafts/arts I. Talking or conversing X c. Exercise/sports			 2. Always compliant with reminder, verbal prompts 3. Compliant some of the time (80% of time or more often) or with some medications 	h		
	(Adapted to resident's	X c. Exercise/sports m. Helping others d. Dancing n. Doing chores around the		MISUSE	4. Rarely or never compliant Misuse of prescription or over-the-counter medications in the last 6 mo			
	current	X e. Music house/facility	8.	OF	(e.g., resident uses more or less than the directed dose, is using medic			
	abilities)	X f. Reading/writing O. Cooking/baking		MEDICATION	for a purpose other than intended) X 0. No 1. Yes			
		g. Spiritual/religious activity b p. Computer activities c g . Volunteering	SE	CTION P. SPEC	CIAL TREATMENTS AND PROCEDURES			
		X h. Trips/shopping Image: q. Volunteering Image: imag	1.	SPECIAL TREATMENTS,	a. SPECIAL CARE-Check treatments or programs received during the las days [Note-count only post admission treatments]	st 1	4	
		i. Watching TV □ s. NONE OF ABOVE		PROCE-		roti	urn	
\vdash	5. PREFERRED	(Check all that apply)		DURES, AND	a. Chemotherapy or radiation I. Training in skills required to to the community (e.g., takin		m	
	ACTIVITY	a. Individual c. Larger group		PROGRAMS	b. Oxygen therapy medications, house work, shopping, transportation, AD	2		
	5121	X b. Small group d. No preference			c. Dialysis j. Case management	JLS)	
	6. ENCES IN	a. Resident prefers change in type of activity			PROGRAMS Image: second sec			
	DAILY	b. Resident prefers change in extent of involvement in activities (e.g., more or less)			program I. Sheltered workshop/employ	/me	ent	
		c. Resident prefers change in location of activities			e. Alzheimer's/dementia			
	(Check all that apply)	d. Resident prefers activity at different time of day			special care unit In. Transportation f. Hospice care O. Psychological rehabilitation			
		e. Resident prefers stability in daily routine			\square g . Home health \square p . Formal education			
\vdash		X f. NONE OF ABOVE			h. Home care X q. NONE OF ABOVE			
7	7. INTERACTION WITH FAMILY				b. THERAPIES—Record the number of days each of the following therapies administered (for at least 15 minutes a day) in the last 7 calendar days (
	AND FRIENDS				O if name as loss than 15 min a day)			
		facility 5. 2 or 3 times a week but not			(Note-count only post admission therapies) (A) = # of days administered for 15 minutes or more	SITE (B)	Ē	
		2. None daily X 3. 1-3 times/month 6. Daily			Check B if therapy was received at home or in facility	N SITE	E SI	
						SN0	ď	
		b. How often has resident talked by telephone with family and friends in the last 30 days? (check only one)			a. Speech-language pathology and auditory services 0 b. Occupational therapy 0	⊢	╞	
		□ 1. No family or friends outside X 4. Once a week			b. Occupational therapy 0 c. Physical therapy 0	\vdash	\vdash	
		facility 5. 2 or 3 times a week but not			d. Respiratory therapy 0		\vdash	
		2. None daily 3. 1-3 times/month 6. Daily			e. Psychological therapy (by any licensed mental health professional) 0		Γ	
-	8. VOTING	Is resident registered to vote? 0. No X 1. Yes	2		Check all interventions or strategies used in the last 7 days unless othe	ər ti.	me	
	9. SOCIAL ACTIVITES	Resident's current level of participation in social, religious or other personal		VENTION PROGRAMS	specified-no matter where received) a. Special behavior environment to address			
	(Check only	activities compared to resident's status 180 days ago (since admission if less than 180 days):		FOR MOOD, BEHAVIOR.	symptom evaluation mood/behavior patterns-	<u> </u>		
	one.)	0. No change X 1. Improved 2. Declined		COGNITIVÉ	program providing bureau in which rummage	ιU		
-			1	LOSS	b. Special behavior management program	g		
SE	ECTION O. MEE	(Recent the number of different medications used in the last 7 days)	1		c. Evaluation by a licensed g. Validation/Redirection			
	MEDICATION				mental health specialist in L h. Crisis intervention in facilit			
1	2. NEW	(Resident currently receiving medicatons that were initiated during the last 90 days)			last 90 days i. Crisis stabilization unit in l d. Group therapy 90 days	last	•	
	MEDICATION	S X 0. No 🗌 1. Yes			e. Resident-specific j. Other (specify)		_	
1	3. INJECTIONS	(Record the number of DAYS injections of any type received during the last 30 days ; enter "0" if none used)			deliberate changes in the X k. NONE OF ABOVE			

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

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			CONFIDENTIA	AL.			
Res	sident Name: _	O7/13/200 Bertha D. Brown Date:)4 Soc. Sec	5: # _)	29-75-8486 Facility Pr	rovider #	9999999999
SE	CTION P. SPEC	IAL TREATMENTS AND PROCEDURES (cont.)	SEC	TION Q. SER	VICE PLANNING		
3.	ON-GOING MONITORING REHABILITA-	(Code for person responsible for monitoring) 0. No monitoring required 2. RCF Other Staff 1. RCF nurse 3. Home health nurse a. Acute physical or psychiatric condition - not chronic b. New treatment/med RECORD THE number of days each of the following rehabilitation or restorative		RESIDENT GOALS (Check all areas in which: resident has self-identified goals)	X d. Rehabilitation-skilled	king friends learning cognitive function mmunity	
	TION/ Restorative Care	techniques or practices was provided to the resident for more than or equal to minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.)	2.	CONFLICT	 a. Any disagreement betwee service plan? b. Any disagreement betwee 	0. No X 1. Yes	0
5.	SKILL TRAINING	o e. Transfer o j. Communication 0 f. Walking o k. Time management 0 g. Dressing or grooming o l. Other (specify) 0 h. Eating or swallowing Record the number of days, in the last 30 days that each of the following were performed with assistance from staff as a skill training activity identified the resident's spring alago.		DISCHARGE POTENTIAL	 a. Does resident of X1. Yes b. Does resident have a supp discharge? 0. No c. Has resident's self-sufficier since admission, if less that the support of the sup	X 1. Yes ncy changed compared to 6 an 6 months?	towards
		<u>0</u> a. Meal Preparation (snacks, <u>0</u> h. Arranges Shopping light meals) (makes list, acquires	S				
		b. Telephone Use help)		1	ESSMENT INFORMATION		
		own bed, takes care of incidentals)		TION	a. Resident: 0. No b. Family: X 0. No	X 1. Yes 2. No Fam	nilv
		0 belongings) 0 j. Transportation (trave		ASSESS- MENT	c. Other Non-Staff: X 0. No		
6.		0 washes own laundry 0 washes own laundry 1 e. Managing Incontinence Supplies (pads, briefs, ostomy, catheter) o 1 f. Managing Cash (handles cash, makes purchases) o 2 g. Managing Finances (banking, handling checkbook, or paying bills) o	nts or 2. ra-	a. Signatu	S OF PERSONS COMPLETING re of Assessment Coordinator (sig sessment Coordinator signed as o natures Title	n on line above)	- 2004 Vear
6.	WITH	In the last 6 months, compliant all or most of the time with special treatm therapies and programs:	ents,	d.			Date
	TREATMENTS/ Therapies/ Programs	X 0. Always compliant 3. No treatments or progra 1. Compliant 80% of time 8. Unknown 2. Compliant less than 80% of the time	ams 3.	e. CASE MIX GROUP			Date
7.	HOSPITAL	Record number of times resident was admitted to an acute care hospital with an overnight stay in last 6 months (or since last	0 0 SEC		entive Health/Health Behaviors		
	STAY(S)	assessment if less than 6 months.) (Enter "0" if no hospital admissions)		PREVENTIVE	(Check all the procedures the re	esident received during the	past 12 months)
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)	0 0	HEATH	 X a. Blood pressure monitorir b. Hearing assessment c. Vision test 	ng g. Breast exam h. Pap smear i. PSA or rectal	0
9.	VISITS	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		 d. Dental visit X e. Influenza vaccine 	X j. Other (specify, LACTOSE	
10	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)	0 1		f. Pneumococcal vaccine (ANY time)		
11.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission if less than 90 days)? 0. No X 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)	0 0				
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)	0 0				

		CONFIDENTIAL		
Bertha D. Brown	07/13/	2004 529-7	5-8486	999999999
sident Name:	Date:	Soc. Sec. #	Facility	Provider #
	SECTIO	N U. MEDICATIONS LIST		
List all medications given during the	e last 7 days. Include medications use	d regularly less than weekly as	part of the resident's treatment reg	gimen.
1. List the medication name and the	e dosage			
2. RA (Route of Administration). U	se the appropriate code from the follow	ving list:		
1 = by mouth (PO)	3 = intramuscular (IM)	5 = subcutaneous (SubQ)	7 = topical	9 = enteral tube
2 = sublingual (SL)	4 = intravenous (IV)	6 = rectally	8 = inhalation	10 = other
3. FREQ (Frequency): Use the ap	propriate frequency code to show the n	umber of times per day that the	medication was given.	
PR = (PRN) as necessary	8H = (q8h) every eight hours	5D = five times a da	V	
1H = (qh) every hour	1D = (qd or hs) once daily	1W = (QWeek) once	SVV = IIVE	e times every week times every week
2H = (q2h) every two hours	2D = (BID) two times daily	2W = twice every we	eek 1M = (QN	Month) once every month
3H = (q3h) every three hours	(includes every 12 hours)	3W = three times ev	ery week 2M = twic	ce every month
4H = (q4h) every four hours 6H = (q6h) every six hours	3D = (TID) three times daily 4D = (QID) four times daily	QO = every other da 4W = four times eve		
			O = other	r

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

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

1. Medication Name and Dosage	2. RA	3. Freq	4. PRN-n	5. NDC Codes								
EXAMPLE: Coumadin 2.5 mg Digoxin 0.125 mg Humulin R 25 Units Robitussin 15cc	1 1 5 1	1W 1D 1D PR	2									
Zestril 40 mg	01	1D		0 0	0	3	8	0	1	3	4	1 0
									1			
								<u> </u>				
									<u> </u>	L	<u> </u>	
					I	1	1	I	1	1		I
								1				
					I	I	I	I	I	I		I
									1	I		
						I	I	1	1	I		
					1	1	1		1	1		
	1		1	1				1	1	1	1	

MINIMUM DATA SET - RESIDENTIAL CARE ASSESSMENT (MDS-RCA)

CORRECTION REQUEST FORM

Use this form:

- 1. To request correction of error(s) in an MDS-RCA assessment record or error(s) in an MDS-RCA Discharge Tracking
- record that has been previously accepted into the State MDS-RCA database; and
- 2. To identify the inaccurate record.

A correction request can be made to either MODIFY or INACTIVATE a record.

TO MODIFY A RECORD IN THE STATE DATABASE:

- 1. Complete a new corrected assessment or discharge tracking form. Include all the items on the form, not just those in need of correction;
- 2. Complete and attach this Correction Request Form to the corrected assessment or discharge tracking form;
- 3. Place a hard copy of the complete assessment and correction form in the Clinical Record;
- 4. Create a new electronic record including the corrected assessment or tracking form AND the Correction Request Form; and
- 5. Electronically submit the new record (as in #3) to the MDS-RCA database at the State.
- TO INACTIVATE A RECORD IN THE STATE DATABASE:
- 1. Complete this correction request form;
- 2. Create an electronic record of the Correction Request Form;
- 3. Place a hard copy of the complete assessment and correction form in the Clinical Record; and
- 4. Electronically submit this Correction Request record to the MDS-RCA database at the State.

PRIOR RECORD SECTION:

THIS SECTION IDENTIFIES THE ASSESSMENT OR TRACKING FORM THAT IS IN ERROR. (In this section, reproduce the information EXACTLY as it appeared in the erroneous record, even if the information is wrong. This information is necessary in order to locate the record in the State database.)

Prior AA1	RESIDENT NAME	Bertha D Brown	
		a.(First) b.(Middle Initial) c.(Last) d.(Jr/Sr)
Prior AA2	GENDER	1. Male 2. Female	2
Prior AA3	BIRTHDATE	0 3 - 0 7 - 1 9 7 5 Month Day Year	
Prior AA5a	SOCIAL Security	a. Social Security Number 5 2 9 7 5 8 4 9	6
Prior A6 OR D1.8	REASON FOR Assessment	ASSESSMENT 1. Admission assessment 2. Annual assessment 3. Significant change in status assessment 4. Semi-Annual 5. Other DISCHARGE TRACKING 6. Discharged 7. Discharged prior to completing initial assessment	2
	PRIOR DATE	PRIOR DATE (Complete one only) Complete Prior A5 if Primary Reason (Prior A6) equals 1,2,3,4 or 5 Complete Prior D3.2 if Primary Reason (Prior D1.8) equals 6 or 7	
Prior A5	ASSESSMENT DATE	a. Last day of MDS observation period 0 7 1 3 2 0 4 Month Day Year	
Prior D3.2	DISCHARGE Date	Date of Discharge	

CORRECTION SECTION:

COMPLETE THIS SECTION TO EXPLAIN THE CORRECT REQUEST

CORRECTION Sequence NUMBER	(Enter total number of correction for this record, including the present one)	02
ACTION REQUESTED	 MODIFY record in error (Attach and submit a COMPLETE assessment or tracking form. Do NOT submit the corrected items ONLY. Proceed to item AT3 below). INACTIVE record in error. (Don NOT submit an assessment or tracking form. Submit the correction request only. Skip to item AT4). 	1
REASONS FOR Modification	If AT2=1, check at least one of the following reasons; check all that apply, then skip to AT5) a. Transcription error b. Data entry error c. Software product error d. Item coding error e. Other error If "Other checked, please specify:	a. X b. c. d. X e.
REASONS FOR INACTIVATION	 (If At2=2, check at least one of the following reasons; check all that apply.) a. Test record submitted as production record b. Event did not occur c. Inadvertent submission of non-required record d. Other reason requiring inactivation If "Other" checked, please specify: 	a. b. c. d.
	SEQUENCE NUMBER ACTION REQUESTED REASONS MODIFICATION REASONS FOR	SEQUENCE NUMBER including the present one) ACTION REQUESTED 1. MODIFY record in error (Attach and submit a COMPLETE assessment or tracking form. Do NOT submit the corrected items ONLY. Proceed to item AT3 below). 2. INACTIVE record in error. (Don NOT submit an assessment or tracking form. Submit the correction request only. Skip to item AT4). REASONS FOR MODIFICATION If AT2=1, check at least one of the following reasons; check all that apply, then skip to AT5) a. Transcription error b. Data entry error c. Software product error d. Item coding error e. Other error If "Other checked, please specify: REASONS FOR INACTIVATION (If At2=2, check at least one of the following reasons; check all that apply.) a. Test record submitted as production record b. Event did not occur c. Inadvertent submission of non-required record d. Other reason requiring inactivation

MDS-RCA COORDINATOR SIGNATURE AND DATE COMPLETION

AT5.	INDIVIDUAL NAME	Nancy Smith		RCA Director						
		a.(First)	b.(Last)	c.(Title)						
	SIGNATURE									
AT6.	CORRECTION DATE	0 8 —	0 2 — 2 Day	0 0 4 Year						

MINIMUM DATA SET (MDS)[©] RESIDENTIAL CARE ASSESSMENT (RCA)

BASIC ASSESSMENT TRACKING FORM

GENERAL INSTRUCTIONS:

Complete this form for all assessments and discharges.

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	Bertha D Brown	
		a. (First) b. (Middle Initial) c. (Last)	d. (Jr/Sr)
2.	GENDER	□ 1. Male X 2. Female	
3.	BIRTHDATE	03-07-197 Month Day Year	5
4.	RACE/ ETHNICITY (Check only one.)	2. Asian/Pacific Islander X 5 3. Black, not of Hispanic origin	 Hispanic White, not of Hispanic origin Other
5.	SOCIAL SECURITY and MEDICARE NUMBERS (C in 1 st box if no med. no.)	a. Social Security Number 5 2 9 7 5 8 4 8 b. Medicare number (or comparable railroad insuran	U
6.	FACILITY NAME AND PROVIDER NO.	a. Facility Name MCBVI b. Provider No. 9 9 9 9 9 9 9 9	
7.	MAINECARE No.	[Record a "+" if pending, "N" if not a MaineCare recip 0 4 2 3 2 7 9 1 A	pient]
	.,	OF PERSON(S) COMPLETING FACE SHEET:	
a . S	Signatures	Title Sections	Date
b.			Date
C.	DATE Completed	Record date background information was complet 0 7 Month Day Year	4

MINIMUM DATA SET (MDS)[©] RESIDENTIAL CARE ASSESSMENT (RCA)

FACE SHEET: BACKGROUND INFORMATION ONLY AT ADMISSION

Res	ident Name:	Bertha D. Brown	Date: 7/13/2004		Soc. Sec.	#:	529-75-8486	Facility	Provider	#:	999999	9999
SE	CTION AB.	DEMOGRAPHIC INFORMATION		SE	CTION AC.	С	USTOMARY ROUT	NE				
1.	DATE Of Entry	Date the stay began. (Note — Does not include readmission in time of temporary discharge to hospital, etc. In such cases, us 0 7 0 3 1 9 9 4 Month Day Year	f record was closed at se prior admission date.)	1.	CUSTOMARY ROUTINE (In year prior to DATE OF ENTRY	L.	heck all that apply. If <u>all info</u> CLE OF DAILY EVENTS a. Stayed up late at nigh b. Napped regularly duri	t (e.g., afte	er 9 pm)		box [z] or	nly.)
2.	ADMITTED FROM (AT ENTRY) (Check only one.)	X 1. Private home/apt. 2. Other board and care/assisted living/group hor 3. Nursing home 4. Acute care hospital 5. Psychiatric hospital 6. MR/DD facility 7. Rehabilitation hospital 8. Other (specify)	ne		to this home, or year last in community if now being admitted from another home, nursing home, or hospital)	X X	 c. Went out 1+ days a we d. Stayed busy with hobb e. Spent most of time ald f. Moved independently i g. Used tobacco product h. NONE OF ABOVE TING PATTERNS i. Distinct food preference 	ies, reading one or watc ndoors (wit ts at least d	ching TV th appliance			
3.	LIVED ALONE (PRIOR TO ENTRY) (Check only one.)	X 0. No Image: Im					j. Ate between meals al k. Used alcoholic bevera I. NONE OF ABOVE	l or most da				
4.	PRIOR PRIMARY RESIDENCE	Provide town, state, zip code for Resident's primary residence prior to admission Sebago Lake Maine Town State	e 0 4 0 7 5 Zip Code				L PATTERNS m. In bedclothes much o n. Wakened to toilet all c o. Had irregular bowel mo	or most nigh				
5.	RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	 (Check all settings resident lived in during 5 years prior to dat given in item AB1 above) X a. Prior stay at this home b. Nursing home c. Other residential facility—board and care home group home d. MH/psychiatric hospital 					 p. Shower for bathing q. Sponge bath r. Bathed in PM s. NONE OF ABOVE VOLVEMENT PATTERNS t. Daily contact with relation 					
6.	LIFETIME Occupation	□ e. MR/DD facility □ f. NONE OF ABOVE Put a "/" between two occupations. S t u d e n t					 u. Usually attended chur v. Found strength in faith w. Daily animal companio x. Involved in group activ y. NONE OF ABOVE 	n/presence		e (etc.)	
7.	EDUCATION (Highest Level Completed) (Check only one.)	1. No schooling X 5. Technical or tr 2. 8th grade or less 6. Some college 3. 9–11 grades 7. Bachelor's de 4. High school 8. Graduate de	e egree	SE	CTION AD.	FA	Z. UNKNOWN-Reside				nformatio	en END
8.	PRIMARY LANGUAGE (Check only one.)	X 0. English 2. French 1. Spanish 3. Other (specified)	fy)		SIGNATURE(S) (Signatures	OF P	PERSON(S) COMPLETING FA Title	CE SHEET:	Sections		Da	te
9.	Mental Health History	b. Mental illness X 0. No	? 1. Yes 1. Yes 1. Yes	b. 2.	DATE Completed		Record date background in	iformation v	· · ·	eted.	Da	te
10.	CONDITIONS RELATED TO MR/DD STATUS	(Check all conditions that are related to MR/DD status the manifested before age 22, and are likely to continue indefinit. X a. Not applicable—no MR/DD (<i>Skip to AB11</i>) MR/DD with organic condition b. Down's syndrome b. Down's syndrome e. Cerebral palsy c. Autism f. Other organic condition d. Epilepsy g. MR/DD with no organic condition	ely) lition related to MR/DD ganic condition				0 7 — 1 5 Month Day		Year			
	alzheimer Dementia History	Does resident's RECORD indicate any history of the following a. Alzheimer's disease X 0. b. Dementia other than Alzheimer's disease X 0.	No 🗌 1. Yes									

CONFIDENTIAL MINIMUM DATA SET (MDS)[®] RESIDENTIAL CARE ASSESSMENT (RCA)

(STATUS IN LAST 7 DAYS UNLESS OTHERWISE NOTED)

SE				CTION C.	COMMUNICATION/HEARING PATTERNS				
S⊑ 1.	RESIDENT	Bertha D Brown	1.	HEARING	(With hearing appliance, if used)				
	NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)		(Check only one.)					
2.	SOCIAL	a. Social Security Number			1. <i>MINIMAL DIFFICULTY</i> when not in quiet setting				
-	SECURITY and MEDICARE	5 2 9 - 7 5 - 8 4 8 6			2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust				
	NUMBERS	b. Medicare number (or comparable railroad insurance number)		COMMUNICA	tonal quality and speak distinctly 3. <i>HIGHLY IMPAIRED</i> –absence of useful hearing				
	(C in 1 st box if no med. no.)				5				
	no meu. no.)		2.	COMMUNICA- TION DEVICES/	(Check all that apply during last 7 days.)				
3.	FACILITY	a. Facility Name MCBVI		TECHNIQUES	a. Hearing aid, present and used				
	AND	b. Provider No.			 b. Hearing aid, present and not used regularly c. Other receptive communication techniques used (e.g., lip reading 				
	PROVIDER NO.				X d. NONE OF ABOVE				
		9 9 9 9 9 9 9 9 9 9	3.	MAKING SELF	(Expressing information content—however able)				
4.	MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient]	0.	UNDERSTOOD					
	NU.	0 4 2 3 2 7 9 1 A		(Check only one.)	X 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or				
-	100500105117				finishing thoughts				
5.	ASSESSMENT DATE	Last day of observation period $\begin{array}{c ccccccccccccccccccccccccccccccccccc$			2. SOMETIMES UNDERSTOOD—ability is limited to making				
					concrete requests 3. RARELY/NEVER UNDERSTOOD				
-		Month Day Year (Check primary reason for assessment)			(Understanding information content—however able)				
6.	REASON FOR ASSESSMENT		4.	ABILITY TO UNDERSTAND					
		X 2. Annual assessment 5. Other (specify)		OTHERS	X 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part / intent of				
		3. Significant change in status assessment		(Check only one.)	message				
7.	MARITAL	X 1. Never married 3. Widowed 5. Divorced			2. SOMETIMES UNDERSTANDS—responds adequately to simple,				
	STATUS (Check only one.)	2. Married 4. Separated			direct communication 3. RARELY/NEVER UNDERSTANDS				
8.	CURRENT	(Billing Office to indicate; check all that apply in last 30 days or since last admission if less than 30 days)	5.	0000000000					
	PAYMENT		5.	COMMUNICA- TION	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				
	SOURCES FOR STAY	c. Thirdle pay		(Check only one.)	180 days.				
		X b. SSI f. Private insurance C. VA (including co-payment)			X 0. No change . 1. Improved . 2. Declined				
		C. VA (including co-payment) d. Social Security g. SSDI	SE		VISION PATTERNS				
		h. Other <i>(specify)</i>	_		(Ability to see in adequate light and with glasses if used)				
9.	RESPONSI-	SI- (Check all that apply)	1.						
	BILITY/ Legal Guardian	a. Legal guardian e. Family member responsible		(Check only one.)	O. ADEQUATE—sees fine detail, including regular print in newspapers/books				
		RDIAN b. Other legal oversight X f. Self C. Durable power of attorney/health care g. Legal Conservator attorney/health care d. Durable power of i. NONE OF ABOVE i.			I. IMPAIRED—sees large print, but not regular print in newspapers/				
					books				
					2. MODERATELY IMPAIRED—limited vision; not able to see				
		attorney/financial			newspaper headlines, but can identify objects 3. <i>HIGHLY IMPAIRED</i> —object identification in guestion, but eyes				
10.	ADVANCED	Does resident have any of the following advanced directives in place?			appear to follow objects				
	DIRECTIVES				X 4. SEVERELY IMPAIRED—no vision or sees only light, colors, or				
		c. Do not hospitalize X 0. No 1. Yes			shapes; eyes do not appear to follow objects				
		d. Organ donation X 0. No I 1. Yes	2.	VISUAL Appliances	a. Glasses, contact lenses X 0. No				
		e. Other X 0. No I. Yes			ES b. Artificial eye X 0. No 🗆 1. Yes				
		(If "yes," specify)	SE	CTION E. I	MOOD AND BEHAVIOR PATTERNS				
SF	CTION B	COGNITIVE PATTERNS	1.	INDICATORS	(CODE: Record the appropriate code for the frequency of the symptom(s)				
_		(Recall of what was learned or known)		OF DEPRESSION,	observed <u>in last 30 days</u> , irrespective of the assumed cause) 0. Not exhibited in last 30 days				
1.	MEMORY	a. Short-term memory OK—seems/appears to recall after 5 minutes		ANXIETY,	 This type exhibited up to 5 days a week 				
		X 0. Memory OK I. Memory problem		SAD MOOD	2. This type exhibited daily or almost daily (6, 7 days/week)				
		b. Long-term memory OK—seems/appears to recall long past			VERBAL EXPRESSIONS OF DISTRESS				
		X 0. Memory OK I. Memory problem			<u>0</u> a. Resident made negative statements—e.g., "Nothing matters;				
2.	MEMORY/	(Check all that resident was normally able to recall during last 7 days)			Would rather be dead; What's the use; Regrets having lived so long; Let me die."				
1	RECALL	Xa.Current seasonXd.That he/she is in a facility/home			0 b. Repetitive questions—e.g., "Where do I go; What do I do?"				
	ABILITY	X b. Location of own room e. NONE OF ABOVE are recalled			c. Repetitive verbalizations—e.g., calling out for help,				
		X c. Staff names/faces			("God help me")				
3.	COGNITIVE	(Made decisions regarding tasks of daily life)			0_ d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in facility; anger at care received				
	SKILLS FOR DAILY	X 0. INDEPENDENT—decisions consistent/reasonable			e. Self deprecation—e.g.,"I am nothing; I am of no use to anyone"				
	DECISION-	1. MODIFIED INDEPENDENCE—some difficulty in new situations only			f. Expressions of what appear to be unrealistic fears—e.g., fear of				
	MAKING	2. MODERATELY IMPAIRED—decisions poor; cues/			being abandoned, left alone, being with others				
	(Check only one.)	supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions			0 g. Recurrent statements that something terrible is about to happen				
-	COONTRAC	-			-e.g., believes he or she is about to die, have a heart attack				
4.	COGNITIVE Status	Resident's cognitive status or abilities now compared to resident's status 180 days ago (or since admission if less than 180 days).			0_ h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions				
	(Check only one.)	X 0. No change							
		1. Improved			0_ i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding				
		2. Declined			schedules, meals, laundry, clothing, relationship issues				
			1	1	(continued next page)				

CONFIDENTIAL 7/13/2004 Date:___

Soc. Sec. #_

529-75-8486

h. Dangerous non-violent behavior (e.g., falling asleep while smoking) 0	SEC	CTION E. N	IOOD and BEHAVIOR PATTERNS (cont.)					SE	CTION F. PSYCHOSOCIAL WELL-BEING		
INDICATORS OF MANA	1.	OF Depression, Anxiety,	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/A SLEEP-CYCLE ISSUES _0	week) furro hand	wed I	brov	,		INITIATIVE/ INVOLVEMENT X b. At ease doing planned or structured activities (Check all that apply) X b. At ease doing self-initiated activities (Check all that apply) 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 g. NONE OF ABOVE UNSETTLED RELATION- SHIPS (Check all that apply) a. Covert/open conflict with or repeated criticism of staff b. Unhappy with residents other than roommate c. Unhappy with residents other than roommate X d. Openly expresses conflict/anger with family/friends g. Absence of personal contact with family/friends f. Recent loss of close family member/friend g. Does not adjust easily to change in routines g. Does not adjust easily to change in routines		
2 MODD (check org) very PERSISTING (check org) very PERSISTING (check org) very (check or			INDICATORS OF MANIA 2q. Inflated self-worth, exaggerated self-opinion; ir about one's own ability, etc. 0r. Excited behavior, motor excitation (e.g., height	ened	phys	ical	/)	3.	LIFE- EVENTS HISTORY Events in past 2 years B a. Serious accident or physical illness D b. Health concerns for other person (Check all c. Death of family member or close friend		
 Concent admission if less than 180 days; 2. Declined A 0. No change COLUMM & COBES: Nexroft the appropriate days in the second of the second of the appropriate days in the second appropriot days in the second days in the second days i		PERSISTENCE (Check only one.)	 (above) were not easily altered by attempts to "cheer up", or reassure the resident over last 7 days. X 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered 	consc	ole, or		10		 e. Robbed/physically attacked X f. Conflict laden or severed relationship g. Loss of income leading to change in lifestyle h. Sexual assault/abuse i. Child custody issues j. Change in marital/partner status 		
4. BEHAVIDRAL (CMUMH & CDBES Record the sproporties in test 7 days 0. Betavior or the try bency of the symptom in test 7 days 0. Betavior or the type courred 110 3 days in 2. Betavior or the type courred 110 3 days in 2. Betavior or the type courred 110 3 days in 2. Betavior or the type courred 110 3 days in 2. Betavior or the type courred 110 3 days in 2. Betavior or the type courred 110 3 days in 2. Betavior or the type courred 110 3 days in 2. Betavior or the type courred 110 3 days in 2. Betavior or the type courred 110 3 days in 2. Betavior or the type courred 110 3 days in 2. Betavior or the type courred 110 3 days in 2. Betavior or the type courred 110 3 days in 2. Betavior or the type courred 110 3 days in 2. Betavior or the type courred 110 3 days in 2. Betavior or the type courred 110 3 days in 2. Betavior or the type courred 110 1 days in 2. Betavior or the type courred 110 1 days in 2. Betavior or the type courred 110 1 days in 2. Betavior or the type courred 110 1 days in 2. Betavior or the type courred 110 1 days in 2. Betavior or the type courred 110 1 days in 2. Betavior or the type courred 110 1 days in 2. Betavior or the type courred 110 1 days in 3. Betavior or the type courred 110 1 days in 3. Betavior or the type courred 110 1 days in 3. Betavior or the type courred 110 1 days in 3. Betavior or the type courred 110 1 days in 3. Betavior or the type courred 110 1 days in 3. Betavior or the type courred 110 1 days in 3. Betavior or the type courred 110 1 days in 3. Betavior or the type courred 110 1 days in 3. Betavior or the type courred 110 1 days in 3. Betavior or the type courred 110 1 days in 3. Betavior or the type courred 110 1 days in 3. Betavior or the type courred 110 1 days in 3. Betavior or the type courred 110 1 days in 3. Betavior or the type courred 110 1 days in 3. Betavior or the type courred 110 1 days in 3. Betavior or the type courred 110 1 days in 3. Betavior or the type courred 110 1 days in 3. Betavior or the type courred 110 1 days in 3. Betavior or	з.		(or since admission if less than 180 days):		ouuy	Jug)	
A. WANDERING (moved with no rational purpose, seemingly oblivious to 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.		code for the frequency of the symptom in last 7 days) Alterability of symptoms in symptoms in 0. Behavior not exhibited in last 7 days 0. Not prese 1. Behavior of this type occurred 1 to 3 days in last 7 days 1. Behavior in 2. Behavior of this type occurred 4 to 6 days but less than daily 3. Behavior of this type occurred daily (COLUMN C CODES: History of this behavior in the last 6 months)	nf beha n <u>last</u> nt or e not ea A	avioral 7 day: easily sily al B	<u>s</u>) alter terec C	ed	-	 (A) ADL SELF-PERFORMANCE INDEPENDENT—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during 1 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or times during last 7 days LIMITED ASSISTANCE—Resident highly involved in activity; received physical help in gu 	last or 2 iidec	
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were int, threatened, screamed at, cursed at) 0 <td>a.</td> <td></td> <td>i (moved with no rational purpose, seemingly oblivious to</td> <td>-</td> <td></td> <td>0</td> <td></td> <td></td> <td>3. EXTENSIVE ASSISTANCE-While resident performed part of activity, over last 7-day period</td> <td></td> <td></td>	a.		i (moved with no rational purpose, seemingly oblivious to	-		0			3. EXTENSIVE ASSISTANCE-While resident performed part of activity, over last 7-day period		
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused, gross physical assaul) 0 0 0 d. SOCIALLY INAPPROPREMITE/DISRUPTIVE BEHAVIORAL (B) ADL SUPPORT CODES (or MOST SUPPORT PROVIDED OVER EACH 24 High proformance of activity during last 7 days; searing, searing, searing, self-mutiation) 0 0 0 e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, a duse, self-mutiation) 0	b.	VERBALLY A	BUSIVE BEHAVIORAL SYMPTOMS (others were	0	0	0			- Weight-bearing support		
d. SOCIALLY INAPPROPRIATE/DISRUTTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, sexual behavior, disrobing in public, smared/threw food/faces, housing attrough others' belongings, stealing, self-abusive acts, substance abuse, self-mutilation) 0	c.	PHYSICALLY	ABUSIVE BEHAVIORAL SYMPTOMS (others were hit,	0	0	0			4. TOTAL DEPENDENCE—Full staff performance of activity during last 7 days		
belongings, stealing, self-abusive acts, substance abuse, self-mutilation) 0 <td>d.</td> <td>SOCIALLY IN SYMPTOMS</td> <td>APPROPRIATE/DISRUPTIVE BEHAVIORAL (made disruptive sounds, sexual behavior, disrobing in</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>(B) ADL SUPPORT CODES (CODE for MOST SUPPORT PROVIDED OVER EACH HOUR PERIOD) during last 7 days; code regardless of person's A</td> <td>E</td> <td></td>	d.	SOCIALLY IN SYMPTOMS	APPROPRIATE/DISRUPTIVE BEHAVIORAL (made disruptive sounds, sexual behavior, disrobing in						(B) ADL SUPPORT CODES (CODE for MOST SUPPORT PROVIDED OVER EACH HOUR PERIOD) during last 7 days; code regardless of person's A	E	
g. ELOPEMENT 0	•	belongings, st	ealing, self-abusive acts, substance abuse, self-mutilation)	0	0	0	+		Sein-performance classification. O. No setup or physical help from staff Orden below the setup.	ANCE	
g. ELOPEMENT 0		assistance, or	eating)						Setup neip only Setup neip only One-person physical assist To the persons physical assist A detuite did not occur during entire 7 days	ERFORM	
h. Dangerous non-violent behavior (e.g., falling asleep while smoking) 0 0 0 i. Dangerous violent behavior 0 0 0 0 0 j. FIRE SETTING 0<	g.	,	-	0	-		╡║┝		BED MOBILITY – How resident moves to and from lying position, turns side to	- I.	0
i. Dangerous violent behavior 0	h.	0		-	-	-] -		side, and positions body while in bed	+	_
 SUICIDAL IDEATION Resident demonstrated suicidal thoughts or actions in the last 30 days: X 0. No I. Yes Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present on 2 or more days during last 7 days Check all present all present on 2 or more days during last 7 days Check all present all present on 2 or more days during last 7 days Check all present all present on 2 or more days during last 7 days Check all present all present all problem Check all present all present all present all problems Check all present all present all present all problem Check all present		0		-			$+ \downarrow$		wheelchair, standing position (EXCLUDE to/from bath/toilet)	_	_
SUCLDAL IDEATION X 0. No 1. Yes 0 1 6. SLEEP PROBLEMS Check all present on 2 or more days during last 7 days d. Interrupted sleep X b. Difficulty falling asleep d. Interrupted sleep 0 0 7. INSIGHT INTO MENTAL HEALTH Resident has insight about his/her mental problem 0. No 1. Yes 2. No mental health problems 0 0 8. BEHAVIORS (Check and vane) Resident's current behavior status compared to resident's status 180 days ago (or since admission if less than 180 days): No 1. Yes 0 0 8. BEHAVIORS Resident's current behavior status compared to resident's status 180 days ago (or since admission if less than 180 days): 0 0				-		-			areas set aside for dining, activities, or treatments). If facility has only one floor,		
6. SLEEP PROBLEMS One of the product product of the off both only of during lack r days 0 9. Institute of the off both only of during lack r days 0 0. Image: the off both only of the off both only of during lack r days 0 0. Image: the off both only of the off both only of the only		IDEATION					_ -		sufficiency once in chair	-	0
X b. Difficulty falling asleep Ie. NONE OF ABOVE nourishment by other means (e.g., tube feeding, total parenteral nutrition) 0 INSIGHT c. Resident has insight about his/her mental problem f. TOILET USE – How resident uses the toilet room (or commode, bed-pan, urinal); transfer on/off toilet, cleanese, changes pad, manages ostomy or catheter, adjusts clothes 0 7. INSIGHT Resident has insight about his/her mental problem 0 8. BEHAVIORS Resident's current behavior status compared to resident's status 180 days): 0 (Check only one) mask 0	6.		, , , , ,	ed sle	ер				clothing, including donning/removing prosthesis 0	\downarrow	C
7. INSIGHT INTO MENTAL HEALTH Resident has insight about his/her mental problem X 0. 0 8. BEHAVIORS (Check only one) Resident's current behavior status compared to resident's status 180 days ago (or since admission if less than 180 days): 0 0				ABC	VE				nourishment by other means (e.g., tube feeding, total parenteral nutrition)		0
HEALTH combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers) 0 8. BEHAVIORS Resident's current behavior status compared to resident's status 180 days ago (or since admission if less than 180 days): 0 0	7.	INTO Mental	Resident has insight about his/her mental problem	alth p	roble	ms		g.	urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes 0 PERSONAL HYGIENE – How resident maintains personal hygiene, including		0
days ago (or since admission if less than 180 days):	8.	HEALTH	Resident's current behavior status compared to resident's sta	atus 1	80		-		combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		0
			days ago (or since admission if less than 180 days):					h.	STAIRS – How resident climbs stairs 0		0

0 0

SELF-PERFORMANCE SUPPORT

> 0 0

0 0

0 0

0 0

0 0

Res	ident Name:	_Bertha Brown Date:_7-13-2004		Soc	. Sec. #52	9-75-8486 Facility Provider #_9999999999				
SE	CTION G. P	HYSICAL FUNCTIONING (cont.)		SE	CTION G.	PHYSICAL FUNCTIONING (cont.)				
2.	BATHING SELF- Performance	 X 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 	s in/out <u>s</u> t			 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 				
3A.	MODES OF Locomotion	(Check all that apply during last 7 days) a. Cane/walker/crutch b. Wheeled self c. Other person wheeled X d. 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 b. Hearing aid (e.g., button hook, velcro closings) c. Cane or walker g. Dentures				
3B.	MAIN Mode of Locomotion	Was wheelchair the primary mode of locomotion during the last 7 day X 0. No 1. Yes	ys?			d. Wheelchair h. Other (specify) e. Assistive feeding devices (e.g., plate X i. NONE OF ABOVE				
3C.	BEDFAST/ Chairfast	(Check if health condition keeps resident in his/her room 22+ hours p in last 7 days)	oer day			guard, stabilized built-up utensil)				
		 a. Bedfast all or most of time b. Chairfast all or most of the time X c. NONE OF ABOVE 		8.	SELF- Performance In Iadls	Resident's current IADL status or abilities compared to resident's status 180 days ago (or since admission if less than 180 days): X 0. No change 1. Improved 2. Declined				
4.	SELF- Performance	Resident's current ADL status or abilities compared to resident's stat	us 180	SE	CTION H.	CONTINENCE IN LAST 14 DAYS				
	(Check only one.)	X 0. No change 1. Improved 2. Declined			CONTINENCE SELF-CONTROL CATEGORIES (Cade for resident's PERFORMANCE OVER ALL SHIFTS) 0. CONTINENT—Complete control (includes use of indwelling urinary ca ostomy device that does not leak urine or stool) 1. USUALLY CONTINENT—BLADDER, Incontinent episodes once a we					
5A.	IADL SELF- PERFOR- MANCE	 Code for level of independence in the last 30 days based on residen involvement in the activity. SELF-PERFORMANCE CODES: INDEPENDENT : (with/without assistive devices)—No help p DONE WITH HELP: Resident involved in activity but help (inc supervision, reminders, and/or physical help) is provided. DONE BY OTHERS: Full performance of the activity is done by others. The resident is involved at all when the activity is performed. 	rovided. Iuding	a.	BOWEL, 2. OCCASI daily; BO 3. FREQUE some cor 4. INCONTI all (or alm	OCCASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not daily; BOWEL, once a week FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g. on day shift); BOWEL, 2-3 times a week INCONTINENT—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time BOWEL Control of bowel movement, with appliance or bowel continence				
		 Activity did not occur in the last 30 days. 		b.	BLADDER	Control of urinary bladder function with appliances (e.g. foley) or				
		IADL	SELF- PERFORMANCE	2.	CONTINENCE	continence programs, if employed 0 Bowel elimination pattern regular—at least one movement every three days Diarrhea c. A. Fecal Impaction d. Resident is Independent e.				
		a. Resident arranged for shopping for clothing, snacks, other incidentals.	0	3.	APPLIANCES	Constipation b. X NONE OF ABOVE f.				
		b. Resident shopped for clothing, snacks, or other incidentals.	0	3.	and PROGRAMS	Any scheduled toileting plan a. Did not use toilet room/ commode/urinal f.				
		 Resident arranged for suitable transportation to get to appointments, outings, necessary engagements. 	0		FROUNAINS	External (condom) catheter c. Pads/briefs used g.				
		d. Resident managed finances including banking, handling checkbook, or paying bills.	0	1		Indwelling catheter d. Enemas/irrigation h. Intermittant entheter e. Ostomy present i.				
		e. Resident managed cash, personal needs allowance.	0			Intermittent catheter e. Ostorily present i. X NONE OF ABOVE j. X				
		f. Resident prepared snacks, light meals.	0	4.	USE OF INCONTINENC	Resident's management of incontinence supplies (pads, briefs, ostomy, catheter) in last 14 days.				
		g. Resident used phone.h. Resident did light housework such as making own bed,	0		SUPPLIES (Check only one.)	X 0. Always continent				
		dusting, or taking care of belongings. i. Resident sorted, folded, or washed own laundry.	0			independently. 2. Resident incontinent and receives assistance with managing				
5B.	TRANSPOR- TATION	Check all that apply for level of independence in the last 30 days bas on resident's involvement in the activity.				 a. Resident incontinent and does not use incontinence supplies. a. Resident incontinent and does not use incontinence supplies. 				
		 a. Resident drove car or used public transportation independent get to medical, dental appointments, necessary engagements other activities. X b. Resident rode to destination with staff, family, others (in car, vai public transportation) but was not accompanied to medical, 	s, or	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): X 0. No change 1. Improved 2. Deteriorated				
		dental appointments, necessary engagements, or other activit				IAGNOSES				
		 X c. Resident rode to destination with staff, family, others (in car, val public transportation) and <u>was accompanied</u> to medical, den appointments, necessary engagements, or other activities. d. Activity did not occur. 		and	l behavior statu	diagnoses that have a relationship to current ADL status, cognitive status, mood is, medical treatments, nurse monitoring, or risk of death. (Do not list inactive le apply, CHECK item xx. NONE OF ABOVE)				
6.	ADL AND IADL FUNCTIONAL REHABILI- TATION OR IMPROVE- MENT POTENTIAL (Check all that apply.)	 X a. Resident believes he/she is capable of increased independence at least some ADLs or IADLs. X 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 morning evenings e. Resident requires or only understands a one-step direction. <i>(continued in next column)</i> 		1.	DIAGNOSES	ENDOCRINE/METABOLIC/ NUTRITIONAL HEART/CIRCULATION a. Diabetes mellitus d. Arteriosclerotic heart disease (ASHD) b. Hyperthyroidism e. Cardiac dysrhythmia c. Hypothyroidism f. Congestive heart failure g. Deep vein thrombosis h. Hypertension i. Hypotension j. Peripheral vascular disease k. Other cardiovascular disease k. Other cardiovascular disease				

_		Bertha D. Brown	7/13/2004	_	_	529-75-8486	999999999	÷
	sident Name:		Date:		Sec #			
SE	CTION I. DIAGI	NOSES (cont.) MUSCULOSKELETAL I. Arthritis m. Hip fracture n. Missing limb (e.g., amputation) o. Osteoporosis	ff. Manic depressive (Bipolar) gg. Schizophrenia PULMONARY hh. Asthma ii. Emphysema/COPD	SEC		LTH CONDITIONS AND POSSIBLI During the last 7 days, how much normal activities such as visiting w 1. All of the time 2. Some of the time	of the time did pain interfere with	resident's
		p. Pathological bone fracture	SENSORY	6.	PAIN MANAGE- MENT	 1. No pain treatment X 2. Treated, full control 	 3. Treated, partial control 4. Treated, no or minimal of the second second	control
		NEUROLOGICAL q. Alzheimer's disease r. Aphasia s. Cerebral palsy	Kk. Diabetic retinopathy Il. Glaucoma mm. Macular degeneration	7.	ACCIDENTS (Check all that apply)	a. Fell in past 30 days	d. Other fracture in last 18 X e. NONE OF ABOVE	
		 L. Cerebrovascular accident (stroke) U. Dementia other than Alzheimer's disease V. Hemiplegia/ hemiparesis M. Multiple sclerosis x. Paraplegia 	X nn. Allergies (<i>specify</i>) <u>LACTOSE</u> oo. Anemia pp. Cancer qq. Benal failure rr. Tuberculosis-TB ss. HIV tt. Mental retardation(e.g., Down's Syndrome, Autism, or other organic condition related to	8.	DANGER OF FALL (Check all that apply)	a. Has unsteady gait b. Has balance problems wh	- nen standing sident or family fearful of resident t	falling
		y. Parkinson's disease	Mental Retardation or Developmental disability (MR/	SEC	CTION K. ORA	L/NUTRITIONAL STATUS		
		z. Quadriplegia aa. Seizure disorder bb. Transient ischemic attack (TIA)	DD) uu. Substance abuse (alcohol or drug) vv. Other psychiatric diagnosis (e.g., paranoia, phobias,	1.	ORAL PROBLEMS (Check all that apply)	a. Mouth is "dry"when eating b. Chewing Problem c. Swallowing Problem	g a meal 🗌 d. Mouth Pain X e. NONE OF ABC)VE
		Cc. Traumatic brain injury PSYCHIATRIC/MOOD dd. Anxiety disorder	personality disorder) ww. Explicit terminal prognosis xx. NONE OF ABOVE	2.	HEIGHT AND WEIGHT	Record (a.) height in inches and (b.) u measure in last 30 days; measure weig practice-e.g., in a.m. after voiding, before	ght consistently in accord with standau ore meal, with shoes off, and in nightc	rd facility
		ee. Depression			WEIQUT	a. HT (in.)		-
2	. OTHER CURRENT DIAGNOSIS	a	008.45	3.	WEIGHT Change	a. Unintended weight loss–5% more in last 180 days X 0. No 1. Ye:		, or
	AND ICD-9 CODES	b c				b. Unintended weight gain–5% more in last 180 days		or
SEC	CTION J. HEAL	TH CONDITIONS AND POSSIBI	LE MEDICATION SIDE EFFECTS			X 0. No 1. Yes	s	
1	PROBLEM CONDITIONS	 (Check all problems present in last a. Inability to lie flat due to shortness of breath b. Shortness of breath c. Edema d. Dizziness/vertigo e. Delusions f. Hallucinations 	 t7 days unless other time frame is indicated) i. Headache j. Numbness/tingling k. Blurred vision I. Dry mouth m. Excessive salivation or drooling n. Change in normal appetite 	4.	NUTRI- TIONAL PROBLEMS OR AP- PROACHES (Check all that apply)	 a. Complains about the taster of many foods b. Regular or repetitive complaints of hunger c. Leaves 25% of food uneaten at most meals d. Therapeutic diet e. Mechanically altered (or pureed) diet 	 f. Noncompliance with a g. Eating disorders h. Food allergies (specify) i. Restrictions (specify) X j. NONE OF ABOVE 	diet
		g. Hostility	O. Other (specify)	SEC	TION L. ORA	L/DENTAL STATUS		
2	EXTRA- PYRAMIDAL SIGNS AND SYMPTOMS	h. Suspiciousness Check all present at any point d INCREASE IN MOTOR ACTIVITY X a. Akathisia-resident report need for movement b. Dyskinesia-chewing, pu irregular movements of C. Tremor-regular rhythmia mouth, or tongue DECREASE IN MOTOR ACTIVITY	X p. NONE OF ABOVE	1.	ORAL STATUS AND DISEASE PREVENTION (check all that apply)	 a. Has dentures or removable b. Some/all natural teeth lost (or partial plates) c. Broken, loose or carious to d. Inflamed gums (gingiva); sulcers or rashes 	t-does not have or does not use of eeth swollen or bleeding gums; oral ab ntures or daily mouth care-by resi	ns; oral abscesses; are-by resident or
		continuous or cogwheel		SEC	CTION M. SKI	N CONDITION		
		usually with a decrease f. Bradykinesis–decrease body movement or <i>pove</i> MUSCLE CONTRACTIONS g. Dystonia–muscle hyper	in pendular arm movement in spontaneous movements (e.g., reduced <i>erty of</i> facial expression, gestures, speech) tonicity (e.g., muscle spasms or stiffness, ard deviation of the eyes)	1.	SKIN PROBLEMS (Check all that apply) ULCERS	Any troubling skin conditions or ct a. Abrasions (scrapes) or cu b. Burns (2nd or 3rd degree) c. Bruises X d. Rashes, itchiness, body licc Record the number of ulcers at eacl If none present at a stage, record "0	e Open sores or lesic f. Other (<i>specify</i>) g. NONE OF ABOVE h ulcer stage-regardless of cause.	
3	PAIN	(Code the highest level of resident's	s pain present in the last 7 days) 01		(Due to	last 7 days. Code 9=9 or more) Req		Number at Stage
	SYMPTOMS	On a scale of 1 to 10, where 1 is			any cause)	a. Stage 1. A persistent area of skir the skin) that does not disappear w	hen pressure is relieved.	ਟ ਢ 1
4	PAIN SITE	(If pain is present in the last 7 days) a. Back pain	s)			b. Stage 2. A partial thickness loss of clinically as an abrasion, blister, or s	shallow crater.	0
		 b. Bone pain c. Chest pain while doing 	 g. Joint pain (other than hip) h. Soft tissue pain (e.g., lesion, 			c. Stage 3. A full thickness of skin is ous tissues–presents as a deep cra undermining adjacent tissue.		0
		usual activities X d. Headache	muscle)			d. Stage 4. A full thickness of skin a exposing muscle or bone.	ind subcutaneous tissue is lost,	0
		🗌 e. Hip pain	j. Other (specify)	L	1			

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

		CONF	DENTI	AL			
Re	sident Name:	Bertha D. Brown 7/13/2004 Date:	Soc.	5 Sec #	529-75-8486 999999999 Facility Provider #		
SE	ECTION M. SKI				DICATIONS (cont.)		
	3. FOOT PROBLEMS	 a. Resident or someone else inspects resident's feet on a regular basis? X 0. No	4A 4B	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) 0a. Antipsychotic _0d. Hypnotic _0g. 0b. Antianxiety _0e. Diuretic g. 0c. Antidepressant f. Aricept	Ins	ulin
				MEDICATIONS	emotional or nervous condition, or behavioral problem?		
	TINAE						
	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: X a. Morning d. Night (Bedtime to A.M.) X b. Afternoon X c. Evening	5.	SELF- ADMINSTERED MEDICATIONS (Check all that apply.)	a. Insulin a. Insulin b. Oxygen X f. Over-the-counter Meds		_
2	2. AVERAGE TIME INVOLVED IN	(When awake and not receiving treatments or ADL care) 1. Most-more than 2/3 of time	6.	MEDICATION Preparation Administra-		day	ys?
	ACTIVITIES (Check only one.)	 X 2. Some-from 1/3 to 2/3 of time ☐ 3. Little-less than 1/3 of time ☐ 4. None 		TION	 0. No Meds 1. Resident prepared and administrated <u>NONE</u> of his/her own medica 2. Resident prepared and administrated <u>SOME</u> of his/her own medication X 3. Resident prepared and administrated <u>ALL</u> of his/her own medication 	atior	ns.
3	3. PREFERRED	(Check all settings in which activities are preferred)	7.				
	ACTIVITY Settings	X a. Own room X d. Away from facility b. Day/activity room e. NONE OF ABOVE		MEDICATION	Resident's level of compliance with medications prescribed by a phys psychiatrist during last 30 days: 0. No Meds	icia	.n/
		X c. Outside facility (e.g., in yard)		(Check one)	X 1. Always compliant		
4	4. GENERAL ACTIVITY PREFER- ENCES	(Check all PREFERENCES whether or not activity is currently available to resident) X a. Cards/other games K Gardening or plants X b. Crafts/arts I. Talking or conversing X c. Exercise/sports m. Helping others			 Always compliant with reminder, verbal prompts Compliant some of the time (80% of time or more often) or wis some medications 	ith	
	(Adapted to resident's	X c. Exercise/sports m. Helping others d. Dancing n. Doing chores around the		MISUSE	4. Rarely or never compliant Misuse of prescription or over-the-counter medications in the last 6 m		he
	current	X e. Music house/facility	8.	OF	(e.g., resident uses more or less than the directed dose, is using med		
	abilities)	X f. Reading/writing O. Cooking/baking		MEDICATION	for a purpose other than intended) X 0. No 1. Yes		
		g. Spiritual/religious activity p. Computer activities X h. Trips/shopping g. Volunteering	SE	CTION P. SPEC	CIAL TREATMENTS AND PROCEDURES		
		X h. Trips/shopping q. Volunteering i. Walking/wheeling outdoors r. Other (specify)	1.	SPECIAL TREATMENTS,	a. SPECIAL CARE-Check treatments or programs received during the la days [Note-count only post admission treatments]	ist 1	14
		i. Watching TV □ s. NONE OF ABOVE		PROCE-		a rot	turn
\vdash	5. PREFERRED	(Check all that apply)		DURES, AND	a. Chemotherapy or radiation I raining in skills required to to the community (e.g., taki		.um
	ACTIVITY	a. Individual c. Larger group		PROGRAMS	b. Oxygen therapy medications, house work, shopping, transportation, A		2)
	5121	X b. Small group d. No preference			c. Dialysis j. Case management	DL	5)
	6. ENCES IN	a. Resident prefers change in type of activity			PROGRAMS		
	DAILY	b. Resident prefers change in extent of involvement in activities (e.g., more or less)			program I. Sheltered workshop/emplo	ym	ent
		c. Resident prefers change in location of activities			e. Alzheimer's/dementia		
	(Check all that apply)	d. Resident prefers activity at different time of day			special care unit In. Transportation f. Hospice care O. Psychological rehabilitation	n	
		e. Resident prefers stability in daily routine			g. Home health □ p. Formal education		
\vdash		X f. NONE OF ABOVE			h. Home care X q. NONE OF ABOVE		
7	7. INTERACTION WITH FAMILY				b. THERAPIES—Record the number of days each of the following therapies administered (for at least 15 minutes a day) in the last 7 calendar days		
	AND FRIENDS				0 if none or less than 15 min. a day)		
		facility 5. 2 or 3 times a week but not			(Note-count only post admission therapies) (A) = # of days administered for 15 minutes or more		SITE (C)
		2. None daily X 3. 1-3 times/month 6. Daily			Check B if therapy was received at home or in facility Days	N SITE	E SI
		· · · · · · · · · · · · · · · · · · ·			Check C if therapy was received out-of-home or facility (A)	ō	E O
		b. How often has resident talked by telephone with family and friends in the last 30 days? (check only one)			a. Speech-language pathology and auditory services 0 b. Occupational therapy 0	+	+
		□ 1. No family or friends outside X 4. Once a week			b. Occupational therapy 0 c. Physical therapy 0	+	+
		facility 5. 2 or 3 times a week but not			d. Respiratory therapy 0	+	+
		2. None daily 3. 1-3 times/month 6. Daily			e. Psychological therapy (by any licensed mental health professional) 0	T	
-	8. VOTING	Is resident registered to vote? 0. No X 1. Yes	2		Check all interventions or strategies used in the last 7 days unless oth	ier t	ime
	9. SOCIAL ACTIVITES	Resident's current level of participation in social, religious or other personal		VENTION PROGRAMS	specified-no matter where received) a. Special behavior environment to address		
	(Check only	activities compared to resident's status 180 days ago (since admission if less than 180 days):		FOR MOOD, BEHAVIOR.	symptom evaluation mood/behavior patterns-		
	one.)	0. No change X 1. Improved 2. Declined		COGNITIVÉ	program providing bureau in which rummage	11 (0	'
			'	LOSS	b. Special behavior management program	ng	
SE	ECTION O. MEE	(Becard the number of different mediactions used in the last 7 days)			c. Evaluation by a licensed g. Validation/Redirection		
	MEDICATION				mental health specialist in L h. Crisis intervention in facil		
1	2. NEW	(Resident currently receiving medicatons that were initiated during the last 90 days)			last 90 days i. Crisis stabilization unit in d. Group therapy 90 days	las	Τ.
	MEDICATION	X 0. No 🗌 1. Yes			□ u. Group merapy □ u. Group merapy □ e. Resident-specific □ j. Other (specify)		
1	3. INJECTIONS	(Record the number of DAYS injections of any type received during the last 30 days ; enter "0" if none used)			deliberate changes in the X k. NONE OF ABOVE		

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

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			CONFIDENTIA	AL.				
Res	sident Name: _	O7/13/200 Bertha D. Brown Date:)4 Soc. Sec	5: # _)	29-75-8486 Facility Pr	rovider #	9999999999	
SE	CTION P. SPEC	IAL TREATMENTS AND PROCEDURES (cont.)	SEC	TION Q. SER	VICE PLANNING			
3.	ON-GOING MONITORING REHABILITA-	(Code for person responsible for monitoring) 0. No monitoring required 2. RCF Other Staff 1. RCF nurse 3. Home health nurse 0. a. Acute physical or psychiatric condition - not chronic 2 b. New treatment/med 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		RESIDENT GOALS (Check all areas in which: resident has self-identified goals)	X d. Rehabilitation-skilled	king friends learning cognitive function mmunity		
	TION/ Restorative Care	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 0 d. Bed mobility	2.	CONFLICT a. Any disagreement between resident and family about goals of service plan? 0. No X 1. Yes b. Any disagreement between resident/family and staff about go service plan? X 0. No 1. Yes CONFLICT TION R. DISCHARGE POTENTIAL				
5.	SKILL TRAINING	o e. Transfer o j. Communication 0 f. Walking o k. Time management 0 g. Dressing or grooming o l. Other (specify) 0 h. Eating or swallowing Record the number of days, in the last 30 days that each of the following were performed with assistance from staff as a skill training activity identified the resident's spring alago.		DISCHARGE POTENTIAL	 a. Does resident of X1. Yes b. Does resident have a supp discharge? 0. No c. Has resident's self-sufficier since admission, if less that the super super	X 1. Yes ncy changed compared to 6 an 6 months?	towards	
		<u>0</u> a. Meal Preparation (snacks, <u>0</u> h. Arranges Shopping light meals) (makes list, acquires	S					
		b. Telephone Use help)		1	ESSMENT INFORMATION			
		own bed, takes care of incidentals)		TION	a. Resident: 0. No b. Family: X 0. No	X 1. Yes 2. No Fam	nilv	
	0 belongings) 0 incidentals) d. Laundry (sorts, folds, or j. Transportation (travel by			ASSESS- MENT	c. Other Non-Staff: X 0. No			
		0 washes own laundry 0 washes own laundry 1 e. Managing Incontinence Supplies (pads, briefs, ostomy, catheter) o 1 f. Managing Cash (handles cash, makes purchases) o 2 g. Managing Finances (banking, handling checkbook, or paying bills) o	nts or 2. ra-	a. Signatu	S OF PERSONS COMPLETING re of Assessment Coordinator (sig sessment Coordinator signed as o natures Title	n on line above)	- 2004 Vear	
6.	WITH	In the last 6 months, compliant all or most of the time with special treatm therapies and programs:	ents,	d.			Date	
	TREATMENTS/ Therapies/ Programs	X 0. Always compliant 3. No treatments or progra 1. Compliant 80% of time 8. Unknown 2. Compliant less than 80% of the time	ams 3.	e. CASE MIX GROUP			Date	
7.	HOSPITAL	Record number of times resident was admitted to an acute care hospital with an overnight stay in last 6 months (or since last	0 0 SEC		entive Health/Health Behaviors			
	STAY(S)	assessment if less than 6 months.) (Enter "0" if no hospital admissions)		PREVENTIVE	(Check all the procedures the re	esident received during the	past 12 months)	
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)	0 0	HEATH	 X a. Blood pressure monitorir b. Hearing assessment c. Vision test 	ng g. Breast exam h. Pap smear i. PSA or rectal	0	
9.	VISITS	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		 d. Dental visit X e. Influenza vaccine 	X j. Other (specify, LACTOSE		
10	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)	0 1		f. Pneumococcal vaccine (ANY time)			
11.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission if less than 90 days)? 0. No X 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)	0 0					
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)	0 0					

		CONFIDENTIAL		
Bertha D. Brown	07/13/	2004 529-7	5-8486	999999999
sident Name:	Date:	Soc. Sec. #	Facility	Provider #
	SECTIO	N U. MEDICATIONS LIST		
List all medications given during the	e last 7 days. Include medications use	d regularly less than weekly as	part of the resident's treatment reg	gimen.
1. List the medication name and the	e dosage			
2. RA (Route of Administration). U	se the appropriate code from the follow	ving list:		
1 = by mouth (PO)	3 = intramuscular (IM)	5 = subcutaneous (SubQ)	7 = topical	9 = enteral tube
2 = sublingual (SL)	4 = intravenous (IV)	6 = rectally	8 = inhalation	10 = other
3. FREQ (Frequency): Use the ap	propriate frequency code to show the n	umber of times per day that the	medication was given.	
PR = (PRN) as necessary	8H = (q8h) every eight hours	5D = five times a da	V	
1H = (qh) every hour	1D = (qd or hs) once daily	1W = (QWeek) once	SVV = IIVE	e times every week times every week
2H = (q2h) every two hours	2D = (BID) two times daily	2W = twice every we	eek 1M = (QN	Month) once every month
3H = (q3h) every three hours	(includes every 12 hours)	3W = three times ev	ery week 2M = twic	ce every month
4H = (q4h) every four hours 6H = (q6h) every six hours	3D = (TID) three times daily 4D = (QID) four times daily	QO = every other da 4W = four times eve		
			O = other	r

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

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

1. Medication Name and Dosage	2. RA	3. Freq	4. PRN-n			5.	ND	C Co	odes	\$		
EXAMPLE: Coumadin 2.5 mg Digoxin 0.125 mg Humulin R 25 Units Robitussin 15cc	1 1 5 1	1W 1D 1D PR	2									
Zestril 40 mg	01	1D		0 0	0	3	8	0	1	3	4	1 0
									1			
								<u> </u>				
									<u> </u>	L	<u> </u>	
					I	1	1	I	1	I		I
								1				
					I	I	I	I	I	I		I
									1	I		
						I	I	1	1	I		
					1	1	1		1	1		
	1		1	1				1	1	1	1	

MINIMUM DATA SET (MDS)[©] RESIDENTIAL CARE ASSESSMENT (RCA)

BASIC ASSESSMENT TRACKING FORM

GENERAL INSTRUCTIONS:

Complete this form for all assessments and discharges.

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT	
1.	NAME	ANDREW W CAVANAUGH
		a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER	X 1. Male 2. Female
3.	BIRTHDATE	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$
4.	RACE/ ETHNICITY (Check only one.)	 1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic X 5. White, not of Hispanic origin 6. Other
5.	SOCIAL SECURITY and MEDICARE NUMBERS (C in 1 st 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)
6.	FACILITY NAME AND PROVIDER NO.	a. Facility Name MCBVI b. Provider No. 9 9 9 9 9 9 9
7.	MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient] 3 2 4 6 7 3 7 0 A
8.	SIGNATURE(S)	OF PERSON(S) COMPLETING FACE SHEET:
	Signatures	Title Sections Date RCA DIRECTOR ALL 12/14/1993
b.		Date
2.	DATE Completed	Record date background information was completed. 0 7 1 4 2 0 0 4 Month Day Year

MINIMUM DATA SET (MDS)[®] RESIDENTIAL CARE ASSESSMENT (RCA)

FACE SHEET: BACKGROUND INFORMATION ONLY AT ADMISSION

Resid	dent Name:	ANDREW W CAVANAUGH Date: 07/07/2004	Soc.	Sec. #004	4-78-8974	Facility Provider #	999999999			
SE	CTION AB.	DEMOGRAPHIC INFORMATION	SE	ECTION AC.	. CUSTOMA	RY ROUTINE				
1.	DATE Of Entry	Date the stay began. (Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date.) 1 2 0 4 1 9 9 3 Month Day Year	1.	CUSTOMARY ROUTINE (In year prior to DATE OF ENTRY to this home,	CYCLE OF DAILY E	IPPIY. If <u>all</u> information UNKNOWN, ch EVENTS up late at night (e.g., after 9 pm) regularly during day (at least 1 hou				
2.	ADMITTED FROM (AT ENTRY) (Check only one.)			or year last in community if now being admitted from another home, nursing home, or hospital)	X d. Stayed bi e. Spent m X f. Moved in g. Used tol h. NONE C EATING PATTERNS	 X c. Went out 1+ days a week X d. Stayed busy with hobbies, reading, or a fixed daily routine e. Spent most of time alone or watching TV X f. Moved independently indoors (with appliances, if used) g. Used tobacco products at least daily h. NONE OF ABOVE 				
3.	LIVED ALONE (PRIOR TO ENTRY) (Check only one.)	X 0. No I 1. Yes Image: Comparison of the second			☐ j. Ate betw ☐ k. Used ald X I. NONE O	food preferences veen meals all or most days coholic beverage(s) at least weekly <i>FABOVE</i>	,			
4.	PRIOR Primary Residence	Provide town, state, zip code for Resident's primary residence prior to admission MAINE 0 4 1 0 6 Town State Zip Code			ADL PATTERNS					
5.	RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	 (Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above) a. Prior stay at this home b. Nursing home X c. Other residential facility—board and care home, assisted living, group home d. MH/psychiatric hospital e. MR/DD facility f. NONE OF ABOVE 			X p. Shower fr q. Sponge X r. Bathed in s. NONE (C INVOLVEMENT P/ t. Daily co u. Usually : v. Found s	or bathing bath PM DF ABOVE	ue (etc.)			
6.	LIFETIME Occupation	Put a "/" between two occupations. C L E R K			Xx. Involved in y. NONE (group activities DF ABOVE				
7.	EDUCATION (Highest Level Completed) (Check only one.)	1. No schooling 5. Technical or trade school 2. 8th grade or less 6. Some college 3. 9–11 grades 7. Bachelor's degree X 4. High school 8. Graduate degree	SE	CTION AD.		WN—Resident/family unable to pr	E			
8.	PRIMARY LANGUAGE (Check only one.)	X 0. English 2. French 1. Spanish 3. Other (specify)	a.	Signatures	OF PERSON(S) CO	MPLETING FACE SHEET: Title Sections A DIRECTOR ALL	Date 12/14/1993			
9.	MENTAL Health History	Does resident's RECORD indicate any history of the following? a. Mental retardation X 0. No 1. Yes b. Mental illness X 0. No 1. Yes c. Developmental disability X 0. No 1. Yes	b. 2.	DATE Completed		background information was compl				
10.	CONDITIONS RELATED TO MR/DD STATUS	(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely) X a. Not applicable—no MR/DD (Skip to AB11) MR/DD with organic condition b. Down's syndrome e. Cerebral palsy c. Autism f. Other organic condition related to MR/DD d. Epilepsy g. MR/DD with no organic condition			I 2 Month	14 1 9 9 Day Year	3			
11.	ALZHEIMER Dementia History	Does resident's RECORD indicate any history of the following? a. Alzheimer's disease 0. No X 1. Yes b. Dementia other than Alzheimer's disease 0. No X 1. Yes								

END

CONFIDENTIAL MINIMUM DATA SET (MDS)[®] RESIDENTIAL CARE ASSESSMENT (RCA)

(STATUS IN LAST 7 DAYS UNLESS OTHERWISE NOTED)

SE			SE	CTION C.	COMMUNICATION/HEARING PATTERNS
1.	RESIDENT	ANDREW W CAVANAUGH	1.	HEARING	(With hearing appliance, if used)
	NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)		(Check only one.)	X 0. HEARS ADEQUATELY—normal talk, TV, phone
2.	SOCIAL	a. Social Security Number			1. <i>MINIMAL DIFFICULTY</i> when not in quiet setting
	SECURITY and MEDICARE				2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust
	NUMBERS (C in 1 st box if	b. Medicare number (or comparable railroad insurance number)			tonal quality and speak distinctly 3. <i>HIGHLY IMPAIRED</i> –absence of useful hearing
	no med. no.)	c — —	2.	COMMUNICA-	(Check all that apply during last 7 days.)
3.	FACILITY	a. Facility Name MCBVI		TION DEVICES/ TECHNIQUES	a. Hearing aid, present and used
0.	NAME			TEORINGOED	b. Hearing aid, present and not used regularly
	AND PROVIDER NO.	b. Provider No.			c. Other receptive communication techniques used (e.g., lip reading)
		9 9 9 9 9 9 9 9 9 9 9			X d. NONE OF ABOVE
4.	MAINECARE	[Record a "+" if pending, "N" if not a MaineCare recipient]	3.	MAKING SELF UNDERSTOOD	(Expressing information content—however able)
	NO.	3 2 4 6 7 3 7 0 A		(Check only one.)	X 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or
					finishing thoughts
5.	ASSESSMENT DATE	Last day of observation period			2. SOMETIMES UNDERSTOOD—ability is limited to making
					concrete requests 3. RARELY/NEVER UNDERSTOOD
6.	REASON FOR	Month Day Year (Check primary reason for assessment)	4.	ABILITY TO	(Understanding information content—however able)
0.	ASSESSMENT	I. Admission assessment X 4. Semi-Annual		UNDERSTAND	0. UNDERSTANDS
		2. Annual assessment 5. Other (specify)		(Check only one.)	X 1. USUALLY UNDERSTANDS—may miss some part / intent of
	MADITAL	3. Significant change in status assessment		(encorrently encly	
7.	MARITAL STATUS	X 1. Never married 3. Widowed 5. Divorced			2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication
	(Check only one.)	2. Married 4. Separated			3. RARELY/NEVER UNDERSTANDS
8.	CURRENT	(Billing Office to indicate; check all that apply in last 30 days or since last admission if less than 30 days)	5.	COMMUNICA-	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
	SOURCES FOR	X a. MaineCare 🗌 e. Private pay		TION (Check only one.)	180 days.
	SIAI	X b. SSI f. Private insurance			X 0. No change I. Improved I. 2. Declined
			SE		
		□ h. Other (<i>specify</i>)			(Ability to see in adequate light and with glasses if used)
9.	RESPONSI-	(Check all that apply)	1.	VISION	
	BILITY/ LEGAL	X a. Legal guardian X e. Family member responsible b. Other legal oversight f. Self		(Check only one.)	X 0. ADEQUATE—sees fine detail, including regular print in newspapers/books
	GUARDIAN	□ b. Other legal oversight □ f. Self □ c. Durable power of □ g. Legal Conservator			1. <i>IMPAIRED</i> —sees large print, but not regular print in newspapers/
		attorney/health care h. Representative Payee			books 2. MODERATELY IMPAIRED—limited vision; not able to see
		d. Durable power of i. NONE OF ABOVE			newspaper headlines, but can identify objects
10.	ADVANCED	attorney/financial Does resident have any of the following advance <u>d</u> directives in place?			3. HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects
	DIRECTIVES	a. Living Will X 0. No L 1. Yes			4. SEVERELY IMPAIRED—no vision or sees only light, colors, or
		b. Do not resuscitate (DNR) X 0. No 1. Yes c. Do not hospitalize X 0. No 1. Yes			shapes; eyes do not appear to follow objects
		d. Organ donation X 0. No \Box 1. Yes	2.	VISUAL Appliances	a. Glasses, contact lenses D 0. No X 1. Yes
		e. Other X 0. No 🗌 1. Yes		AFFLIANGES	b. Artificial eye X 0. No 1. Yes
		(If "yes," specify)	SE	CTION E. I	MOOD AND BEHAVIOR PATTERNS
SE	CTION B.	COGNITIVE PATTERNS	1.	INDICATORS	(CODE: Record the appropriate code for the frequency of the symptom(s)
1.	MEMORY	(Recall of what was learned or known)		OF Depression,	 observed in last 30 days, irrespective of the assumed cause) 0. Not exhibited in last 30 days
		a. Short-term memory OK—seems/appears to recall after 5 minutes		ANXIETY, SAD MOOD	1. This type exhibited up to 5 days a week
		O. Memory OK X 1. Memory problem			2. This type exhibited daily or almost daily (6, 7 days/week)
		b. Long-term memory OK—seems/appears to recall long past			VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters;
		Other and the second s			Would rather be dead; What's the use; Regrets having lived so
2.	MEMORY/ RECALL	(Check all that resident was normally able to recall during last 7 days) a. Current season X d. That he/she is in a facility/home			long; Let me die."
	ABILITY	X b. Location of own room e. NONE OF ABOVE are recalled			1 b. Repetitive questions—e.g., "Where do I go; What do I do?" 0 c. Repetitive verbalizations—e.g., calling out for help,
		□ c. Staff names/faces			("God help me")
3.	COGNITIVE	(Made decisions regarding tasks of daily life)			 d. Persistent anger with self or others—e.g., easily annoyed, angel at placement in facility: anger at care received
	SKILLS FOR DAILY	0. <i>INDEPENDENT</i> —decisions consistent/reasonable			at placement in facility, anger at care received e. Self deprecation—e.g.,"I am nothing; I am of no use to anyone"
	DECISION- MAKING	1. MODIFIED INDEPENDENCE—some difficulty in new situations only			0 f. Expressions of what appear to be unrealistic fears—e.g., fear of
	(Check only one.)	X 2. MODERATELY IMPAIRED—decisions poor; cues/ supervision required			being abandoned, left alone, being with others
		3. SEVERELY IMPAIRED—never/rarely made decisions			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
4.	COGNITIVE	Resident's cognitive status or abilities now compared to resident's status			 <u>0</u> h. Repetitive health complaints—e.g., persistently seeks medical
	STATUS (Check only one.)	 180 days ago (or since admission if less than 180 days). X 0. No change 			attention, obsessive concern with body functions
	(Uncon Uniy Une.)	1. Improved			2 i. Repetitive anxious complaints/concerns (non-health related)
		2. Declined			e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues
	I	1			(continued next page)

_ Date: 07/07/2004 Soc. Sec. # 004-78-8974

SECTION E. MOOD and BEHAVIOR PATTERNS (cont.)

	PSYCHOSOCIAL	
SECTION F.	PSTCHUSUCIAL	WELL-DEING

1.	INDICATORS OF Depression,	(CODE: Record the appropriate code for the frequency of the symptim last 30 days, irrespective of the assumed cause)	otom(:	s) obs	erved	1.	SEN INIT			
	ANXIETY, SAD MOOD	 Not exhibited in last 30 days This type exhibited up to 5 days a week This type exhibited daily or almost daily (6, 7 days/ 	veek))			(Chec aj			
		SLEEP-CYCLE ISSUES								
		k. Insomnia/change in usual sleep pattern								
		SAD, APATHETIC, ANXIOUS APPEARANCE								
		0 I. Sad, pained, worried facial expressions—e.g., f	urrow	/ed bi	rows	2.				
		0 m. Crying, tearfulness					REL			
		I Repetitive physical movements—e.g., pacing, h restlessness, fidgeting, picking	and v	wringi	ing,		(Cheo aj			
		LOSS OF INTEREST								
		0. Withdrawal from activities of interest—e.g., no in standing activities or being with family/friends	nteres	st in Io	ong					
		 p. Reduced social interaction								
		INDICATORS OF MANIA								
		0 q . Inflated self-worth, exaggerated self-opinion; inf	lated	beliet	F	3	E\			
		about one's own ability, etc.					HIS			
		r. Excited behavior, motor excitation (e.g., heighte activity; excited, loud or pressured speech; incre	eased	l read			(Cl tha			
2.	MOOD PERSISTENCE									
	(Check only one.)	X 0. No mood indicators								
		1. Indicators present, easily altered								
		2. Indicators present, not easily altered								
3.	MOOD (Check only one.)	Resident's current mood status compared to resident's statu (or since admission if less than 180 days):	ls 18	0 day	s ago					
	(UNCON UNITY UNC.)	X 0. No change 1. Improved 2. Dec	lined							
4.	BEHAVIORAL	(COLUMN A CODES: Record the appropriate code for the frequency of the symptom Alterability o			1	SE	СТІС			
	SYMPTOMS	code for the frequency of the symptom <u>Alterability</u> of <u>in last 7 days</u>) symptoms <u>in</u>				1.	(A) A 0. IN			
		0. Behavior not exhibited in last 7 days0. Not prese1. Behavior of this type occurred 1 to 3 days in1. Behavior					du			
		last 7 days	A	B			1. SL			
		 Behavior of this type occurred 4 to 6 days but less than daily Behavior of this type occurred daily 	ζ	È	ž		da tin			
		(COLUMN C CODES: <u>History of this behavior in the last 6 months</u>)	REQUENCY	ALTERABILITY	HISTORY		2. LI			
		0. No 1. Yes	Ë	ALTE	Ť		ma			
a.	WANDERING needs or safe	$\widehat{\mathbf{x}}$ (moved with no rational purpose, seemingly oblivious to ty)	0	0	0		3. EX he			
b.		BUSIVE BEHAVIORAL SYMPTOMS (others were creamed at, cursed at)	2	0	1					
c.		ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, ched, sexually abused, gross physical assault)	0	0	0		4. TC 8. AC			
d.		APPROPRIATE/DISRUPTIVE BEHAVIORAL					(B) A			
		(made disruptive sounds, sexual behavior, disrobing in ed/threw food/feces, hoarding, rummaged through others'	1	0	1		HOL self-			
	belongings, st	tealing, self-abusive acts, substance abuse, self-mutilation)	Ľ	Ľ	<u> </u>		0.			
e.	RESISTS CA assistance, or	RE (resisted taking medications/ injections, ADL	0	0	0		1.			
f.	INTIMIDATIN	G BEHAVIOR (made others feel unsafe, at risk, privacy	1	0	1		2. 3. 8.			
-	invaded) ELOPEMENT	r	0	0	0	a.	BED			
g. h.		on-violent behavior (e.g., falling asleep while smoking)	1	0	1		side, a			
i.		olent behavior	0	0	0	b.	TRAN wheel			
j.	FIRE SETTIN		0	0	0	c.	LOCO			
5.	SUICIDAL	Resident demonstrated suicidal thoughts or actions in the la	ist 30	day	s:	11	areas how r			
	IDEATION	X 0. No					suffici			
6.	SLEEP	Check all present on 2 or more days during last 7 days				d.	DRES			
	PROBLEMS	X a. Inability to awaken when desired d. Interrupted		•		e.	EATI			
		b. Difficulty falling asleep	FAB	OVE			nouris			
	INCIDIT	c. Restless or non-restful sleep				_ f.	TOILI urinal			
7.	INSIGHT INTO	Resident has insight about his/her mental problem	_ /**				cathe			
	MENTAL HEALTH	X 0. No 1. Yes 2. No mental he	eaith p	oroble	ems	g.	PERS comb			
8.	BEHAVIORS	Resident's current behavior status compared to resident's sta	atus 1	80		1	hands			
	(Check only one.)	days ago (or since admission if less than 180 days):				h.	STAI			
		X 0. No change 1. Improved 2. C	eclin	ed						

•	SENSE OF INITIATIVE/ INVOLVEMENT (Check all that apply)	 a. At ease interacting with others b. At ease doing planned or structured activities c. At ease doing self-initiated activities d. Establishes own goals X e. Pursues involvement in life of facility (e.g., makes/keeps frierinvolved in group activities; responds positively to new activassists at religious services) X f. Accepts invitations into most group activities 								
2.	UNSETTLED	g. NONE OF ABOVE a. Covert/open conflict with or repeated criticism of staff								
	RELATION- SHIPS b. Unhappy with roommate (Check all that apply) c. Unhappy with residents other than roommate d. Openly expresses conflict/anger with family/friends e. Absence of personal contact with family/friends f. Recent loss of close family member/friend X g. Does not adjust easily to change in routines h. NONE OF ABOVE									
3.	A. LIFE- EVENTS HISTORY Events in past 2 years X a. Serious accident or physical illness WENTS HISTORY b. Health concerns for other person (Check all that apply.) c. Death of family member or close friend d. Trouble with the law e. Robbed/physically attacked f. Conflict laden or severed relationship g. Loss of income leading to change in lifestyle h. Sexual assault/abuse i. Child custody issues j. Change in marital/partner status k. Review hearings (e.g., forensic, certification, capacity hearing) I. NONE OF ABOVE I. NONE OF ABOVE									
E	CTION G. I	PHYSICAL FUNCTIONING								
-	 (A) ADL SELF-PERFORMANCE (A) ADL SELF-PERFORMANCE (J) INDEPENDENT—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days (J) 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 (J) INITED 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— (J) 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 (J) TOTAL DEPENDENCE—Full staff performance of activity during last 7 days 									
	HOUR PERIC	PORT CODES (CODE for MOST SUPPORT PROVIDED OVER E) DD) during last 7 days; code regardless of person's	ACH 2 A	24 В						
	 No setup Setup he One-per Two+ pe Activity c 	son physical assist rsons physical assist lid not occur during entire 7 days	SELF- PERFORMANCE	SUPPORT						
	side, and posit	IV – How resident moves to and from lying position, turns side to ions body while in bed	0	0						
•	wheelchair, sta	How resident moves between surfaces—to/from: bed, chair, anding position (EXCLUDE to/from bath/toilet)	0	0						
_	areas set aside	${\rm N}$ – How resident moves to and returns from other locations (e.g., e for dining, activities, or treatments). If facility has only one floor, noves to and from distant areas on the floor. If in wheelchair, self- ∞ in chair	0	0						
	clothing, inclu	How resident puts on, fastens, and takes off all items of street ding donning/removing prosthesis	0	0						
	nourishment b	w resident eats and drinks (regardless of skill). Includes intake of y other means (e.g., tube feeding, total parenteral nutrition)	0	0						
		 How resident uses the toilet room (or commode, bed- pan, r on/off toilet, cleanses, changes pad, manages ostomy or ts clothes 	0	0						
•	combing hair, l	IYGIENE – How resident maintains personal hygiene, including brushing teeth, shaving, applying makeup, washing/drying face, rineum (EXCLUDE baths and showers)	0	0						
		v resident climbs stairs	0	0						

			CONFIE	DENT	IAL				
Res	kident Name:	ANDREW W CAVANAUGH Date:07/07	/2004	Soc.	00 Sec. #	4-78-8974	Facili	999999999 y Provider #	
SE	CTION G. P	HYSICAL FUNCTIONING (cont.)		SE	CTION G.	PHYSICAL FUNCTIONI	NG (c	ont.)	
2.	BATHING SELF- Performance	 X 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 	's in/out <u>st</u>			direction. g. Resident could be mo equipment (e.g., cane clothing or shoes) h. Resident could perform IADL activities were br	re inder , walker m more roken in	erstands no more than a two-step pendent if he/she had special , plate guard, velcro closings on independently if some or all of ADL/ to subtasks (task segmentation) pendent if he/she received ADL or	
3A.	MODES OF Locomotion	(Check all that apply during last 7 days) a. Cane/walker/crutch X b. Wheeled self c. Other person wheeled d. NONE OF ABOVE		7.	NEW DEVICES NEEDED (Check all that apply.)	Resident expresses or gives e assistive devices a. Eyeglasses b. Hearing aid c. Cane or walker	□ f.	e of needing new or additional Assistive dressing devices (e.g., button hook, velcro closings) Dentures	
3B	MAIN Mode of Locomotion	Was wheelchair the primary mode of locomotion during the last 7 dat □ 0. No X 1. Yes	ays?			 d. Wheelchair e. Assistive feeding devices (e.g., plate 	□ h	NONE OF ABOVE	
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 X c. NONE OF ABOVE		Image: Image in the image		SELF- Performance In Iadls	days ago (or since admission X0. No change 1. I	s or abil if less tl mprove	ties compared to resident's status 18 an 180 days): d
4.	SELF- PERFORMANCE	Resident's current ADL status or abilities compared to resident's stat days ago (or since admission if less than 180 days):	tus 180	SE		CONTINENCE IN LAST		AYS	
	IN ADLs (Check only one.)	X 0. No change 1. Improved 2. Declined		1.	 CONTINENCE SELF-CONTROL CATEGORIES (Cade for resident's PERFORMANCE OVER ALL SHIFTS) CONTINENT—Complete control (includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool) USUALLY CONTINENT—BLADDER, Incontinent episodes once a week or less; BOWEL, less than weekly OCCASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not daily; BOWEL, once a week FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g. on day shift); BOWEL, 2-3 times a week INCONTINENT—Had inadequate control BLADDER, multiple daily episodes; BOWEL all (or almost all) of the time 				
5A	. IADL SELF- Perfor- Mance	Code for level of independence in the last 30 days based on resident involvement in the activity. SELF-PERFORMANCE CODES: 0. INDEPENDENT : (with/without assistive devices)—No help p 1. DONE WITH HELP: Resident involved in activity but help (ind supervision, reminders, and/or physical help) is provided. 2. DONE BY OTHERS:	orovided.						
		Full performance of the activity is done by others. The resident is involved at all when the activity is performed.	s not	a.	BOWEL Continence	Control of bowel movement, v programs, if employed	with app	liance or bowel continence	
		8. Activity did not occur in the last 30 days.		b.	BLADDER Continence	Control of urinary bladder fun continence programs, if emplo		th appliances (e.g. foley) or	
		IADL	SELF- PERFORMANCE	2.	BOWEL Elimination Pattern	Bowel elimination pattern regular—at least one movement every three days	a.	Diarrhea <u>c</u> Fecal Impaction d Resident is Independent <u>e</u>	
		 Resident arranged for shopping for clothing, snacks, other incidentals. 	8	3.	APPLIANCES	Constipation Any scheduled toileting plan	b. a.	NONE OF ABOVE f. Did not use toilet room/	
		b. Resident shopped for clothing, snacks, or other incidentals.	8	3.	and	First Scheduled tolleting plan		commode/urinal	

		PERI		PATTERN	movement every three days	a.	Resident is Independent	e.			
a.	Resident arranged for shopping for clothing, snacks,	8			Constipation	b.	NONE OF ABOVE	е. _{f.} X			
	other incidentals.		3.	APPLIANCES	Any scheduled toileting plan	a.	Did not use toilet room/				
b.	Resident shopped for clothing, snacks, or other incidentals.	8		and	Bladder retraining program	b.	commode/urinal	f.			
c.	Resident arranged for suitable transportation to get to appointments, outings, necessary engagements.	2		PROGRAMS		c.	Pads/briefs used	g.			
d.	Resident managed finances including banking,	4			Indwelling catheter	d.	Enemas/irrigation	h.			
	handling checkbook, or paying bills.	1			Intermittent catheter	e.	Ostomy present	i.			
e.	Resident managed cash, personal needs allowance.	1					NONE OF ABOVE	j. X			
f.	Resident prepared snacks, light meals.	1	4.	USE OF	Resident's management of incontinence supplies (pads, briefs, ostomy, catheter) in last 14 days.						
g.	Resident used phone.	0		SUPPLIES	X 0. Always continent						
h.	Resident did light housework such as making own bed, dusting, or taking care of belongings.	0		(Check only one.)		and able	e to manage incontinence supplies	S			
i.	Resident sorted, folded, or washed own laundry.	0			2. Resident incontinent and receives assistance with managing						
on	eck all that apply for level of independence in the last 30 days bas resident's involvement in the activity.				incontinence supplies. 3. Resident incontinent a		es not use incontinence supplies.				
	 Resident drove car or used public transportation independent get to medical, dental appointments, necessary engagements other activities. 		5.	CHANGES IN URINARY	Resident's urinary continence has changed as compared to status of 180 days ago (or since last assessment if less than 180 days):						
Х	b. Resident rode to destination with staff, family, others (in car, va	ın,		CONTINENCE	X 0. No change	1. Impr	roved 2. Deteriorated	k			
	public transportation) but was not accompanied to medical, dental appointments, necessary engagements, or other activi		SE	CTION I. DI	AGNOSES						
	c. Resident rode to destination with staff, family, others (in car, v public transportation) and <u>was accompanied</u> to medical, der appointments, necessary engagements, or other activities.	and	behavior status	iagnoses that have a relationshi s, medical treatments, nurse mo e apply, CHECK item xx. <i>NONE</i>	rrent ADL status, cognitive status, g, or risk of death. (Do not list inact <i>30VE</i>)	mood ive					
 v	 d. Activity did not occur. a. Resident believes be/she is capable of increased independent 	1.	DIAGNOSES	ENDOCRINE/METABOLIC/ NUTRITIONAL	HI	EART/CIRCULATION d. Arteriosclerotic heart diseas	se				

X

b.

a. Diabetes mellitus

c. Hypothyroidism

Hyperthyroidism

Information:	Catherine Gunn,	USM, Mu	uskie School o	of Public Service,	PO Box 9300,	Portlan	d, M	E 04104,	207-7	780-5576

(continued in next column)

X a. Resident believes he/she is capable of increased independence in

Difference in ADL/IADL Self-Performance comparing mornings to

b. Direct care staff believes resident is capable of increased

e. Resident requires or only understands a one-step direction.

c. Resident able to perform tasks/activity but is very slow

independence in at least some ADLs or IADLs.

c.

d.

e. f.

g. h.

i.

d.

5B.

6.

Contact

TRANSPOR-

TATION

ADL AND IADL Functional

REHABILI-

TATION OR IMPROVE-

MENT

POTENTIAL

(Check all

that apply.)

at least some ADLs or IADLs.

evenings

Hypertension

Hypotension

(ASHD)

e.

f.

g.

ĥ.

i.

k.

Cardiac dysrhythmia

Congestive heart failure

Peripheral vascular disease

Other cardiovascular disease

(continued on next page)

Deep vein thrombosis

0

0

Resi	dent Name:_	ANDREW W CAVANAUGH 07/07/2004 Date:	_ Soc. S	604- Sec. #	78-8974	Facility	Provider #9	999999999)
SEC	TION I. DIAGI	NOSES (cont.)	SEC	CTION J. HEA	LTH CONDITIONS AND	POSSIBLE MI	EDICATION SIDE	EFFECTS	(cont.)
		MUSCULOSKELETAL ff. Manic depressive (Bipolar) I. Arthritis gg. Schizophrenia m. Hip fracture n. Missing limb (e.g., amputation) O. Osteoporosis H. Asthma ii. Emphysema/COPD	5.	PAIN INTERFERES	During the last 7 days, the normal activities such a Image: 1 the lime 2. Some of the time	s visiting with f		nd so on? e	resident's
		□ p. Pathological bone fracture SENSORY □ ji Cataracts NEUROLOGICAL kk. Diabetic retinopathy □ q. Alzheimer's II.	6. 7.	PAIN MANAGE- MENT ACCIDENTS	 1. No pain treatme 2. Treated, full cor a. Fell in past 30 c 	ntrol	 Treated, partial 4. Treated, no or d. Other fracture 	r minimal c	
		disease ☐ mm. Macular degeneration r. Aphasia s. Cerebral palsy OTHER t. Cerebrovascular X_nn. Allergies (specify) BEE_STING		(Check all that apply)	X b. Fell in past 31-18	-	e. NONE OF AE	BOVE	
		t. Cerebrovascular accident (stroke) X. nn. Allergies (specify) BEE_STING u. Dementia other than Alzheimer's disease oo. Anemia v. Hemiplegia/ hemiparesis rr. Tuberculosis-TB w. Multiple sclerosis Syndrome, Autism, or other organic condition related to	8.	DANGER OF FALL (Check all that apply)	 a. Has unsteady g X b. Has balance pro c. Limits activity be d. Unstable transit e. Other (specify). f. NONE OF ABC 	blems when st ecause resider ion from seate	nt or family fearful of	f resident fa	alling
		y. Parkinson's Mental Retardation or	SEC	TION K. ORA	L/NUTRITIONAL STATU	IS			
		disease Developmental disability (MH/ DD) DD) a.a. Seizure disorder b. Transient ischemic attack (TIA)	1.	ORAL PROBLEMS (Check all that apply)	 a. Mouth is "dry"w b. Chewing Proble c. Swallowing Pro 	/hen eating a m em	neal 🗌 d. Mout X e. NONE		VE
		Cc. Traumatic brain injury PSYCHIATRIC/MOOD dd. Anxiety disorder personality disorder) www. Explicit terminal prognosis xx. NONE OF ABOVE	2.	HEIGHT AND WEIGHT	Record (a.) height in inche measure in last 30 days; m practice–e.g., in a.m. after v	neasure weight co voiding, before m	onsistently in accord v neal, with shoes off, an	vith standard nd in nightcl	d facility othes.
		ee. Depression					1 b. WT (,	
2.	OTHER CURRENT DIAGNOSIS AND ICD-9 CODES	a715. 90 bV66.6 c	3.	WEIGHT Change	 a. Unintended weight more in last 180 day X 0. No b. Unintended weight more in last 180 day 	ys 1. Yes gain-5% or n			
						1. Yes			
1.	PROBLEM CONDITIONS			NUTRI- TIONAL PROBLEMS OR AP- PROACHES (Check all that apply)	 a. Complains about of many foods b. Regular or repert complaints of hut c. Leaves 25% of uneaten at mos d. Therapeutic die e. Mechanically all pureed) diet 	titive unger food t meals t	 f. Noncomplia g. Eating disord X. h. Food allergia (specify) i. Restrictions (specify) j. NONE OF (specify) 	rders ²⁵ EGGS	liet
		Image: f. Hallucinations Image: n. Change in normal appetite X g. Hostility Image: o. Other (specify)	SEC	CTION L. ORA	L/DENTAL STATUS				
2.	EXTRA- Pyramidal Signs and Symptoms	 h. Suspiciousness p. NONE OF ABOVE Check all present at any point during last 3 days INCREASE IN MOTOR ACTIVITY a. Akathisia-resident reports subjective feeling of restlessness or need for movement b. Dyskinesia-chewing, puckering movements of mouth; abnormal irregular movements of lips; or rocking or writhing of trunk c. Tremor-regular rhythmic movements of the fingers, limbs, head, mouth, or tongue DECREASE IN MOTOR ACTIVITY X d. Rigidity-resistance to flexion and extension of muscles (e.g., 	1.	ORAL STATUS AND DISEASE PREVENTION (check all that apply)	 a. Has dentures of X b. Some/all natural (or partial plates c. Broken, loose o d. Inflamed gums ulcers or rashes e. Daily cleaning or staff f. Resident has di g. NONE OF ABC 	teeth lost-doe s) or carious teeth (gingiva); swoll s of teeth/denture fficulty brushing	s not have or does len or bleeding gurr es or daily mouth ca	ns; oral abs	cesses;
		continuous or cogwheeling rigidity)	SEC	CTION M. SKI	N CONDITION				
		 e. Slow shuffling gait–reduction in speed and stride length of gait, usually with a decrease in pendular arm movement f. Bradykinesis–decrease in spontaneous movements (e.g., reduced body movement or <i>poverty of</i> facial expression, gestures, speech) MUSCLE CONTRACTIONS g. Dystonia–muscle hypertonicity (e.g., muscle spasms or stiffness, protruding tongue, upward deviation of the eyes) 	1.	SKIN PROBLEMS (Check all that apply)	Any troubling skin cond a. Abrasions (scra b. Burns (2nd or 3 c. Bruises d. Rashes, itchine	apes) or cuts ird degree) ss, body lice	e. Open som f. Other (sp X g. NONE OF	es or lesion ecify) ABOVE	
	PAIN	h. NONE OF ABOVE	2.	ULCERS (Due to	Record the number of ulc If none present at a stage last 7 days. Code 9=9 or	e, record "0" (ze	ero). Code all that ap		Number at Stage
3.	SYMPTOMS	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)		any cause)	a. Stage 1. A persistent a the skin) that does not di	area of skin red sappear when	Iness (without a bre pressure is relieved	d.	o at
4.	PAIN SITE	(If pain is present in the last 7 days)			b. Stage 2. A partial thick clinically as an abrasion,			nts	
-7.	TAIN OTE	a. Back pain f. Incisional pain X b. Bone pain g. Joint pain (other than hip) C b. Sone pain C b. Sone pain			c. Stage 3. A full thickness ous tissues-presents as	ss of skin is los a deep crater	t, exposing the subo	cutane-	3
		□ c. Chest pain while doing usual activities □ h. Soft tissue pain (e.g., lesion, muscle) □ d. Headache □ i. Stomach pain			undermining adjacent tis d. Stage 4. A full thickness exposing muscle or bone	ss of skin and s	subcutaneous tissue	e is lost,	1 0
		e. Hip pain j. Other (specify)	L	1	R AT		Bof 12/02) (BAL		6/10/05

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

Res	ident Name:	ANDREW W CAVANAUGH 07/07/2004 Date:	Soc.	004- Sec. #	78-8974 9999999999 Facility Provider #			
	TION M. SKIN				ICATIONS (cont.)			
3.	FOOT PROBLEMS	 a. Resident or someone else inspects resident's feet on a regular basis? D. No X 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? 	44	A. DAYS Received The Following Medication	Operation Operation Operation Operating Operating <t< td=""><td>. Insu</td><td></td><td></td></t<>	. Insu		
			4E	B. PRN MEDICATIONS	Does resident have a prescription for any PRN medication for a memotional or nervous condition, or behavioral problem?	iental,	Ι,	
	1							
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: X a. Morning J d. Night (Bedtime to A.M.) X b. Afternoon X c. Evening	5.	SELF- ADMINSTERED MEDICATIONS (Check all that apply.)	Did resident self-administer any of the following in the last 7 days a. Insulin e. Glucosan b. Oxygen f. Over-the-counter Meds c. Nebulizers g. Other (specify) d. Nitropatch X h. NONE OF ABOVE			
2.	AVERAGE	(When awake and not receiving treatments or ADL care)	6.	MEDICATION PREPARATION	Did resident prepare and administer his/her own medications in la: (Check only one.)	.st 7 d	lays	s?
	INVOLVED IN	1. Most–more than 2/3 of time		ADMINISTRA- TION	X 0. No Meds			
	ACTIVITIES	X 2. Some-from 1/3 to 2/3 of time 3. Little-less than 1/3 of time		lion	1. Resident prepared and administrated NONE of his/her own me	edicatio	ons	
	(Check only one.)	4. None			2. Resident prepared and administrated <u>SOME</u> of his/her own me	edicati	ions	6.
3.	,				3. Resident prepared and administrated <u>ALL</u> of his/her own media	cation	IS.	
3.	ACTIVITY	(Check all settings in which activities are preferred) X a. Own room X d. Away from facility	7.	MEDICATION	Resident's level of compliance with medications prescribed by a p	physic	ian	/
	SETTINGS	X a. Ownoon X d. Away nonnacinty X b. Day/activity room e. NONE OF ABOVE		COMPLIANCE	psychiatrist during last 30 days:	-		
		X c. Outside facility (e.g., in yard)		(Check one)	0. No Meds			
4.	GENERAL	(Check all PREFERENCES whether or not activity is currently available to resident)			1. Always compliant			
	ACTIVITY	X a. Cards/other games k. Gardening or plants			2. Always compliant with reminder, verbal prompts			
	PREFER- ENCES	b. Crafts/arts X I. Talking or conversing			X 3. Compliant some of the time (80% of time or more often) of some medications	<u>r</u> wiuri	1	
	(Adapted to	c. Exercise/sports X m . Helping others			4. Rarely or never compliant			
	`resident's	d. Dancing X n. Doing chores around the	8		Misuse of prescription or over-the-counter medications in the last	6 mor	nthe	5
	current abilities)	X e. Music house/facility		OF MEDICATION	(e.g., resident uses more or less than the directed dose, is using n		atio	n
	,	f. Reading/writing X o. Cooking/baking			for a purpose other than intended) X 0. No 1. Ye	85		
		g. Spiritual/religious activity X p. Computer activities X h. Trips/shopping g. Volunteering	SE	CTION P. SPEC	CIAL TREATMENTS AND PROCEDURES			
		X h. Trips/shopping q. Volunteering X i. Walking/wheeling outdoors r. Other (specify)	1.	SPECIAL TREATMENTS,	 a. SPECIAL CARE-Check treatments or programs received during th days [Note-count only post admission treatments] 	ie last	t 14	!
		X j. Watching TV S. NONE OF ABOVE		PROCE-	TREATMEMTS			_
5	. PREFERRED	(Check all that apply)		DURES, AND	a. Chemotherapy or radiation X i. Training in skills required to the community (e.g.,			n
9	ACTIVITY	a. Individual c. Larger group		PROGRAMS	medications, house wor	ork, `	•	
	SIZE	b. Small group X d. No preference				n, ADI	Ls)	
	PREFER-	a. Resident prefers change in type of activity			PROGRAMS X j. Case management X k. Day treatment program			
6	ENCES IN DAILY	b. Resident prefers change in extent of involvement in activities (e.g.,			d. Alcohol/drug treatment	nlovm	nent	ł
	ROUTINE	more or less)			program A i. Shellered workshop/ernp □ e. Alzheimer's/dementia X m. Job training	<i>p.o.j</i>		•
	(Check all	c. Resident prefers change in location of activities			special care unit X n. Transportation			
	that apply)	 d. Resident prefers activity at different time of day X e. Resident prefers stability in daily routine 			Image: f. Hospice careXo. Psychological rehabilitation	ion		
		f. NONE OF ABOVE			g . Home health X p . Formal education			
7	INTERACTION	a. How often has resident visited or been visited by family and friends in the			h. Home care q. NONE OF ABOVE	aniaa i		
1.	WITH FAMILY	last 30 days? (check only one)			b. THERAPIES —Record the number of days each of the following thera administered (for at least 15 minutes a day) in the last 7 calendar d	ipies v days (i	was Ente	er
	AND FRIENDS	1. No family or friends outside X 4. Once a week			0 if none or less than 15 min. a day)	i	@	ΰ
		facility 5. 2 or 3 times a week but not			(Note-count only post admission therapies) (A) = # of days administered for 15 minutes or more	Ì	ON SITE (B)	Ē
		□ 2. None daily □ 3. 1-3 times/month □ 6. Daily				ays	l S	л П
						(A)	ō	6
		b. How often has resident talked by telephone with family and friends in the last 30 days? (check only one)			al opocon la gaago patrology and daditory controco	0	+	~
		□ 1. No family or friends outside X 4. Once a week			b. Occupational therapy 5 c. Physical therapy 5		+	X X
		facility 5. 2 or 3 times a week but not			c. Physical therapy 5 d. Respiratory therapy 0		+	^
		2. None daily			Bychological therapy (by any licensed mental		\neg	v
		3. 1-3 times/month 6. Daily			health professional)	1		х
8		Is resident registered to vote? X 0. No . 1. Yes	2		(Check all interventions or strategies used in the last 7 days unless specified–no matter where received)	other	r tin	ne
9	· SOCIAL ACTIVITES	Resident's current level of participation in social, religious or other personal		VENTION PROGRAMS	environment to addre			
	(Check only	activities compared to resident's status 180 days ago (since admission if less than 180 days):		FOR MOOD, BEHAVIOR,	symptom evaluation mood/behavior patter		•	
	one.)	X 0. No change 1. Improved 2. Declined		COGNITIVÉ	program providing bureau in w rummage	MICH	10	
				LOSS	b. Special behavior management program X f. Reorientation–e.g., cu	leing		
SEC	TION O. MEDI				c. Evaluation by a licensed X g. Validation/Redirection			
1.	NUMBER OF MEDICATIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used) 0 0			mental health specialist in L h. Crisis intervention in			
2.	NEW	(Resident currently receiving medicatons that were initiated during the last 90 days)			last 90 days i. Crisis stabilization un	iit in la	ast	
-	MEDICATIONS	X 0. No 🗌 1. Yes			X d. Group therapy 90 days e. Besident-specific j. Other (specify)			
3.	INJECTIONS	(Record the number of DAYS injections of any type received during			e. Resident-specific j. Other (specify) deliberate changes in the k. NONE OF ABOVE			
.		the last 30 days; enter "0" if none used)						

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

MDS-RCA ME (Rev 12/03) (RAI © copyright 6/19/95)

Resident Name:

SEC	TION P. SPEC	IAL 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/mediate	licat	ion
4.	REHABILITA- TION/ 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 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 TRAINING/SKILL PRACTICE IN: 0 0 e. Transfer 0 f. Amputation/prosthesi 0 g. Dressing or grooming 0 g. Dressing or swallowing	o 15	re
5.	SKILL TRAINING	Record the number of days, in the last 30 days that each of the following were performed with assistance from staff as a skill training activity identified to the following were performed with assistance from staff as a skill training activity identified to the following were performed with assistance from staff as a skill training activity identified to the following were performed with assistance from staff as a skill training activity identified to the following were performed with assistance from staff as a skill training activity identified to the following were performed with assistance from staff as a skill training activity identified to the following were performed with assistance from staff as a skill training activity identified to the following were performed with assistance from staff as a skill training activity identified to the following were performed with assistance from staff as a skill training activity identified to the following were performed with assistance from staff as a skill training activity identified to the following were performed with assistance from staff as a skill training activity identified to the following were performed with assistance from staff as a skill training activity identified to the following were performed with assistance form staff as a skill training activity identified to the following were performed with assistance form and administration fractions (preparents) 00 g. Managing Finances (banking, handling checkbook, or paying bills) 00 k. Medications (preparent of medications) 01 I. Other (specify) DOING TAXE	ified s eries et to nts c ra- tion	in s, y
6.	ADHERENCE WITH TREATMENTS/ THERAPIES/ PROGRAMS	In the last 6 months, compliant all or most of the time with special treatment therapies and programs: □ 0. Always compliant □ 3. No treatments or programs: X 1. Compliant 80% of time □ 8. Unknown □ 2. Compliant less than 80% of the time		
7.	GENERAL Hospital Stay(S)	Record number of times resident was admitted to an acute care hospital with an overnight stay in last 6 months (or since last assessment if less than 6 months.) (Enter "0" if no hospital admissions)	0	0
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)	0	0
9.	PHYSICIAN VISITS	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.	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)	0	0
11.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission if less than 90 days)? 0. No 1. Yes		
12.	PSYCHIATRIC Hospital Stay(s)	Record number of times resident was admitted to a psychiatric hospital with an overnight stay in the last 6 months (or since last assessment if less than 6 months.) (Enter "0" if no psychiatric hospital admissions)	0	0
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)	0	0

	(Check all	c. Activities/hobbies/adult learning	
	areas in which resident has	d. Rehabilitation-skilled	
	self-identified	e. Maintaining physical or cognitive function	
	goals)	f. Participation in the community	
		g. Other (specify)	
		X h. No goals	
-		 Any disagreement between resident and family about goal 	la or
2.	CONFLICT	service plan? X 0. No I 1. Yes	115 01
		b. Any disagreement between resident/family and staff abou	t goals or
		service plan? X 0. No 🗌 1. Yes	
EC	TION R. DISC	HARGE POTENTIAL	
1.	DISCHARGE Potential	a. Does resident or family indicate a preference to return to co X 0. No □ 1. Yes	ommunity?
		b. Does resident have a support person who is positive towar discharge? 0. No X 1. Yes	rds
		5	atha ar
		c. Has resident's self-sufficiency changed compared to 6 mor since admission, if less than 6 months?	ntris or
		X 0. No change I 1.Improved 2. Decl	inod
-		SSMENT INFORMATION	1
1.	PARTICIPA- TION	a. Resident: 0. No X 1. Yes	
	IN	b. Family: X 0. No 1. Yes 2. No Family	
	ASSESS-		-
		C ()ther Non-Statt: () No 1 Yes X 2 None	
	MENT	c. Other Non-Staff: 0. No 1. Yes X 2. None	
2.	MENT	C. Other Non-Staff: U 0. No U 1. Yes X 2. None	
2.	MENT		
2.	MENT SIGNATURES NANCY	S OF PERSONS COMPLETING THE ASSESSMENT: SMITH	
2.	MENT SIGNATURES NANCY a. Signature	S OF PERSONS COMPLETING THE ASSESSMENT: SMITH e of Assessment Coordinator (sign on line above)	
2.	MENT SIGNATURES NANCY a. Signature	S OF PERSONS COMPLETING THE ASSESSMENT: SMITH e of Assessment Coordinator (sign on line above) essment Coordinator signed as complete	2 0 0 4
2.	MENT SIGNATURES NANCY a. Signature	COPPERSONS COMPLETING THE ASSESSMENT: SMITH e of Assessment Coordinator (sign on line above) essment Coordinator signed as complete $\boxed{0 7}_{Month} - 07_{Dey} - 2$	2 0 0 4 _{Year}
2.	MENT SIGNATURES NANCY a. Signature b. Date Ass	COPPERSONS COMPLETING THE ASSESSMENT: SMITH e of Assessment Coordinator (sign on line above) essment Coordinator signed as complete $\boxed{0 7}_{Month} - 07_{Dey} - 2$	Year
2.	MENT SIGNATURE: NANCY a. Signatur b. Date Ass c. Other Sign	COPPERSONS COMPLETING THE ASSESSMENT: SMITH e of Assessment Coordinator (sign on line above) essment Coordinator signed as complete $\boxed{0 7}_{Month} - 07_{Dey} - 2$	Date
	MENT SIGNATURE: NANCY a. Signatum b. Date Ass c. Other Sign d. e.	COPPERSONS COMPLETING THE ASSESSMENT: SMITH e of Assessment Coordinator (sign on line above) essment Coordinator signed as complete $\boxed{0 7}_{Month} - 07_{Dey} - 2$	Date Date
2.	MENT SIGNATURE: NANCY a. Signatum b. Date Ass c. Other Sign d.	COPPERSONS COMPLETING THE ASSESSMENT: SMITH e of Assessment Coordinator (sign on line above) essment Coordinator signed as complete $\boxed{0 7}_{Month} - 07_{Dey} - 2$	Date Date

SECTION T. Preventive Health/Health Behaviors

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

P11 = 1

07/07/2004 Soc. Sec. #_

1.

004-78-8974

SECTION Q. SERVICE PLANNING

RESIDENT GOALS

CONFIDENTIAL

Date:

 $\hfill\square$ a. Health promotion/wellness/exercise

b. Social involvement/making friends

	CONFIDENTIAL							
F	ANDREW W CAN Resident Name:	/ANAUGH 07/07 Date:	7/2004 Soc. Sec. #	004-78-8974	99999999999999999999999999999999999999			
		SECTIO	N U. MEDICATIONS I	LIST				
	1. List the medication name and the	e last 7 days. Include medications used te dosage Jse the appropriate code from the follow		ly as part of the resident's trea	ıtment regimen.			
	1 = by mouth (PO) 2 = sublingual (SL)	3 = intramuscular (IM) 4 = intravenous (IV)	5 = subcutaneous (SubC 6 = rectally	8 = inhalatio				
	 FREQ (Frequency): Use the ap PR = (PRN) as necessary 1H = (qh) every hour 2H = (q2h) every two hours 3H = (q3h) every three hours 4H = (q4h) every four hours 6H = (q6h) every six hours 	propriate frequency code to show the n 8H = (q8h) every eight hours 1D = (qd or hs) once daily 2D = (BID) two times daily (includes every 12 hours) 3D = (TID) three times daily 4D = (QID) four times daily	5D = five times 1W = (QWeek 2W = twice eve	s a day c) once every week rery week nes every week ther day	5W = five times every week 6W = six times every week 1M = (QMonth) once every month 2M = twice every month C = continuous O = other			

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

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

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

MINIMUM DATA SET - RESIDENTIAL CARE ASSESSMENT (MDS-RCA)

CORRECTION REQUEST FORM

Use this form:

- 1. To request correction of error(s) in an MDS-RCA assessment record or error(s) in an MDS-RCA Discharge Tracking
- record that has been previously accepted into the State MDS-RCA database; and
- 2. To identify the inaccurate record.

A correction request can be made to either MODIFY or INACTIVATE a record.

TO MODIFY A RECORD IN THE STATE DATABASE:

- 1. Complete a new corrected assessment or discharge tracking form. Include all the items on the form, not just those in need of correction;
- 2. Complete and attach this Correction Request Form to the corrected assessment or discharge tracking form;
- 3. Place a hard copy of the complete assessment and correction form in the Clinical Record;
- 4. Create a new electronic record including the corrected assessment or tracking form AND the Correction Request Form; and
- 5. Electronically submit the new record (as in #3) to the MDS-RCA database at the State.
- TO INACTIVATE A RECORD IN THE STATE DATABASE:
- 1. Complete this correction request form;
- 2. Create an electronic record of the Correction Request Form;
- 3. Place a hard copy of the complete assessment and correction form in the Clinical Record; and
- 4. Electronically submit this Correction Request record to the MDS-RCA database at the State.

PRIOR RECORD SECTION:

THIS SECTION IDENTIFIES THE ASSESSMENT OR TRACKING FORM THAT IS IN ERROR. (In this section, reproduce the information EXACTLY as it appeared in the erroneous record, even if the information is wrong. This information is necessary in order to locate the record in the State database.)

Prior AA1	RESIDENT NAME	ANDREW W CAVANAUGH
		a.(First) b.(Middle Initial) c.(Last) d.(Jr/Sr)
Prior AA2	GENDER	1. Male 2. Female 1
Prior AA3	BIRTHDATE	10 Month Day Year
Prior AA5a	SOCIAL Security	a. Social Security Number 0 0 4 7 8 8 9 7 4
Prior A6 OR D1.8	REASON FOR Assessment	ASSESSMENT 1. Admission assessment 2. Annual assessment 3. Significant change in status assessment 4. Semi-Annual 5. Other DISCHARGE TRACKING 6. Discharged 7. Discharged prior to completing initial assessment
	PRIOR DATE	PRIOR DATE (Complete one only) Complete Prior A5 if Primary Reason (Prior A6) equals 1,2,3,4 or 5 Complete Prior D3.2 if Primary Reason (Prior D1.8) equals 6 or 7
Prior A5	ASSESSMENT DATE	a. Last day of MDS observation period 07 - 07 - 20 0 4 Month Day Year
Prior D3.2	DISCHARGE DATE	Date of Discharge

CORRECTION SECTION:

COMPLETE THIS SECTION TO EXPLAIN THE CORRECT REQUEST

AT1.	CORRECTION SEQUENCE	(Enter total number of correction for this record, including the present one)						
AT2.	ACTION REQUESTED	 MODIFY record in error (Attach and submit a COMPLETE assessment or tracking form. Do NOT submit the corrected items ONLY. Proceed to item AT3 below). INACTIVATE record in error. (DO NOT submit an assessment or tracking form. Submit the correction request only. Skip to item AT4). 	2					
AT3.	REASONS FOR Modification	If AT2=1, check at least one of the following reasons; check all that apply, then skip to AT5) a. Transcription error b. Data entry error c. Software product error d. Item coding error e. Other error If "Other" checked, please specify:	a. b. c. d. e.					
AT4.	REASONS FOR Inactivation	(If AT2=2, check at least one of the following reasons; check all that apply.) a. Test record submitted as production record b. Event did not occur c. Inadvertent submission of non-required record d. Other reason requiring inactivation If "Other" checked, please specify:	a. b. c. X d.					

MDS-RCA COORDINATOR SIGNATURE AND DATE COMPLETION

AT5.		NANC	Y SMITH	RCA DIRECTOR	२
		a.(First)	b.(Last)	c.(Title)	
	SIGNATURE				
AT6.	CORRECTION DATE	08 Month	- 17 Day	2 0 0 4 Year	

MINIMUM DATA SET (MDS)[©] RESIDENTIAL CARE ASSESSMENT (RCA)

BASIC ASSESSMENT TRACKING FORM

GENERAL INSTRUCTIONS:

Complete this form for all assessments and discharges.

SECTION AA. IDENTIFICATION INFORMATION

		1									
1.	RESIDENT NAME	ANI	DRE	W	W		CA	<u>N</u> A	N۸	AU	JGH
		a. (First)	b. (N	liddle	Initia	ıl)	c.	(Las	st)	d. (Jr/Sr)
2.	GENDER	X 1. I	Male					2.	Fer	nale	
3.	BIRTHDATE	1 M	o .	- 0	3 Day]—	1	9 Ye	e ear	69	
4.	RACE/ ETHNICITY (Check only one.)	2. /	Asian/P	an India Pacific Is not of Hi	lande	er		e	[2 [K 5	 Hispanic White, not of Hispanic origin Other
5.	SOCIAL SECURITY and MEDICARE NUMBERS (C in 1 st box if no med. no.)		0 4	·]—[7	8 Ipara	[8 ailroad	9 d ins	7 urano	4 ce number)
6.	FACILITY NAME AND PROVIDER NO.	a. Facilit b. Provi	der No.	CBVI	9	9	9	9			
7.	MAINECARE NO.	[Record	1 a "+" ii 2 4	ŕΓ	ig, "N 7	" if no				recip	pient]
8.	SIGNATURE(S)	OF PERSC)N(S) C	OMPLET	'ING F	ACE	SHEE	T:			
a. S	Signatures			Title	•			S	ectio	ns	Date
b.											Date
C.	DATE Completed		rd date 0 7 Month	backgro	ound 2 4 Day			n was 2 0	s cor Yea	0 4	ted. 4

MINIMUM DATA SET (MDS)[®] RESIDENTIAL CARE ASSESSMENT (RCA)

FACE SHEET: BACKGROUND INFORMATION ONLY AT ADMISSION

Resi	dent Name:	ANDREW W CAVANAUGH Date: 07/07/2004	Soc.	Sec. #004	4-78-8974	Facility Provider #_	999999999
SE	CTION AB.	DEMOGRAPHIC INFORMATION	SE	CTION AC.	CUSTOMARY	ROUTINE	
1.	DATE Of Entry	Date the stay began. (Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date.) 1 2 0 4 1 9 9 3 Month Day Year	1.	CUSTOMARY ROUTINE (In year prior to DATE OF ENTRY to this home,	CYCLE OF DAILY EVE	<i>ly.</i> If <u>all</u> information UNKNOWN, cf NTS late at night (e.g., after 9 pm) gularly during day (at least 1 ho	
2.	ADMITTED FROM (AT ENTRY) (Check only one.)			or year last in community if now being admitted from another home, nursing home, or hospital)	e. Spent most f. Moved indep g. Used tobac h. NONE OF EATING PATTERNS	h. NONE OF ABOVE	
3.	LIVED ALONE (PRIOR TO ENTRY) (Check only one.)	X 0. No I. Yes 2. In other facility			☐ j. Ate betwee ☐ k. Used alcoh X I. NONE OF A	n meals all or most days nolic beverage(s) at least weekly	y
4.	PRIOR Primary Residence	Provide town, state, zip code for Resident's primary residence prior to admission MAINE 0 4 1 0 6 So. PORTLAND MAINE Zip Code			 m. In bedcloth n. Wakened to 	DL PATTERNS m. In bedclothes much of day n. Wakened to toilet all or most nights o. Had irregular bowel movement pattern	
5.	RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	 (Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above) a. Prior stay at this home b. Nursing home X c. Other residential facility—board and care home, assisted living, group home d. MH/psychiatric hospital e. MR/DD facility f. NONE OF ABOVE 			X p. Shower for the symptotic symptot symptotic symptot sy	bathing th M ABOVE ERNS ct with relatives/close friends ended church, temple, synagog	jue (etc.)
6.	LIFETIME Occupation	Put a "/" between two occupations. C L E R K			Xx. Involved in gro	oup activities ABOVE	
7.	EDUCATION (Highest Level Completed) (Check only one.)	1. No schooling 5. Technical or trade school 2. 8th grade or less 6. Some college 3. 9–11 grades 7. Bachelor's degree X 4. High school 8. Graduate degree	SE	CTION AD.		N—Resident/family unable to p	EN
8.	PRIMARY LANGUAGE (Check only one.)	X 0. English 2. French 1. Spanish 3. Other (specify)	а.	Signatures	. ,	PLETING FACE SHEET: Title Sections DIRECTOR AL	
9.	MENTAL Health History	Does resident's RECORD indicate any history of the following? a. Mental retardation X 0. No 1. Yes b. Mental illness X 0. No 1. Yes c. Developmental disability X 0. No 1. Yes	b. 2.	DATE Completed		skground information was comp	Date
10.	CONDITIONS Related To MR/DD Status	(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely) X a. Not applicable—no MR/DD (Skip to AB11) MR/DD with organic condition b. Down's syndrome e. Cerebral palsy C. Autism f. Other organic condition related to MR/DD d. Epilepsy g. MR/DD with no organic condition			Month	Day Year	
11.	alzheimer Dementia History	Does resident's RECORD indicate any history of the following? a. Alzheimer's disease 0. No X 1. Yes b. Dementia other than Alzheimer's disease 0. No X 1. Yes					

END

CONFIDENTIAL MINIMUM DATA SET (MDS)[®] RESIDENTIAL CARE ASSESSMENT (RCA)

(STATUS IN LAST 7 DAYS UNLESS OTHERWISE NOTED)

SEC		DENTIFICATION and BACKGROUND INFORMATION	SE	CTION C.	COMMUNICATION/HEARING PATTERNS
1.	RESIDENT	ANDREW W CAVANAUGH	1.	HEARING	(With hearing appliance, if used)
	NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)		(Check only one.)	X 0. HEARS ADEQUATELY—normal talk, TV, phone
2.	SOCIAL	a. Social Security Number			1. <i>MINIMAL DIFFICULTY</i> when not in quiet setting
	SECURITY and MEDICARE	0 0 4 - 7 8 - 8 9 7 4			2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust
	NUMBERS	b. Medicare number (or comparable railroad insurance number)			tonal quality and speak distinctly 3. <i>HIGHLY IMPAIRED</i> –absence of useful hearing
	(C in 1 st box if				5
	no med. no.)	c — —	2.	COMMUNICA- TION DEVICES/	(Check all that apply during last 7 days.)
3.	FACILITY NAME	a. Facility Name MCBVI		TECHNIQUES	a. Hearing aid, present and used b. Hearing aid, present and not used regularly
	AND	b. Provider No.			c. Other receptive communication techniques used (e.g., lip reading)
	PROVIDER NO.	9 9 9 9 9 9 9 9 9			X d. NONE OF ABOVE
			3.	MAKING SELF	(Expressing information content—however able)
4.	MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient]		UNDERSTOOD	X 0. UNDERSTOOD
		3 2 4 6 7 3 7 0 4		(Check only one.)	1. USUALLY UNDERSTOOD—difficulty finding words or
5.	ASSESSMENT	Last day of observation period			finishing thoughts
J.	DATE				2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests
		Month Day Year			3. RARELY/NEVER UNDERSTOOD
6.	REASON FOR	(Check primary reason for assessment)	4.	ABILITY TO	(Understanding information content—however able)
	ASSESSMENT	I. Admission assessmentX4. Semi-Annual		UNDERSTAND OTHERS	0. UNDERSTANDS
		2. Annual assessment 5. Other (specify)		(Check only one.)	X 1. USUALLY UNDERSTANDS—may miss some part / intent of
	MADITAL	3. Significant change in status assessment		(* * * 5,* * 7,	
7.	MARITAL Status	X 1. Never married 3. Widowed 5. Divorced			2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication
	(Check only one.)	2. Married 4. Separated			3. RARELY/NEVER UNDERSTANDS
8.	CURRENT PAYMENT	(Billing Office to indicate; check all that apply in last 30 days or since last admission if less than 30 days)	5.	COMMUNICA-	Resident's current ability to express him/herself or understand others
	SOURCES FOR	X a. MaineCare e. Private pay		TION (Check only one.)	compared to resident's status 180 days ago or since admission if less than 180 days.
	STAY	X b. SSI f. Private insurance		(*******	X 0. No change I 1. Improved I 2. Declined
		c. VA (including co-payment)			
		d. Social Security g. SSDI h. Other (specify)	SE	CTION D.	
9.	RESPONSI-	(Check all that apply)	1.	VISION	(Ability to see in adequate light and with glasses if used)
	BILITY/ LEGAL	X a. Legal guardian X e. Family member responsible		(Check only one.)	X 0. ADEQUATE—sees fine detail, including regular print in
	GUARDIAN	b. Other legal oversight f. Self			newspapers/books 1. IMPAIRED—sees large print, but not regular print in newspapers/
		c. Durable power of attorney/health care g. Legal Conservator h. Representative Payee			books
		d. Durable power of i. NONE OF ABOVE			2. <i>MODERATELY IMPAIRED</i> —limited vision; not able to see
		attorney/financial			newspaper headlines, but can identify objects 3. HIGHLY IMPAIRED—object identification in question, but eyes
10.	ADVANCED DIRECTIVES	Does resident have any of the following advanced directives in place? a. Living Will X 0. No 1. Yes			appear to follow objects
	DINEGTIVES	b. Do not resuscitate (DNR) X 0. No II. Yes			4. SEVERELY IMPAIRED—no vision or sees only light, colors, or
		c. Do not hospitalize X 0. No I 1. Yes			shapes; eyes do not appear to follow objects
		d. Organ donation X 0. No 🗌 1. Yes	2.	VISUAL Appliances	a. Glasses, contact lenses \Box 0. No X 1. Yes
		e. Other X 0. No L 1. Yes (If "yes," specify)			b. Artificial eye X 0. No
			SE	CTION E. I	MOOD AND BEHAVIOR PATTERNS
SEC	CTION B.	COGNITIVE PATTERNS	1.	INDICATORS OF	(CODE: Record the appropriate code for the frequency of the symptom(s) observed in last 30 days, irrespective of the assumed cause)
1.	MEMORY	(Recall of what was learned or known)		DEPRESSION,	 Not exhibited in last 30 days
		a. Short-term memory OK—seems/appears to recall after 5 minutes		ANXIETY, SAD MOOD	 This type exhibited up to 5 days a week This type exhibited daily or almost daily (6, 7 days/week)
		O. Memory OK X 1. Memory problem			
		b. Long-term memory OK—seems/appears to recall long past			VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters;
$ \downarrow \rangle$		O. Memory OK X 1. Memory problem			Would rather be dead; What's the use; Regrets having lived so
2.	MEMORY/ RECALL	(Check all that resident was normally able to recall during last 7 days)			long; Let me die."
	ABILITY	Image:			b. Repetitive questions—e.g., where do r go; what do r do?
		b. Location of own room e. NONE OF ABOVE are recailed c. Staff names/faces			("God help me")
3.	COGNITIVE	(Made decisions regarding tasks of daily life)			d . Persistent anger with self or others—e.g., easily annoyed, ange
3.	SKILLS FOR	O. INDEPENDENT—decisions consistent/reasonable			o at placement in facility; anger at care received
	DAILY DECISION-	1. MODIFIED INDEPENDENCE—some difficulty in new situations only			 e. Self deprecation—e.g.,"I am nothing; I am of no use to anyone" f. Expressions of what appear to be uprealistic fears. a.g. fear of
	MAKING	X 2. MODERATELY IMPAIRED—decisions poor; cues/			 Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others
	(Check only one.)	supervision required			g. Recurrent statements that something terrible is about to happen
$\left \right $	000117817	3. SEVERELY IMPAIRED—never/rarely made decisions			-e.g., believes he or she is about to die, have a heart attack
4.	COGNITIVE STATUS	Resident's cognitive status or abilities now compared to resident's status 180 days ago (or since admission if less than 180 days).			0 h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions
((Check only one.)	X 0. No change			 <u>2</u> i. Repetitive anxious complaints/concerns (non-health related)
		1. Improved			e.g., persistently seeks attention/reassurance regarding
1 1		2. Declined		1	schedules, meals, laundry, clothing, relationship issues

X 0. No change

> SUICIDAL IDEATION

> > SL FFP

PROBLEMS

INSIGHT

INTO

MENTAL HEALTH

BEHAVIORS

(Check only one.

2.

3.

4.

a.

b.

C.

d.

e.

f.

g.

h.

i.

j.

5.

6.

7.

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1.

SUPPORT

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0 0

MDS-RCA ME (Rev 12/03)

SECTION E. MOOD and BEHAVIOR PATTERNS (cont

Resident's current behavior status compared to resident's status 180

1. Improved

days ago (or since admission if less than 180 days):

lant Nama, A	NDREW W CAVANAUGH Date:	07	7/07/2	2004	4	0.00	Sec. #_	004-	78-8974 Eacility Provider # 99999999
									Facility Provider #
CTION E. M INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	OOD and BEHAVIOR PATTERNS (cont.) (CODE: Record the appropriate code for the frequency of the symplin 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/s) SLEEP-CYCLE ISSUES 1 j. Unpleasant mood in morning 0 k. Insomnia/change in usual sleep pattern SAD, APATHETIC, ANXIOUS APPEARANCE 0 I. Sad, pained, worried facial expressions—e.g., f 0 m. Crying, tearfulness 1 n. Repetitive physical movements—e.g., pacing, h restlessness, fidgeting, picking LOSS OF INTEREST 0 o. Withdrawal from activities of interest—e.g., no in	week) urrow	ved br	rows ing,		SE 1. 2.	CTION SENS INITIA INVOLV (Check app UNSET RELAT SHI (Check app	SE OF TTIVE/ TEMENT all that all that all that fTLED FION- PS all that	 PSYCHOSOCIAL WELL-BEING a. At ease interacting with others b. At ease doing planned or structured activities c. At ease doing self-initiated activities d. Establishes own goals X e. Pursues involvement in life of facility (e.g., makes/keeps: involved in group activities; responds positively to new a assists at religious services) X f. Accepts invitations into most group activities g. NONE OF ABOVE a. Covert/open conflict with or repeated criticism of staff b. Unhappy with residents other than roommate d. Openly expresses conflict/anger with family/friends e. Absence of personal contact with family/friends f. Recent loss of close family member/friend
	0 p. Reduced social interaction INDICATORS OF MANIA 0 0 q. Inflated self-worth, exaggerated self-opinion; inf about one's own ability, etc. 1 r. Excited behavior, motor excitation (e.g., heighter the self-the self-t	ned p	hysic	al		3	EVE HIST	FE- INTS TORY	 X g. Does not adjust easily to change in routines h. NONE OF ABOVE Events in past 2 years X a. Serious accident or physical illness b. Health concerns for other person c. Death of family member or close friend
MOOD PERSISTENCE (Check only one.) MOOD (Check only one.)	Image: RSISTENCE (above) were not easily altered by attempts to "cheer up", or reassure the resident over last 7 days. Neck only one.) X 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered MOOD Resident's current mood status compared to resident's statue						that a	apply.)	d. Trouble with the law e. Robbed/physically attacked f. Conflict laden or severed relationship g. Loss of income leading to change in lifestyle h. Sexual assault/abuse i. Child custody issues j. Change in marital/partner status k. Review hearings (e.g., forensic, certification, capacity he l. NONE OF ABOVE
X 0. No change 1. Improved 2. Deci BEHAVIORAL SYMPTOMS (COLUMN A CODES: Record the appropriate code for the frequency of the symptom in last 7 days) (COLUMN B Alterability or symptoms in 0. Behavior not exhibited in last 7 days 0. Not preser 1. Behavior of this type occurred 1 to 3 days in last 7 days 1. Behavior no 1. Behavior of this type occurred 4 to 6 days but less than daily 3. Behavior of this type occurred daily 3. Behavior in the last 6 months) 0. No 1. Yes			i <i>vioral <mark>7 days</mark></i> easily a	s) altere		SE 1.	(A) AD 0. INDI duri 1. SUF days time 2. LIM mar	DL SEL EPENDE ing last PERVISION S —OF as durin ITED AS neuveri	PHYSICAL FUNCTIONING F-PERFORMANCE M—No help or oversight —OR— Help/oversight provided only 1 or if 7 days M—Oversight, encouragement or cueing provided 3 or more times of R—Supervision (3 or more times) plus physical assistance provided of g last 7 days SISTANCE—Resident highly involved in activity; received physical help ng of limbs or other non-weight bearing assistance 3 or more times – sistance (3 or more times), plus weight-bearing support provided 1 o
WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety) VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)			0	0			3. EXT help — V — F	o of follo Veight- Full staf	ASSISTANCE—While resident performed part of activity, over last 7-da owing type(s) provided 3 or more times: bearing support f performance during part (but not all) of last 7 days
PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused, gross physical assault)			0	0					ENDENCE—Full staff performance of activity during last 7 days ID NOT OCCUR DURING LAST 7 DAYS
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	1			HÓUF self-po 0. N	R PERIO erform lo setu	PPORT CODES (CODE for MOST SUPPORT PROVIDED OVER OD) during last 7 days; code regardless of person's ance classification. p or physical help from staff
RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating) INTIMIDATING BEHAVIOR (made others feel unsafe, at risk, privacy			0	0			2.0	Dne-pei	elp only rson physical assist ersons physical assist
invaded)			0	1		_	8. A	ctivity o	did not occur during entire 7 days
ELOPEMENT	n-violent behavior (e.g., falling asleep while smoking)	0	0	0	$\left \right $	a.			TY- How resident moves to and from lying position, turns side to tions body while in bed
Dangerous vio		0	0	0		b.			 How resident moves between surfaces—to/from: bed, chair, anding position (EXCLUDE to/from bath/toilet)
FIRE SETTIN	G	0	0	0	1	c.			N - How resident moves to and returns from other locations (e.g.

2. This type exhibited daily or almost daily (6, 7 days/	week,)			appiy)	X e. Pursues involvement in life of facility (e.g., makes/keeps frien	nds:				
SLEEP-CYCLE ISSUES _1_j. Unpleasant mood in morning						involved in group activities; responds positively to new activ assists at religious services)					
k. Insomnia/change in usual sleep pattern						X f. Accepts invitations into most group activities					
SAD, APATHETIC, ANXIOUS APPEARANCE						g. NONE OF ABOVE					
<u>0</u> I. Sad, pained, worried facial expressions—e.g.,	furrow	ved br	ows	2.	UNSETTLED	Covert/open conflict with as repeated aritician of staff		_			
0 m. Crying, tearfulness				2.	RELATION-	 a. Covert/open conflict with or repeated criticism of staff b. Unhappy with roommate 					
n. Repetitive physical movements—e.g., pacing, h	nand v	wringi	ng,		SHIPS	c. Unhappy with residents other than roommate					
restlessness, fidgeting, picking		5	3,		(Check all that apply)	d. Openly expresses conflict/anger with family/friends					
LOSS OF INTEREST						e. Absence of personal contact with family/friends					
0 o. Withdrawal from activities of interest—e.g., no i	nteres	st in lo	ng			f. Recent loss of close family member/friend					
standing activities or being with family/friends						X g. Does not adjust easily to change in routines					
p. Reduced social interaction						h. NONE OF ABOVE					
INDICATORS OF MANIA				3.	LIFE-	Events in past 2 years		_			
 q . Inflated self-worth, exaggerated self-opinion; inf	lated	belief			EVENTS	X a. Serious accident or physical illness					
about one's own ability, etc.					HISTORY	b. Health concerns for other person					
r. Excited behavior, motor excitation (e.g., heighte activity; excited, loud or pressured speech; incr					(Check all	c. Death of family member or close friend					
			uvity)	-	that apply.)	d. Trouble with the law					
Check if one or more indicators of depressed, sad or anxio (above) were not easily altered by attempts to "cheer up",	conso	ole, or				e. Robbed/physically attacked					
reassure the resident over last 7 days.		-,-				f. Conflict laden or severed relationship					
X 0. No mood indicators						g. Loss of income leading to change in lifestyle h. Sexual assault/abuse					
1. Indicators present, easily altered						 □ h. Sexual assault/abuse □ i. Child custody issues 					
2. Indicators present, not easily altered						j. Change in marital/partner status					
Resident's current mood status compared to resident's stat	us 18	0 days	s ago			k. Review hearings (e.g., forensic, certification, capacity hearing	na)				
(or since admission if less than 180 days):							·9/				
X 0. No change 1. Improved 2. Dec											
(COLUMN A CODES: Record the appropriate (COLUMN B code for the frequency of the symptom <u>Alterability</u> (COLUMN B					1	PHYSICAL FUNCTIONING					
<u>in last 7 days</u>) symptom)	1.		F-PERFORMANCE					
0. Behavior not exhibited in last 7 days 0. Not prese					during last	NT—No help or oversight —OR— Help/oversight provided only 1 or 2 tin 7 days	nes				
1. Behavior of this type occurred 1 to 3 days in last 7 days 1. Behavior	not ea A	sily alt B	ered C		 SUPERVISION—Oversight, encouragement or cueing provided 3 or more times (
2. Behavior of this type occurred 4 to 6 days but less than daily					days -OR-Supervision (3 or more times) plus physical assistance provided or						
3. Behavior of this type occurred daily	ENC		ORY			g last 7 days					
(COLUMN C CODES: <u>History of this behavior in the last 6 months</u>)	FREQUENCY	ALTERABILITY	HISTORY			SISTANCE—Resident highly involved in activity; received physical help in ng of limbs or other non-weight bearing assistance 3 or more times —OF		d			
0. No 1. Yes	Æ	ALT				sistance (3 or more times,) plus weight-bearing support provided 1 or 2 ti					
(moved with no rational purpose, seemingly oblivious to	0	0	0			ASSISTANCE-While resident performed part of activity, over last 7-day per	eriod,				
BUSIVE BEHAVIORAL SYMPTOMS (others were	+	-				wing type(s) provided 3 or more times: bearing support					
reamed at, cursed at)	2	0	1			f performance during part (but not all) of last 7 days					
ABUSIVE BEHAVIORAL SYMPTOMS (others were hit,	0	•				ENDENCE—Full staff performance of activity during last 7 days					
ched, sexually abused, gross physical assault)	U	0	0		8. ACTIVITY D	ID NOT OCCUR DURING LAST 7 DAYS					
APPROPRIATE/DISRUPTIVE BEHAVIORAL						PPORT CODES (CODE for MOST SUPPORT PROVIDED OVER EA	CH 24	4			
(made disruptive sounds, sexual behavior, disrobing in						OD) during last 7 days; code regardless of person's	A	В			
ed/threw food/feces, hoarding, rummaged through others' ealing, self-abusive acts, substance abuse, self-mutilation)	1	0	1			ance classification.	Щ	_			
RE (resisted taking medications/ injections, ADL						p or physical help from staff	RMANCE				
eating)	0	0	0		 Setup h One-pe 	roon physical againt	MH				
G BEHAVIOR (made others feel unsafe, at risk, privacy	1	0	1			ersons physical assist	ᇿᇛ				
,,,,,,,,,,,,,,,,,	1	U	1		8. Activity	did not occur during entire 7 days	SELF-				
	0	0	0	a.		TY – How resident moves to and from lying position, turns side to	0	0			
n-violent behavior (e.g., falling asleep while smoking)	1	0	1	b.		tions body while in bed - How resident moves between surfaces—to/from: bed, chair,	-	_			
lent behavior	0	0	0	0.		anding position (EXCLUDE to/from bath/toilet)	0	0			
G	0	0	0	c.		N – How resident moves to and returns from other locations (e.g.,		_			
Resident demonstrated suicidal thoughts or actions in the l	ast 30	days	5:			e for dining, activities, or treatments). If facility has only one floor,	0	C			
X 0. No					sufficiency on	noves to and from distant areas on the noor. If in wheelchair, sell-					
Check all present on 2 or more days during last 7 days				d.		Line and interview on the terms and taken off all theres of stars to	0				
						uding donning/removing prosthesis	°	0			
X a. Inability to awaken when desired . Interrupter				e.		w resident eats and drinks (regardless of skill). Includes intake of	0	0			
	r AB	OVE		<u> </u>		by other means (e.g., tube feeding, total parenteral nutrition)		_			
c. Restless or non-restful sleep				_ f.		 How resident uses the toilet room (or commode, bed- pan, er on/off toilet, cleanses, changes pad, manages ostomy or 	0	0			
Resident has insight about his/her mental problem					catheter, adju		۳	J			
X 0. No 1. Yes 2. No mental he	ealth p	oroble	ms	g.	PERSONAL	HYGIENE - How resident maintains personal hygiene, including		-			
				11	comony nall,	broshing tooth, shaving, applying makeup, washing/urying ldCe,	0	. 0			

hands, and perineum (EXCLUDE baths and showers)

h. STAIRS - How resident climbs stairs

2. Declined

			CONFIE	DENT	AL							
R	esident Name:	NDREW W CAVANAUGH Date:	07/07	/2004	Soc.	Sec. #	004-78-8974	99999999999999999999999999999999999999				
s	ECTION G. P	HYSICAL FUNCTIONING (cont.)			SE	CTION G	i. PHYSICAL FU	UNCTIONING (cont.)				
	2. BATHING Self- Performance	How resident takes full-body bath/shower, sponge bath, and of tub/shower (EXCLUDE washing of back and hair.) <u>Chec</u> <u>dependent</u> in self-performance during last 7 days. X 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	d transfer k for mo s	's in/out <u>st</u>			direction g. Resident equipme clothing d h. Resident IADL act i. Resident	t could be more independent if he/she had special ent (e.g., cane, walker, plate guard, velcro closings on or shoes) t could perform more independently if some or all of ADL/ tivities were broken into subtasks (task segmentation) t could be more independent if he/she received ADL or lls training				
3	A. MODES OF LOCOMOTION	 (Check all that apply during last 7 days) a. Cane/walker/crutch X b. Wheeled self c. Other person wheeled d. 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 b. Hearing aid (e.g., button hook, velcro cle c. Cane or walker g. Dentures					
3	B. MAIN Mode of Locomotion	Was wheelchair the primary mode of locomotion during the \Box 0. NoX1. Yes	e last 7 da	ays?			d. Wheelch e. Assistive devices (hair h . Other (specify)				
3	C. BEDFAST/ Chairfast	 (Check if health condition keeps resident in his/her room 22+ hours per dation last 7 days) a. Bedfast all or most of time b. Chairfast all or most of the time X c. NONE OF ABOVE 			8.	PERFORMANCE IN IADLs days ago (or since admission if less than 180 days): X0. No change 1. Improved 2. Declined						
	4 SELF-	Resident's current ADL status or abilities compared to resid	lent's stat	tus 180	SECTION H. CONTINENCE IN LAST 14 DAYS							
	4. PERFORMANCE IN ADLs (Check only one.)	 days ago (or since admission if less than 180 days): X 0. No change 1. Improved 2. Declined 				CONTINENCE SELF-CONTROL CATEGORIES (Code for resident's PERFORMANCE OVER ALL SHIFTS) 0. CONTINENT—Complete control (includes use of indwelling urinary cathete ostomy device that does not leak urine or stool)						
5	A. IADL SELF- PERFOR- MANCE	involvement in the activity. SELF-PERFORMANCE CODES: 0. INDEPENDENT : (with/without assistive devices)—I 1. DONE WITH HELP: Resident involved in activity but	out assistive devices)—No help provided. ent involved in activity but help (including Vor physical help) is provided. ity is done by others. The resident is not		ity. E CODES: : (with/without assistive devices)—No help provide ELP: Resident involved in activity but help (including inders, and/or physical help) is provided.		 SELF-PERFORMANCE CODES: INDEPENDENT : (with/without assistive devices)—No help provided DONE WITH HELP: Resident involved in activity but help (including supervision, reminders, and/or physical help) is provided. 			BOWE 2. OCCA daily; E 3. FREQ some c 4. INCON	EL, less than weekly SIONALLY INCONT BOWEL, once a week UENTLY INCONTIN control present (e.g.	BLADDER, Incontinent episodes once a week or less; <i>TINENT</i> —BLADDER, 2 or more times a week but not sk <i>VENT</i> —BLADDER, tended to be incontinent daily, but on day shift); BOWEL, 2-3 times a week equate control BLADDER, multiple daily episodes; BOWE
		Full performance of the activity is done by others. The involved at all when the activity is performed.			a.	BOWEL Continent	Control of bowe programs, if em	l movement, with appliance or bowel continence ployed				
		8. Activity did not occur in the last 30 days.				BLADDEF Continen		ry bladder function with appliances (e.g. foley) or grams, if employed				
		IADL		ELF- ERFORMANCE	2.	BOWEL Eliminatio Pattern						

		IADL	SELF- PERFORM
		 Resident arranged for shopping for clothing, snacks, other incidentals. 	8
		b. Resident shopped for clothing, snacks, or other incidentals.	8
		c. Resident arranged for suitable transportation to get to appointments, outings, necessary engagements.	2
		 Resident managed finances including banking, handling checkbook, or paying bills. 	1
		e. Resident managed cash, personal needs allowance.	1
		f. Resident prepared snacks, light meals.	1
		g. Resident used phone.	0
		 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.	TRANSPOR- TATION	Check all that apply for level of independence in the last 30 days bas on resident's involvement in the activity.	ed
		 a. Resident drove car or used public transportation independent get to medical, dental appointments, necessary engagements other activities. 	
		 X b. Resident rode to destination with staff, family, others (in car, var public transportation) but was <u>not accompanied</u> to medical, dental appointments, necessary engagements, or other activit C. Resident rode to destination with staff, family, others (in car, var public transportation) and <u>was accompanied</u> to medical, den appointments, necessary engagements, or other activities. d. Activity did not occur. 	ies. an,
6.	ADL AND IADL FUNCTIONAL REHABILI- TATION OR IMPROVE- MENT POTENTIAL (Check all that apply.)	 X a. Resident believes he/she is capable of increased independence 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 morning evenings e. Resident requires or only understands a one-step direction. 	
		(continued in next column)	

		DEVICES NEEDED (Check all that apply.)	assistive devices	g h X i.	Assistive dressing devices (e.g., button hook, velcro closings Dentures Other (specify) NONE OF ABOVE sil)	\$) 			
	8.	SELF- Performance In Iadls	days ago (or since admission i		<u> </u>	180			
-	SE	CTION H. C	ONTINENCE IN LAST	14 DA	YS				
	1.	CONTINENC	E SELF-CONTROL CATEGOR	RIES					
		•	lent's PERFORMANCE OVER ALL		,				
	 CONTINENT—Complete control (includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool) USUALLY CONTINENT—BLADDER, Incontinent episodes once a week or less; BOWEL, less than weekly OCCASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not 								
		3. FREQUE			ended to be incontinent daily, but	:			
			rol present (e.g. on day shift);		:L, 2-3 times a week DER, multiple daily episodes; BOW	/=1			
			st all) of the time	DLADI	DER, multiple dally episodes, BOW	с∟,			
	a.	BOWEL Continence	Control of bowel movement, w programs, if employed	vith app	liance or bowel continence	0			
	b.	BLADDER Continence	Control of urinary bladder function continence programs, if emplo		h appliances (e.g. foley) or	0			
_	2.	BOWEL Elimination Pattern	Bowel elimination pattern regular—at least one movement every three days Constipation	a. b.	Diarrhea Fecal Impaction Resident is Independent NONE OF ABOVE	<u>с.</u> d. е. f. X			
	3.	APPLIANCES	Any scheduled toileting plan	a.	Did not use toilet room/	<u> .</u>			
	0.	and	Bladder retraining program	b.	commode/urinal	f.			
		PRUGRAINS	External (condom) catheter	c.	Pads/briefs used	g.			
			Indwelling catheter	d.	Enemas/irrigation	h.			
			Intermittent catheter	e.	Ostomy present	i.			
-	4.	USE OF Incontinence Supplies		contine	NONE OF ABOVE Ince supplies (pads, briefs, ostomy	j. X ,			
		(Check only one.)	 Resident incontinent a independently. 	nd abl	e to manage incontinence supplies	i i			
			incontinence supplies.		eives assistance with managing				
	_								
	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): X 0. No change 1. Improved 2. Deteriorated								
	SECTION I. DIAGNOSES								
	and	behavior status		hitoring	rrent ADL status, cognitive status, r , or risk of death. (Do not list inactiv OVE)				
-	1.	DIAGNOSES	ENDOCRINE/METABOLIC/ NUTRITIONAL a. Diabetes mellitus b. Hyperthyroidism c. Hypothyroidism		 ART/CIRCULATION d. Arteriosclerotic heart disease (ASHD) e. Cardiac dysrhythmia f. Congestive heart failure g. Deep vein thrombosis h. Hypertension i. Hypotension j. Peripheral vascular disease k. Other cardiovascular disease (continued on next page) 	æ			
	4 14			RCAN	IE (Rev 12/03) (RAI © copyright 6	/19/95)			
IN	a, M	E 04104, 207-7	0/55/0						

(continued in next column)

oc. Sec. #	-78-8974 9999999999 Facility Provider #
	LTH 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? I. All of the time X 3. Little of the time I. Some of the time Image: All of the time Image: All of the time Image: All of the time Image: All of the time Image: All of the time Image: All of the time Image: All of the time Image: All of the time Image: All of the time Image: All of the time Image: All of the time Image: All of the time Image: All of the time
6. PAIN MANAGE- MENT	Image: Interpretending Image: Interpretending X 3. Treated, partial control Image: Interpretending Image: Interpretending Image: Interpretending Image: Interpretending Image: Interpretending Image: Interpretending Image: Interpretending Image: Interpretending
7. ACCIDENTS (Check all that apply)	a. Fell in past 30 days d. Other fracture in last 180 days X b. Fell in past 31-180 days e. NONE OF ABOVE c. Hip fracture in last 180 days
8. DANGER OF FALL (Check all that apply)	a. Has unsteady gait
SECTION K. OBA	
1. ORAL PROBLEMS (Check all that apply)	a. Mouth is "dry"when eating a meal d. Mouth Pain b. Chewing Problem X e. NONE OF ABOVE c. Swallowing Problem X
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.) 7 1 b. WT (lb.) 1 8 5
3. WEIGHT Change	 a. Unintended weight loss–5% or more in last 30 days; or 10% or more in last 180 days X 0. No I. Yes b. Unintended weight gain–5% or more in last 30 days; or 10% or
	more in last 180 days
	X 0. No I. Yes
TIONAL PROBLEMS OR AP- PROACHES (Check all that apply)	of many foods g. Eating disorders b. Regular or repetitive complaints of hunger X h. Food allergies (specify)
SECTION L. ORA	AL/DENTAL STATUS
1. ORAL STATUS AND DISEASE PREVENTION (check all that apply)	 a. Has dentures or removable bridge X b. Some/all natural teeth lost-does not have or does not use dentures (or partial plates) c. Broken, loose or carious teeth d. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes e. Daily cleaning of teeth/dentures or daily mouth care-by resident or staff f. Resident has difficulty brushing teeth or dentures
	g. NONE OF ABOVE
SECTION M. SKII	N CONDITION
1. SKIN	Any troubling skin conditions or changes in the last 7 days?
(Check all that apply)	 a. Abrasions (scrapes) or cuts b. Burns (2nd or 3rd degree) c. Bruises d. Rashes, itchiness, body lice F. Other (specify) X g. NONE OF ABOVE
2. ULCERS	
(Due to	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.
any cause)	a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. 0
	b. Stage 2. A partial thickness loss of skin layers that presents
	clinically as an abrasion, blister, or shallow crater.
	c. Stage 3. A full thickness of skin is lost, exposing the subcutane-
	ous tissues-presents as a deep crater with or without
	ous tissues-presents as a deep crater with or without
	 SECTION J. HEA PAIN INTERFERES PAIN MANAGE- MENT ACCIDENTS (Check all that apply) DANGER OF FALL (Check all that apply) DANGER (Check all that apply) MUTRI- TIONAL PROBLEMS (Check all that apply) HEIGHT WEIGHT WEIGHT WEIGHT WEIGHT WEIGHT MUTRI- TIONAL PROBLEMS OR AP- PROACHES (Check all that apply) SECTION L. ORAL (Check all that apply) SECTION M. SKIN (Check all that apply) SECTION M. SKIN (Check all that apply) ULCERS

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

Res	ANDREW W CAVANAUGH 07/07/2004 004-78-8974 999999999 Resident Name:								
	TION M. SKIN		SEC	TION O. MED	ICATIONS (cont.)				
3.	FOOT PROBLEMS	 a. Resident or someone else inspects resident's feet on a regular basis? O. No X 1. Yes D. 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? 	4A. 4B.	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 f. Aricept				
SEC	TION N. ACTI	O. No X 1. Yes VITY PURSUIT PATTERNS	40.	PRN MEDICATIONS	Does resident have a prescription for any PRN medication for a mental, emotional or nervous condition, or behavioral problem? X 0. No 1. Yes				
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: X a. Morning Image: Imag	5.	SELF- ADMINSTERED MEDICATIONS (Check all that apply.)	Did resident self-administer any of the following in the last 7 days: a. Insulin e. Glucosan b. Oxygen f. Over-the-counter Meds c. Nebulizers g. Other (specify) d. Nitropatch X h. NONE OF ABOVE				
2.	AVERAGE TIME INVOLVED IN ACTIVITIES (Check only	(When awake and not receiving treatments or ADL care) 1. Most-more than 2/3 of time X 2. Some-from 1/3 to 2/3 of time 3. Little-less than 1/3 of time	6.	MEDICATION Preparation Administra- tion	 Did resident prepare and administer his/her own medications in last 7 days? (<i>Check only one.</i>) X 0. No Meds 1. Resident prepared and administrated <u>NONE</u> of his/her own medications. 2. Resident prepared and administrated <u>SOME</u> of his/her own medications. 				
3.	one.) PREFERRED ACTIVITY SETTINGS	Image: Antiperiod content of the setting of the set of	7.	MEDICATION COMPLIANCE (Check one)	 3. Resident prepared and administrated <u>ALL</u> of his/her own medications. Resident's level of compliance with medications prescribed by a physician/ psychiatrist during last 30 days: 0. No Meds 1. Always compliant 				
4.	GENERAL ACTIVITY PREFER- ENCES (Adapted to	(Check all PREFERENCES whether or not activity is currently available to resident) X a. Cards/other games k. Gardening or plants b. Crafts/arts X I. Talking or conversing c. Exercise/sports X m. Helping others d. Dancing X n. Doing chores around the			 2. Always compliant with reminder, verbal prompts X 3. Compliant some of the time (80% of time or more often) or with some medications 4. Rarely or never compliant 				
	resident's current abilities)	□ d. Dancing X n. Doing chores around the house/facility X e. Music house/facility □ f. Reading/writing X o. Cooking/baking	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 medicationfor a purpose other than intended)X0. No1. Yes				
		g. Spiritual/religious activity X p. Computer activities	SEC	TION P. SPEC	AL TREATMENTS AND PROCEDURES				
		X h. Trips/shopping q. Volunteering X i. Walking/wheeling outdoors r. Other (specify)	1.	SPECIAL TREATMENTS, PROCE- DURES,	 a. SPECIAL CARE-Check treatments or programs received during the last 14 days [Note-count only post admission treatments] TREATMEMTS a. Chemotherapy or X i. Training in skills required to return 				
5.	PREFERRED ACTIVITY SIZE	(Check all that apply) a. Individual c. Larger group b. Small group X d. No preference		AND Programs	a. Orientationary of radiation to the community (e.g., taking medications, house work, shopping, transportation, ADLs) b. Oxygen therapy shopping, transportation, ADLs) c. Dialysis X				
6.	PREFER- ENCES IN DAILY ROUTINE	 a. Resident prefers change in type of activity b. Resident prefers change in extent of involvement in activities (e.g., more or less) 			PROGRAMS X k. Day treatment program d. Alcohol/drug treatment program X k. Day treatment program Y k. Sheltered workshop/employment				
	(Check all that apply)	 c. Resident prefers change in location of activities d. Resident prefers activity at different time of day X e. Resident prefers stability in daily routine f. NONE OF ABOVE 			e. Alzheimer sidemental special care unit X n. Transportation f. Hospice care X o. Psychological rehabilitation g. Home health X p. Formal education				
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 X 4. Once a week 			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				
		facility 5. 2 or 3 times a week but not daily 2. None daily 3. 1-3 times/month 6. Daily			(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				
		 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 X 4. Once a week 			a. Speech-language pathology and auditory services 0 b. Occupational therapy 5				
		facility 5. 2 or 3 times a week but not daily 2. None daily 3. 1-3 times/month 6. Daily			c. Physical therapy 5 X d. Respiratory therapy 0 e. Psychological therapy (by any licensed mental health professional) 1 X				
8.	VOTING	Is resident registered to vote? X 0. No	2.	INTER-	Check all interventions or strategies used in the last 7 days unless other time				
9.	SOCIAL ACTIVITES (Check only one.)	Resident's current level of participation in social, religious or other personal activities compared to resident's status 180 days ago (since admission if less than 180 days): X 0. No change 1. Improved 2. Declined	2.	VENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	 specified-no matter where received) a. Special behavior symptom evaluation program b. Special behavior 				
SEC	TION O. MEDI	CATIONS			management program X f. Reorientation-e.g., cueing				
1.	NUMBER OF MEDICATIONS NEW	(Record the number of different medications used in the last 7 days;			 c. Evaluation by a licensed mental health specialist in last 90 days X g. Validation/Redirection h. Crisis intervention in facility i. Crisis stabilization unit in last 				
	MEDICATIONS	X 0. No 1. Yes (Record the number of DAYS injections of any type received during			X d. Group therapy 90 days e. Resident-specific j. Other (specify) deliberate changes in the k. NONE OF ABOVE				
		the last 30 days; enter "0" if none used)							

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MDS-RCA ME (Rev 12/03) (RAI © copyright 6/19/95)

Res	ident Name:	ANDREW W CAVANAUGH 0//0//	2004	Soc. Sec. # Facility Provider #
		IAL TREATMENTS AND PROCEDURES (cont.)		SECTION Q. SERVICE PLANNING
3.	NEED FOR ON-GOING MONITORING REHABILITA- TION/	(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 BECORD THE number of days each of the following rehabilitation or restorative to provide to the provided to the pro		1. RESIDENT GOALS a. Health promotion/wellness/exercise (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
	CARE	techniques or practices was provided to the resident for more than or equal to 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 TRAINING/SKILL PRACTICE IN:	10	2. CONFLICT a. Any disagreement between resident and family about goals or service plan? X 0. No b. Any disagreement between resident/family and staff about goals or service plan? X 0. No construction constrestres const
5.	SKILL TRAINING	0 d. Bed mobility 0 i. Amputation/prosthesis 0 e. Transfer 0 j. Communication 4 f. Walking 7 k. Time management 0 g. Dressing or grooming 0 I. Other (specify) 0 h. Eating or swallowing Record the number of days, in the last 30 days that each of the following were performed with assistance from staff as a skill training activity identification.	- IADLs	SECTION R. DISCHARGE POTENTIAL 1. DISCHARGE POTENTIAL a. Does resident or family indicate a preference to return to community X 0. No b. Does resident have a support person who is positive towards discharge? c. Has resident's self-sufficiency changed compared to 6 months or since admission, if less than 6 months?
		100 a. Meal Preparation (snacks, light meals) 00 h. Arranges Shopping (makes list, acquires (makes (makes own bed, takes care of belongings) 0 b. Telephone Use 04 30 c. Light Housework (makes own bed, takes care of belongings) 04 04 Laundry (sorts, folds, or washes own laundry) 00 0 e. Managing Incontinence Supplies (pads, briefs, ostomy, catheter) 00 1 Managing Cash (handles cash, makes purchases) 00 00 g. Managing Finances (banking, handling checkbook, or paying bills) 01	ries, el by t to ts or a- on	X 0. No change 1.Improved 2. Declined SECTION S. ASSESSMENT INFORMATION 1. PARTICIPA- TION IN ASSESS- MENT a. Resident: 0. No X 1. Yes 1 b. Family: X 0. No 1. Yes 2. No Family 0 c. Other Non-Staff: 0. No 1. Yes X. No ne 2 2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT: NANCY SMITH NANCY SMITH a. Signature of Assessment Coordinator (sign on line above) b. Date Assessment Coordinator signed as complete C. Other Signatures Title Sections Date
6.	ADHERENCE WITH TREATMENTS/ THERAPIES/ PROGRAMS	In the last 6 months, compliant all or most of the time with special treatment therapies and programs: 0. Always compliant 3. No treatments or programs: X 1. Compliant 80% of time 8. Unknown 2. Compliant less than 80% of the time		d. Date e. Date 3. CASE MIX
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)	0 0	
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)	0	X a. Blood pressure monitoring g. Breast exam or mammogra b. Hearing assessment h. Pap smear c. Vision test i. PSA or rectal exam
9.	PHYSICIAN VISITS Physician	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) In the last 14 days (or since admission if less than 14 days in	0 1	 d. Dental visit j. Other (<i>specify</i>) e. Influenza vaccine f. Pneumococcal vaccine
	ORDERS	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) Has the resident had any abnormal lab values during the last 90	0 0	(ANY time)
11. 12.	ABNORMAL LAB VALUES PSYCHIATRIC HOSPITAL STAY(S)	days (or since admission if less than 90 days)? □ 0. No □ 1. Yes Record number of times resident was admitted to a psychiatric	0	P11 = 1
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.)	0 0]

Name:	ANDREW	W	CAVANAUGH	

6 months (or since last assessment if less than 6 months.)

(Enter "0" if no outpatient surgery)

07/07/2004 Soc. Sec. # 004-78-8974

	CONFIDENTIAL								
F	ANDREW W CAN Resident Name:	/ANAUGH 07/07 Date:	7/2004 Soc. Sec. #	004-78-8974	99999999999999999999999999999999999999				
		SECTIO	N U. MEDICATIONS I	LIST					
	List all medications given during the last 7 days. Include medications used regularly less than weekly as part of the resident's treatment regimen. 1. List the medication name and the dosage 2. RA (Route of Administration). Use the appropriate code from the following list:								
	1 = by mouth (PO) 2 = sublingual (SL)	3 = intramuscular (IM) 4 = intravenous (IV)	5 = subcutaneous (SubC 6 = rectally	8 = inhalatio					
	 FREQ (Frequency): Use the ap PR = (PRN) as necessary 1H = (qh) every hour 2H = (q2h) every two hours 3H = (q3h) every three hours 4H = (q4h) every four hours 6H = (q6h) every six hours 	propriate frequency code to show the n 8H = (q8h) every eight hours 1D = (qd or hs) once daily 2D = (BID) two times daily (includes every 12 hours) 3D = (TID) three times daily 4D = (QID) four times daily	5D = five times 1W = (QWeek 2W = twice eve	s a day c) once every week rery week nes every week ther day	5W = five times every week 6W = six times every week 1M = (QMonth) once every month 2M = twice every month C = continuous O = other				

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

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

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

MINIMUM DATA SET (MDS)[©] RESIDENTIAL CARE ASSESSMENT (RCA)

BASIC ASSESSMENT TRACKING FORM

GENERAL INSTRUCTIONS:

Complete this form for all assessments and discharges.

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	JO	ΗN		Ľ)		(CO	N۷	۷A	Y			
		a. (Firs	st)		b. (N	/liddle	e Initi	al)		c. (La	ist)			d. (Jr/S	r)
2.	GENDER	X 1.	Male)				[2. Fe	male				
3.	BIRTHDATE	0) Month	6	1	d Day)	- 1		9 2 Year	(D			
4.	RACE/ ETHNICITY (Check only one.)	2.	Asia	erican n/Pac k, not	ific Is	lande	ər		ive		X 5	4. His . Wh Hi 6. Ot	ite, n ispan		
5.	SOCIAL	a. Soc	ial Se	curity	Num	ber		_					_		
	SECURITY and MEDICARE NUMBERS	0	0	4	—	2	8	—	3	2	2	0			
	(C in 1 st box if	b. Mec	dicare	numb	er (c	r con	npara	able	railro	ad ins	suran	ce nu	imbe	r)	
	no med. no.)	0	0	4	0	7	4	6	8	9	—	С	1		
6.	FACILITY NAME AND	a. Faci	-	ame BVI											
	PROVIDER NO.	b. Pro	vider	No.											
		9	9 9	9 9	9	9	9	9 9	9						
7.	MAINECARE	[Reco	rd a "-	+" if pe	endir	ng, "N	l" if n	ot a	Main	eCare	e recip	oient]			
	NO.	3	1	9	9	2	0	1 (D	Α					
8.	SIGNATURE(S)	of Pers	SON(S) CON	IPLE	TING	FACE	SHE	ET:						
	Signatures	Ή	RCA		Title EC		ł			Section ALL		7/2	3/20	Date 004	
b.														Date	
C.	DATE Completed		ord da 0 Mon	ate ba 7 [–] th	ickgr	ound 2 Day	3	mati [on w 2	as co 0 Yea	0	ed. 4			

MINIMUM DATA SET (MDS)[©] RESIDENTIAL CARE ASSESSMENT (RCA)

FACE SHEET: BACKGROUND INFORMATION ONLY AT ADMISSION

Resi	ident Name:_J	OHN D CONWAY Date: 07/13/2004	Soc. Sec. #004-28-3220
SE	CTION AB.	DEMOGRAPHIC INFORMATION	SECTION AC. CUST
1.	DATE OF ENTRY	Date the stay began. (Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date.)	1. CUSTOMARY ROUTINE (Check a) CYCLE OF (In year prior
		0 2 0 3 0 4 8 Month Day Year	DATE OF ENTRY to this home,
2.	ADMITTED FROM (AT ENTRY) (Check only one.)	 X 1. Private home/apt. 2. Other board and care/assisted living/group home 3. Nursing home 4. Acute care hospital 5. Psychiatric hospital 6. MR/DD facility 7. Rehabilitation hospital 8. Other (<i>specify</i>) 	or year last in community if now being admitted from another home, or hospital) A C. SU X d. SI D e. S X f. M G g. U h. A EATING PA i. C.
3.	LIVED ALONE (PRIOR TO ENTRY) (Check only one.)	X 0. No □ 1. Yes □ 2. In other facility	□ j. A X k. U: □ l. /
4.	PRIOR Primary Residence	Provide town, state, zip code for Resident's primary residence prior to admission MAINE 0 4 1 0 6 SOUTH PORTLAND MAINE 0 4 1 0 6 Town State Zip Code	ADL PATT
5.	RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	 (Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above) a. Prior stay at this home b. Nursing home c. Other residential facility—board and care home, assisted living, group home d. MH/psychiatric hospital e. MR/DD facility X f. NONE OF ABOVE 	□ p. € □ q. € □ r. E □ s. / INVOLVEI X t. D: X u. U: X v. Fo X w. D:
6.	LIFETIME Occupation	Put a "/" between two occupations. P R 0 D U C T I O N W O R K E R	□ x. lı □ y. / □ z. l
7.	EDUCATION (Highest Level Completed) (Check only one.)	1. No schooling 5. Technical or trade school X 2. 8th grade or less 6. Some college 3. 9–11 grades 7. Bachelor's degree 4. High school 8. Graduate degree	SECTION AD. FACE
8.	PRIMARY LANGUAGE (Check only one.)	X 0. English 2. French 1. Spanish 3. Other (specify)	1. SIGNATURE(S) OF PERSO a. Signatures NANCY SMITH
9.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of the following? a. Mental retardation X 0. No 1. Yes b. Mental illness X 0. No 1. Yes c. Developmental disability X 0. No 1. Yes	b. 2. DATE COMPLETED Recor
10.	CONDITIONS RELATED TO MR/DD STATUS	(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely) X a. Not applicable—no MR/DD (<i>Skip to AB11</i>) MR/DD with organic condition	
11.	alzheimer Dementia History	Does resident's RECORD indicate any history of the following? a. Alzheimer's disease X 0. No 1. Yes b. Dementia other than Alzheimer's disease X 0. No 1. Yes	

TION AC.	CUSTOMARY ROUTINE							
USTOMARY	(Check all that apply. If <u>all</u> information UNKNOWN, check last box [z] only.)						
ROUTINE	CYCLE OF DAILY EVENTS							
(In year prior to	a. Stayed up late at night (e.g., after 9 pm)							
ATE OF ENTRY	X b. Napped regularly during day (at least 1 hour)							
o this home, or year last	X c. Went out 1+ days a week							
n community if now being	X d. Stayed busy with hobbies, reading, or a fixed daily routine							
dmitted from	e. Spent most of time alone or watching TV							
nother home, ursing home,	X f. Moved independently indoors (with appliances, if used)							
or hospital)	g. Used tobacco products at least daily							
	h. NONE OF ABOVE							
	EATING PATTERNS							
	i. Distinct food preferences							
	j. Ate between meals all or most days							
	X k. Used alcoholic beverage(s) at least weekly							
	I. NONE OF ABOVE							
	ADL PATTERNS							
	m. In bedclothes much of day							
	X n. Wakened to toilet all or most nights							
	o. Had irregular bowel movement pattern							
	p. Shower for bathing							
	q. Sponge bath							
	r. Bathed in PM							
	s. NONE OF ABOVE							
	INVOLVEMENT PATTERNS							
	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							
	x. Involved in group activities v. NONE OF ABOVE							
	z. UNKNOWN —Resident/family unable to provide information							
		END						

_____ Facility Provider #____999999999

SECTION AD. FACE SHEET SIGNATURES and DATES

1. SIGNATURE(S) OF PERSON(S) COMPLETING FACE SHEET:									
a. Signatu	ures	Title Sections	Date						
NANC	Y SMITH	RCA DIRECTOR ALL	12/12/1968						
b.			Date						
2.	date	Record date background information was completed 1 2 1 2 1 9 6 8 Month Day Year							
CO	Impleted]						

CONFIDENTIAL MINIMUM DATA SET (MDS)[®] RESIDENTIAL CARE ASSESSMENT (RCA)

(STATUS IN LAST 7 DAYS UNLESS OTHERWISE NOTED)

05		DENTIFICATION and BACKGROUND INFORMATION			COMMUNICATION/HEARING PATTERNS
5E	RESIDENT	JOHN D CONWAY] [1		(With hearing appliance, if used)
2.	NAME SOCIAL SECURITY and MEDICARE NUMBERS (C in 1 st box if	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr) a. Social Security Number 0 0 4 - 2 8 - 3 2 2 0 b. Medicare number (or comparable railroad insurance number) -		(Check only one.,	
3.	FACILITY FACILITY NAME AND PROVIDER NO.	0 0 4 0 7 4 6 8 9 C I a. Facility Name MCBVI b. Provider No. 9 9 9 9 9 9 9 9 9	2	- COMMUNICA- Tion Devices/ Techniques	 (Check all that apply during last 7 days.) X a. Hearing aid, present and used b. Hearing aid, present and not used regularly c. Other receptive communication techniques used (e.g., lip reading) d. NONE OF ABOVE
4.	MAINECARE No.	[Record a "+" if pending, "N" if not a MaineCare recipient] 3 1 9 9 2 0 1 0 A	3	MAKING SELF UNDERSTOOD (Check only one.)	X 0 UNDERSTOOD
5.	ASSESSMENT DATE	Last day of observation period 0 7 1 3 2 0 0 4 Month Day Year			2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY/NEVER UNDERSTOOD
6.	REASON FOR ASSESSMENT	(Check primary reason for assessment) 1. Admission assessment 2. Annual assessment 3. Significant change in status assessment	4	ABILITY TO UNDERSTAND OTHERS (Check only one.	O. UNDERSTANDS X 1. USUALLY UNDERSTANDS—may miss some part / intent of message
7.	MARITAL STATUS (Check only one.)	X 1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated			 SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication RARELY/NEVER UNDERSTANDS
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 e. Private pay X b. SSI f. Private insurance	5	COMMUNICA- TION (Check only one.,	compared to resident's status 180 days ago or since admission if less than
		C. VA (including co-payment) X d. Social Security g. SSDI	SE	ECTION D.	VISION PATTERNS
9.	RESPONSI- Bility/ Legal Guardian	h. Other (specify) (Check all that apply) a. Legal guardian b. Other legal oversight c. Durable power of attorney/health care d. Durable power of attorney/financial b. Other legal oversight c. Durable power of d. Durable power of attorney/financial	1	• VISION (Check only one.)	 (Ability to see in adequate light and with glasses if used) 0. ADEQUATE—sees fine detail, including regular print in newspapers/books 1. IMPAIRED—sees large print, but not regular print in newspapers/books 2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects
10.	ADVANCED Directives	Does resident have any of the following advanced directives in place? a. Living Will X 0. No 1. Yes b. Do not resuscitate (DNR) X 0. No 1. Yes c. Do not hospitalize X 0. No 1. Yes			 3. HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects X 4. SEVERELY IMPAIRED—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects
		d. Organ donation X 0. No 1. Yes e. Other X 0. No 1. Yes (If "yes," specify)	2	APPLIANCES	a. Glasses, contact lenses X 0. No □ 1. Yes b. Artificial eye X 0. No □ 1. Yes
CE		COGNITIVE PATTERNS	SE 1		MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s)
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		DEPRESSION, ANXIETY, SAD MOOD	 observed in last 30 days, irrespective of the assumed cause) o. 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)
2.	MEMORY/ Recall Ability	b. Long-term memory OK—seems/appears to recall long past X 0. Memory OK 1. Memory problem (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 Image: a constraint of			VERBAL EXPRESSIONS OF DISTRESS 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")
3.	COGNITIVE SKILLS FOR DAILY DECISION- MAKING (Check only one.)	 (Made decisions regarding tasks of daily life) X 0. INDEPENDENT—decisions consistent/reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues/ supervision required 			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 or being abandoned, left alone, being with others 0 g. Recurrent statements that something terrible is about to happen
4.	COGNITIVE STATUS (Check only one.)	 3. SEVERELY IMPAIRED—never/rarely made decisions 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 			 -e.g., believes he or she is about to die, have a heart attack h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions
		1. Improved 2. Declined			i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues (continued next page)

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SECTION E. MOOD and BEHAVIOR PATTERNS (cont.)

1.	INDICATORS OF	in last 30 days, irrespective of the assumed cause)									
	DEPRESSION, ANXIETY,										
	SAD MOOD	1. This type exhibited up to 5 days a week									
		2. This type exhibited daily or almost daily (6, 7 days/v	veek))							
		SLEEP-CYCLE ISSUES				_					
		0 j. Unpleasant mood in morning									
		k. Insomnia/change in usual sleep pattern									
		SAD, APATHETIC, ANXIOUS APPEARANCE									
		I. Sad, pained, worried facial expressions—e.g., fi m. Crying, tearfulness	urrow	/ed bi	OWS						
			l -								
		restlessness, fidgeting, picking	and	wringi	ng,						
		LOSS OF INTEREST O. Withdrawal from activities of interest—e.g., no ir standing activities or being with family/friends	nteres	st in Ic	ong						
		INDICATORS OF MANIA 2 a Inflated self-worth exaggerated self-oninion; infl	otod	holiof							
		q. Inflated self-worth, exaggerated self-opinion; infl about one's own ability, etc.	aleu	Dellel							
		r. Excited behavior, motor excitation (e.g., heighte activity; excited, loud or pressured speech; incre				,					
2.	MOOD	Check if one or more indicators of depressed, sad or anxiou	ıs ma	ood							
	PERSISTENCE	(above) were not easily altered by altempts to "cheer up", or reassure the resident over last 7 days .	consc	ole, or							
	(Check only one.)	X 0. No mood indicators									
		1. Indicators present, easily altered									
		2. Indicators present, not easily altered									
3.	MOOD	Resident's current mood status compared to resident's statu	is 18	0 dav	s ago	5					
•	(Check only one.)	(or since admission if less than 180 days):		,							
		X 0. No change 1. Improved 2. Dec									
4.	BEHAVIORAL	(COLUMN A CODES: Record the appropriate code for the frequency of the symptom Alterability o			,						
	SYMPTOMS	code for the frequency of the symptom <u>Alterability</u> o in last 7 days) symptoms in									
		0. Behavior not exhibited in last 7 days 0. Not prese	nt or e	easily	altere	d					
		1. Behavior of this type occurred 1 to 3 days in last 7 days 1. Behavior r									
		2. Behavior of this type occurred 4 to 6 days but less than daily	A	B ≻							
		3. Behavior of this type occurred daily	REQUENCY	ALTERABILITY	HISTORY						
		(COLUMN C CODES: <u>History of this behavior in the last 6 months</u>)	EQU	ERAI	HIST						
		0. No 1. Yes	Æ	ALT							
a.	WANDERING needs or safe	 (moved with no rational purpose, seemingly oblivious to ty) 	0	0	0						
b.		BUSIVE BEHAVIORAL SYMPTOMS (others were creamed at, cursed at)	0	0	0						
c.	PHYSICALLY	ABUSIVE BEHAVIORAL SYMPTOMS (others were hit,									
	shoved, scrate	ched, sexually abused, gross physical assault)	0	0	0						
d.		APPROPRIATE/DISRUPTIVE BEHAVIORAL									
	public, smear	(made disruptive sounds, sexual behavior, disrobing in ed/hrew food/feces, hoarding, rummaged through others' paling actif aburity acts avidations of the statistical acting actif aburity acts avidations of the statistical acting acting the statistical acting and the statistical acting acting acting acting and acting acti	0	0	0						
e.	RESISTS CA	ealing, self-abusive acts, substance abuse, self-mutilation) RE (resisted taking medications/ injections, ADL	0	0	0						
f.		eating) G BEHAVIOR (made others feel unsafe, at risk, privacy	0	0							
	invaded)	-	-	-	0						
g.	ELOPEMENT		0	0	0						
h.		on-violent behavior (e.g., falling asleep while smoking)	0	0	0						
i.	0	blent behavior	0	0	0						
j.	FIRE SETTIN		0	0	0	Ц					
5.	SUICIDAL Ideation	Resident demonstrated suicidal thoughts or actions in the la	ist 30) day	s:						
6.	SLEEP	Check all present on 2 or more days during last 7 days									
υ.	PROBLEMS	a. Inability to awaken when desired X d. Interrup	oted s	sleep							
		b. Difficulty falling asleep		•							
		c. Restless or non-restful sleep									
-	INSIGHT	Posident has insight about his has manted weaklew				-					
7.	INTO	Resident has insight about his/her mental problem X 0. No 1. Yes 2. No mental he	alth •	aroble	me						
	MENTAL Health		aur	JUDIE	1115						
8.	BEHAVIORS	Resident's current behavior status compared to resident's sta	itus 1	80		-					
	(Check only one.)	days ago (or since admission if less than 180 days):									
	UIICON UTILY UIIC.)	X 0. No change 1. Improved 2. D	eclin	ed							

SE	CTION F. P	SYCHOSOCIAL WELL-BEING										
1.	SENSE OF	X a. At ease interacting with others										
	INITIATIVE/ INVOLVEMENT	X b. At ease doing planned or structured activities										
	(Check all that	X c. At ease doing self-initiated activities										
	apply)	 d. Establishes own goals e. Pursues involvement in life of facility (e.g., makes/keeps fri 	ionde [.]									
		involved in group activities; responds positively to new acti										
		assists at religious services)										
		f. Accepts invitations into most group activities g. NONE OF ABOVE										
-												
2.	RELATION-											
	(Check all that C. Unhappy with residents other than roommate											
	apply)	d. Openly expresses conflict/anger with family/friends										
		e. Absence of personal contact with family/friends										
		 f. Recent loss of close family member/friend g. Does not adjust easily to change in routines 										
	g. Does not adjust easily to change in routines X h. NONE OF ABOVE											
3.	LIFE-	Events in past 2 years										
	EVENTS HISTORY	a. Serious accident or physical illness										
		 b. Health concerns for other person c. Death of family member or close friend 										
	(Check all that apply.)	d. Trouble with the law										
		e. Robbed/physically attacked										
		f. Conflict laden or severed relationship										
		X g. Loss of income leading to change in lifestyle										
		h. Sexual assault/abuse i. Child custody issues										
		j. Change in marital/partner status										
		k. Review hearings (e.g., forensic, certification, capacity hear	ring)									
		I. NONE OF ABOVE										
SE	CTION G. I	PHYSICAL FUNCTIONING										
1.	. ,	F-PERFORMANCE										
	during last	NT—No help or oversight —OR— Help/oversight provided only 1 or 2 ti 7 days	mes									
	1. SUPERVISIO	ON-Oversight, encouragement or cueing provided 3 or more times dur	ing las	st 7								
		— Supervision (3 or more times) plus physical assistance provided only g last 7 days	y 1 or	2								
	2. LIMITED AS	SISTANCE—Resident highly involved in activity; received physical help in		ed								
		ng of limbs or other non-weight bearing assistance 3 or more times —C sistance (3 or more times,) plus weight-bearing support provided 1 or 2										
	3. EXTENSIVE	ASSISTANCE-While resident performed part of activity, over last 7-day										
		wing type(s) provided 3 or more times: bearing support										
	•	f performance during part (but not all) of last 7 days										
	4. TOTAL DEPL	ENDENCE—Full staff performance of activity during last 7 days										
		ID NOT OCCUR DURING LAST 7 DAYS										
		PPORT CODES (CODE for MOST SUPPORT PROVIDED OVER E) OD) during last 7 days; code regardless of person's										
		ance classification.	A	B								
		o or physical help from staff	ANCI									
	 Setup he One-per 	eip oniy son physical assist	RM	뮲								
	3. Two+ pe	ersons physical assist	SELF- PERFORMANCE	SUPPORT								
		did not occur during entire 7 days	8 2 2	പ								
a.	side, and posit	IV- How resident moves to and from lying position, turns side to tions body while in bed	0	0								
b.	wheelchair, sta	 How resident moves between surfaces—to/from: bed, chair, anding position (EXCLUDE to/from bath/toilet) 	0	0								
c.		N – How resident moves to and returns from other locations (e.g., e for dining, activities, or treatments). If facility has only one floor,										
	how resident r	noves to and from distant areas on the floor. If in wheelchair, self-	0	0								
d.	sufficiency once in chair DRESSING – How resident puts on, fastens, and takes off all items of street											
	clothing, inclu	uding donning/removing prosthesis	0	0								
e.	nourishment b	w resident eats and drinks (regardless of skill). Includes intake of y other means (e.g., tube feeding, total parenteral nutrition)	0	0								
f.		 How resident uses the toilet room (or commode, bed- pan, er on/off toilet, cleanses, changes pad, manages ostomy or 	0	0								
	catheter, adjus	sts clothes		Ľ								
g.		TYGIENE – How resident maintains personal hygiene, including brushing teeth, shaving, applying makeup, washing/drying face,	0	0								
	hands, and pe	rineum (EXCLUDE baths and showers)	-									
h.	STAIRS - How	w resident climbs stairs	0	0								

			CONFIE	DENT	IAL					
Ros	JC ident Name:	DHN D CONWAY 07-13-2 Date:	004	Soc	004-2 . Sec. #	28-3220	Facility	999999999 Provider #		
		HYSICAL FUNCTIONING (cont.)				PHYSICAL FUNCTIONI	,			
2.	BATHING SELF- PERFORMANCE	How resident takes full-body bath/shower, sponge bath, and transfer of tub/shower (EXCLUDE washing of back and hair.) <u>Check for mos</u> <u>dependent</u> in self-performance during last 7 days. X 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			stands no more than a two-step ndent if he/she had special plate guard, velcro closings on dependently if some or all of AE subtasks (task segmentation) ndent if he/she received ADL or	DL/				
3A.	MODES OF Locomotion	 (Check all that apply during last 7 days) a. Cane/walker/crutch b. Wheeled self c. Other person wheeled X d. NONE OF ABOVE 		7.	NEW DEVICES NEEDED (Check all that apply.)	 j. NONE OF ABOVE Resident expresses or gives a assistive devices a. Eyeglasses b. Hearing aid c. Cane or walker 	 f. Assistive dressing devices (e.g., button hook, velcro closir g. Dentures 			
3B.	MAIN Mode of Locomotion	Was wheelchair the primary mode of locomotion during the last 7 dat X 0. No I Yes					X i. N	Other (specify)		
3C.	BEDFAST/ Chairfast	 (Check if health condition keeps resident in his/her room 22+ hours p in last 7 days) a. Bedfast all or most of time b. Chairfast all or most of the time X c. NONE OF ABOVE 	ber day	8.	SELF- Performance In Iadls	days ago (or since admission	or abilitie	es compared to resident's status n 180 days):	s 180	
	SELF-	Resident's current ADL status or abilities compared to resident's stat	us 180	SE	CTION H.	CONTINENCE IN LAST	14 DAY	(S		
4.	PERFORMANCE IN ADLs (Check only one.)	 days ago (or since admission if less than 180 days): X 0. No change 1. Improved 2. Declined 		1	(Code for res 0. CONTIN ostomy de	f indwelling urinary catheter or				
5A	IADL SELF- PERFOR- Mance	 Code for level of independence in the last 30 days based on resident involvement in the activity. SELF-PERFORMANCE CODES: INDEPENDENT : (with/without assistive devices)—No help p DONE WITH HELP: Resident involved in activity but help (ind supervision, reminders, and/or physical help) is provided. DONE BY OTHERS: Full performance of the activity is done by others. The resident is 	rovided. Iuding	ng	BOWEL, 2. <i>OCCASI</i> daily; BO 3. <i>FREQUE</i> some cor	nt episodes once a week or les 2 or more times a week but no nded to be incontinent daily, bu , 2-3 times a week ER, multiple daily episodes; BOV ance or bowel continence	ot ut			
		involved at all when the activity is performed. 8. Activity did not occur in the last 30 days.			BLADDER	programs, if employed		appliances (e.g. felov) or	0	
		IADL	SELF- PERFORMANCE	2.	BOWEL ELIMINATION PATTERN	Control of urinary bladder fund continence programs, if emplo Bowel elimination pattern regular—at least one movement every three days		Diarrhea Fecal Impaction Resident is Independent	0 <u>c.</u> d.	
		 Resident arranged for shopping for clothing, snacks, other incidentals. 	2	3.	APPLIANCES	Constipation Any scheduled toileting plan	b. a.	NONE OF ABOVE	e. _{f.} X	
		 Besident shopped for clothing, snacks, or other incidentals. Desident arranged for suitable transportation to get to 	1		and PROGRAMS	Bladder retraining program	b.	commode/urinal	f.	
		 Resident arranged for suitable transportation to get to appointments, outings, necessary engagements. 	2			External (condom) catheter	с. d.	Pads/briefs used Enemas/irrigation	g. h.	
		 Resident managed finances including banking, handling checkbook, or paying bills. 	1			Indwelling catheter Intermittent catheter	e.	Ostomy present	i.	
		e. Resident managed cash, personal needs allowance.	0 8	4.	USE OF	Resident's management of ir	continen	NONE OF ABOVE ce supplies (pads, briefs, ostom	j.χ νν	
		f. Resident prepared snacks, light meals.g. Resident used phone.	0	.					,	
		 Resident did light housework such as making own bed, dusting, or taking care of belongings. 	0		(Check only one.)	1. Resident incontinent a	and able t	to manage incontinence supplie	¥S	
		i. Resident sorted, folded, or washed own laundry.	2			independently. 2. Resident incontinent a incontinence supplies		ves assistance with managing		
5B.	TRANSPOR- TATION	Check all that apply for level of independence in the last 30 days bas on resident's involvement in the activity.						not use incontinence supplies.		
		 a. Resident drove car or used public transportation independent get to medical, dental appointments, necessary engagements other activities. b. Resident rode to destination with staff, family, others (in car, va) 	s, or	5.	CHANGES IN URINARY Continence	days ago (or since last asse				
		 public transportation) but was <u>not accompanied</u> to medical, dental appointments, necessary engagements, or other activi X c. Resident rode to destination with staff, family, others (in car, va public transportation) and <u>was accompanied</u> to medical, der appointments, necessary engagements, or other activities. d. Activity did not occur. 	n,	Che and dia	eck only those of behavior statu gnoses.) (If non	AGNOSES diagnoses that have a relationsh s, medical treatments, nurse mc e apply, CHECK item xx. NONE ENDOCRINE/METABOLIC/	nitoring, c	or risk of death. (Do not list inac	, mood tive	
6.	ADL AND IADL FUNCTIONAL REHABILI- TATION OR IMPROVE- MENT POTENTIAL (Check all that apply.)	 a. Resident believes he/she is capable of increased independent at least some ADLs or IADLs. X 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 morning evenings e. Resident requires or only understands a one-step direction. <i>(continued in next column)</i> 		1.	DIAGNOSES	AUTRITIONAL a. Diabetes mellitus b. Hyperthyroidism c. Hypothyroidism		 Artroince Dariolo (Astroince) Arteriosclerotic heart disea: (ASHD) Cardiac dysrhythmia Congestive heart failure Deep vein thrombosis Hypertension Hypotension Peripheral vascular disease K. Other cardiovascular disease (continued on next page) 	e	

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Resi	dent Name:	OHN D CONWAY	_ Soc. 8	Sec. #0	04-28-3220	Facility Provider #	999999999	9
SEC	TION I. DIAG	IOSES (cont.)	SEC	CTION J. HEA	LTH CONDITIONS AN	D POSSIBLE MEDICATION SID	E EFFECTS	(cont.)
		MUSCULOSKELETAL ff. Manic depressive (Bipolar) I. Arthritis gg. Schizophrenia m. Hip fracture n. Missing limb (e.g., amputation) h. Asthma i. Emphysema/COPD	5.	PAIN INTERFERES			, and so on? time	resident's
		p. Pathological bone fracture SENSORY X jj. Cataracts NEUROLOGICAL k. Diabetic retinopathy	6.	PAIN MANAGE- MENT	 1. No pain treat 2. Treated, full c 			ontrol
		q. Alzheimer's disease II. Glaucoma mm. Macular degeneration r. Aphasia s. OTHER	7.	ACCIDENTS (Check all that apply)	 a. Fell in past 30 b. Fell in past 31 c. Hip fracture in 	I-180 days X e. NONE OF A) days
		t. Cerebrovascular accident (stroke) nn. Allergies (specify) u. Dementia other than Alzheimer's disease pp. Cancer v. Hemiplegia/ hemiparesis ss. HIV w. Multiple sclerosis Syndrome, Autism, or other organic condition related to	8.	DANGER OF FALL (Check all that apply)	c. Limits activity	boroblems when standing because resident or family fearfu sition from seated to standing ()	l of resident f	alling
		y. Parkinson's Mental Retardation or Developmental disability (MR/	SEC	CTION K. ORA	L/NUTRITIONAL STA	rus		
		z. Quadriplegia DD) aa. Seizure disorder uu. bb. Transient ischemic attack (TIA) Other psychiatric diagnosis (e.g., paranoia, phobias,	1.	ORAL PROBLEMS (Check all that apply)	 a. Mouth is "dry b. Chewing Pro c. Swallowing F 	blem X e. A	outh Pain IONE OF AB	OVE
		Cc. Traumatic brain injury PSYCHIATRIC/MOOD	2.	HEIGHT AND WEIGHT	measure in last 30 days;	thes and (b.) weight in pounds. Base measure weight consistently in accor r voiding, before meal, with shoes off,	d with standar	d facility othes.
		dd. Anxiety disorder ee. Depression			4	a. HT (in.) 6 8 b. WT (lk	D.) 1 7	6
2.	OTHER Current Diagnosis And ICD-9	a	3.	WEIGHT Change	more in last 180 of X 0. No	☐ 1. Yes	•	
	CODES	c			b. Unintended weig more in last 180 c X 0. No	ht gain–5% or more in last 30 d lays 1. Yes	ays; or 10%	or
SEC	I ION J. HEAL	TH CONDITIONS AND POSSIBLE MEDICATION SIDE EFFECTS	4.	NUTRI-	a. Complains ab	out the taste f. Noncom	oliance with c	liet
1.	PROBLEM CONDITIONS	(Check all problems present in last 7 days unless other time frame is indicated) a. Inability to lie flat due to shortness of breath i. Headache b. Shortness of breath k. Blurred vision c. Edema I. Dry mouth d. Dizziness/vertigo m. Excessive salivation or drooling f. Hallucinations n. Change in normal appetite	4.	TIONAL PROBLEMS OR AP- PROACHES (Check all that apply)	 of many foods b. Regular or report complaints of c. Leaves 25% of uneaten at maximum X d. Therapeutic diality pureed) diet 	s g. Eating di bettive h. Food alle (specify) of food i. Restriction (specify) ost meals (specify) et j. NONE C	sorders ergies ons	
		□ g. Hostility □ o. Other (<i>specify</i>)	SEC	CTION L. ORA	L/DENTAL STATUS			
2.	EXTRA- PYRAMIDAL SIGNS AND SYMPTOMS	□ h. Suspiciousness X p. NONE OF ABOVE Check all present at any point during last 3 days INCREASE IN MOTOR ACTIVITY □ a. Akathisia-resident reports subjective feeling of restlessness or need for movement □ b. Dyskinesia-chewing, puckering movements of mouth; abnormal irregular movements of lips; or rocking or writhing of trunk □ c. Tremor-regular rhythmic movements of the fingers, limbs, head, mouth, or tongue	1.	ORAL STATUS AND DISEASE PREVENTION (check all that apply)	(or partial plat c. Broken, loose d. Inflamed gum ulcers or rash e. Daily cleaning staff	ral teeth lost-does not have or do es) e or carious teeth is (gingiva); swollen or bleeding gi	ums; oral abs care–by resi	scesses;
		DECREASE IN MOTOR ACTIVITY					28	
		 d. Rigidity-resistance to flexion and extension of muscles (e.g., continuous or cogwheeling rigidity) 	SEC	TION M. SKIN				
		e. Slow shuffling gait–reduction in speed and stride length of gait,	1.	SKIN		nditions or changes in the last 7 d	lays?	
		 usually with a decrease in pendular arm movement f. Bradykinesis-decrease in spontaneous movements (e.g., reduced body movement or <i>poverty of</i> facial expression, gestures, speech) MUSCLE CONTRACTIONS g. Dystonia-muscle hypertonicity (e.g., muscle spasms or stiffness, 		PROBLEMS (Check all that apply)	 a. Abrasions (see b. Burns (2nd or c. Bruises X d. Rashes, itching 	3rd degree) f. Other (ores or lesion (specify) OF ABOVE	ns
		protruding tongue, upward deviation of the eyes) X h. NONE OF ABOVE	2.	ULCERS	Record the number of	ulcers at each ulcer stage-regardle	ess of cause.	ber Ige
3.	PAIN	(Code the highest level of resident's pain present in the last 7 days) 00		(Due to any cause)	last 7 days. Code 9=9 d	ge, record "0" (zero). Code all that or more) Requires full body exam.		Number at Stage
	SYMPTOMS	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)		any outdoo)	the skin) that does not	t area of skin redness (without a b disappear when pressure is reliev ckness loss of skin layers that pre	ved.	3
4.	PAIN SITE	(If pain is present in the last 7 days) □ a. Back pain □ f. Incisional pain			clinically as an abrasio	n, blister, or shallow crater.		0
		□ b. Bone pain □ g. Joint pain (other than hip) □ c. Chest pain while doing □ h. Soft tissue pain (e.g., lesion,				ess of skin is lost, exposing the su as a deep crater with or without tissue.	upcutane-	1
		usual activities muscle) d. Headache i. Stomach pain			d. Stage 4. A full thickn exposing muscle or bo	ess of skin and subcutaneous tiss ne.	sue is lost,	0
		e. Hip pain j. Other (<i>specify</i>)						

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		OHN D CONWAY Date: 07/13/2004	Soc.	Sec. #004	4-28-3220 Facility Provider # 999999999	
SE	CTION M. SKIN	CONDITION	SEC	TION O. MED	ICATIONS (cont.)	
3	FOOT PROBLEMS	 a. Resident or someone else inspects resident's feet on a regular basis? O. No X 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? 	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. Ins 0 b. Antianxiety 0 e. Diuretic 0 g. Ins 0 c. Antidepressant 0 f. Arcept 0 f. Arcept	sulin
SE		X 0. No 1. Yes /ITY PURSUIT PATTERNS	4B	PRN MEDICATIONS	Does resident have a prescription for any PRN medication for a menta emotional or nervous condition, or behavioral problem? X 0. No 1. Yes	al,
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: X a. Morning Image: d. Night (Bedtime to A.M.) X b. Afternoon Image: e. NONE OF ABOVE X c. Evening	5.	SELF- ADMINSTERED MEDICATIONS (Check all that apply.)	Did resident self-administer any of the following in the last 7 days: a. Insulin e. Glucosan b. Oxygen f. Over-the-counter Meds c. Nebulizers g. Other (specify) d. Nitropatch X h. NONE OF ABOVE	
2	TIME INVOLVED IN ACTIVITIES (Check only one.)	(When awake and not receiving treatments or ADL care) X 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	6.	MEDICATION PREPARATION ADMINISTRA- TION	 Did resident prepare and administer his/her own medications in last 7 (<i>Check only one.</i>) X 0. No Meds 1. Resident prepared and administrated <u>NONE</u> of his/her own medica 2. Resident prepared and administrated <u>SOME</u> of his/her own medica 3. Resident prepared and administrated <u>ALL</u> of his/her own medication 	ations.
3	PREFERRED ACTIVITY SETTINGS	(Check all settings in which activities are preferred) X a. Own room X d. Away from facility X b. Day/activity room □ e. NONE OF ABOVE X c. Outside facility (e.g., in yard)	7.	MEDICATION COMPLIANCE (Check one)	Resident's level of compliance with medications prescribed by a physi psychiatrist during last 30 days: X 0. No Meds 1. Always compliant	ician/
4	ACTIVITY PREFER- ENCES (Adapted to	(Check all PREFERENCES whether or not activity is currently available to resident) a. Cards/other games X k. Gardening or plants b. Crafts/arts X I. Talking or conversing c. Exercise/sports X m. Helping others			 Always compliant with reminder, verbal prompts Compliant some of the time (80% of time or more often) or wit some medications A. Rarely or never compliant 	
	resident's current abilities)	□ d. Dancing X n. Doing chores around the house/facility X e. Music house/facility □ f. Reading/writing □ o. Cooking/baking	8.	MISUSE OF Medication	Misuse of prescription or over-the-counter medications in the last 6 mc (e.g., resident uses more or less than the directed dose, is using medi for a purpose other than intended) X 0. No I 1. Yes	
		X g. Spiritual/religious activity D. Computer activities	SEC	TION P. SPEC	CIAL TREATMENTS AND PROCEDURES	
		X h. Trips/shopping q. Volunteering X i. Walking/wheeling outdoors r. Other (specify) X j. Watching TV s. NONE OF ABOVE	1.	SPECIAL TREATMENTS, PROCE-	a. SPECIAL CARE-Check treatments or programs received during the la. days [Note-count only post admission treatments] TREATMEMTS	
Ę	5. PREFERRED ACTIVITY SIZE	(Check all that apply) a. Individual x b. Small group d. No preference		DURES, AND Programs	 a. Chemotherapy or radiation b. Oxygen therapy c. Dialysis i. Training in skills required to to the community (e.g., takin medications, house work, shopping, transportation, All 	ng
6	BREFER- ENCES IN DAILY ROUTINE	 a. Resident prefers change in type of activity b. Resident prefers change in extent of involvement in activities (e.g., more or less) 			PROGRAMS j. Case management d. Alcohol/drug treatment program k. Day treatment program X i. Sheltered workshop/employing	ment
	(Check all that apply)	 c. Resident prefers change in location of activities d. Resident prefers activity at different time of day X e. Resident prefers stability in daily routine f. NONE OF ABOVE 			e. Alzheimer's/dementia special care unit n. Job training f. Hospice care o. Psychological rehabilitation g. Home health p. Formal education h. Home care q. NONE OF ABOVE	I
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 2. None 3. 1-3 times/month 6. Daily 			 b. THERAPIES-Record the number of days each of the following therapies administered (for at least 15 minutes a day) in the last 7 calendar days 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 (A) 	(Enter (E) (E) (E) (E) (E) (E) (E) (E) (E) (E)
		b. How often has resident talked by telephone with family and friends in the last 30 days? (check only one)			a. Speech-language pathology and auditory services 0 b. Occupational therapy 0	
		 1. No family or friends outside 4. Once a week facility 5. 2 or 3 times a week but not daily 			c. Physical therapy 0 d. Respiratory therapy 0 g. Respiratory therapy 0	
		3. 1-3 times/month X 6. Daily			e. Psychological therapy (by any licensed mental health professional) 0	
6		Is resident registered to vote? X 0. No 1. Yes 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): X 0. No change 2. Declined	2.	INTER- VENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE	(Check all interventions or strategies used in the last 7 days unless other specified-no matter where received) a. Special behavior symptom evaluation program environment to address mood/behavior patterns-providing bureau in which rummage	-e.g.,
SF	CTION O. MEDI	CATIONS		LOSS	b. Special behavior f. Reorientation–e.g., cuein f.	ng
1	NUMBER OF MEDICATIONS	(Record the number of different medications used in the last 7 days; 0 3			c. Evaluation by a licensed mental health specialist in last 90 days g. Validation/Redirection h. Crisis intervention in facili i. Crisis stabilization unit in	,
2	MEDICATIONS	(Resident currently receiving medicatons that were initiated during the last 90 days) X 0. No 1. Yes			d. Group therapy 90 days e. Resident-specific j. Other (specify)	
3		(Record the number of DAYS injections of any type received during the last 30 days ; enter "0" if none used)			deliberate changes in the X k. NONE OF ABOVE	

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

MDS-RCA ME (Rev 12/03) (RAI © copyright 6/19/95)

Res	ident Name:	JOHN D CONWAY Date: 07/13/2004	Soc. S	
SEC	TION P. SPEC	IAL TREATMENTS AND PROCEDURES (cont.) (Code for person responsible for monitoring)	SEC	CTION Q. SERVICE PLANNING RESIDENT a. Health promotion/wellness/exercise
	ON-GOING Monitoring	0. No monitoring required 2. RCF Other Staff 1. RCF nurse 3. Home health nurse		GOALS Image: Control of the control
		a. Acute physical or psychiatric condition - not chronic b. New treatment/medication		areas in which resident has self-identified goals) X d. Rehabilitation–skilled e. Maintaining physical or cognitive function f. Participation in the community
4.	REHABILITA- Tion/ 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)	2.	g. Other (specify) h. No goals CONFLICT a. Any disagreement between resident and service plan? X 0. No b. Any disagreement between resident/farmi service plan? X 0. No
		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	SEC	DISCHARGE Does resident or family indicate a preferer POTENTIAL a. Does resident or family indicate a preferer X 0. No 1. Yes
	SKILL	0 g. Dressing or grooming 1 I. Other (specify) PREP 0 h. Eating or swallowing Record the number of days, in the last 30 days that each of the following IADLs		 b. Does resident have a support person who discharge? X 0. No 1. Yes c. Has resident's self-sufficiency changed co
5.	TRAINING	were performed with assistance from staff as a skill training activity identified in the resident's service plan. $\begin{array}{c} \underline{00} \\ \underline{00} \end{array}$ a. Meal Preparation (snacks, $\begin{array}{c} \underline{00} \\ \underline{00} \end{array}$ h. Arranges Shopping		since admission, if less than 6 months? X 0. No change 1.Improved
		light meals) (makes list, acquires 00 b. Telephone Use help)		CTION S. ASSESSMENT INFORMATION
		00 c. Light Housework (makes own bed, takes care of belongings) 00 i. Shopping (for groceries, clothes, or other incidentals) 00 b. Light Housework (makes own bed, takes care of belongings) 00 ii. Shopping (for groceries, clothes, or other incidentals) 00 b. Light Housework (makes own bed, takes care of belongings) 00 iii. Shopping (for groceries, clothes, or other incidentals)	1.	PARTICIPA- TION a. Resident: 0. No X 1. Yes IN b. Family: X 0. No 1. Yes ASSESS- MENT c. Other Non-Staff: X 0. No 1. Yes
		00 e. Managing Incontinence various means to get to medical appointments or other necessary	2.	
		00 f. Managing Cash (handles cash, makes purchases) 01 k. Medications (preparation and administration of medications) 00 g. Managing Finances I. Other (specify)		 a. Signature of Assessment Coordinator (sign on line above b. Date Assessment Coordinator signed as complete 0 7 Month
		(banking, handling checkbook, or paying bills)		c. Other Signatures Title Sect
6.	ADHERENCE WITH TREATMENTS/	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		d
	THERAPIES/ PROGRAMS	1. Compliant 80% of time 8. Unknown 2. Compliant less than 80% of the time	3.	CASE MIX GROUP
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 0 0	SEC	CTION T. Preventive Health/Health Behaviors
		assessment if less than 6 months.) (Enter "0" if no hospital admissions)	1.	PREVENTIVE (Check all the procedures the resident received
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)		a. Blood pressure monitoring g. B b. Hearing assessment h. P c. Vision test i. P
9.	PHYSICIAN VISITS	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)		Xd. Dental visitXj. OtXe. Influenza vaccineF
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)		f. Pneumococcal vaccine (ANY time)
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)? \Box 0. No \Box 1. Yes	P11	1 = 1 - problem with font could not put x in box
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)		

SEC	TION Q. SERV	ICE PLANNING
1.	RESIDENT GOALS (Check all areas in which resident has self-identified goals)	 a. Health promotion/wellness/exercise b. Social involvement/making friends c. Activities/hobbies/adult learning X d. Rehabilitation-skilled e. Maintaining physical or cognitive function f. Participation in the community g. Other (<i>specify</i>)
2.	CONFLICT	 h. No goals 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 I 1. Yes

9999999999

•	DISCHARGE Potential	a.	Does resident or family indicate a preference to return to community? X 0. No $\hfill D$ 1. Yes
		b.	Does resident have a support person who is positive towards discharge? X 0. No I. Yes
		c.	Has resident's self-sufficiency changed compared to 6 months or since admission, if less than 6 months? X 0. No change 1.Improved 2. Declined

...

SEC	CTION S. ASSESSMENT INFORMATION						
1.	PARTICIPA- TION IN ASSESS- MENT	a. Resident: 0. No X 1. Yes b. Family: X 0. No 1. Yes c. Other Non-Staff: X 0. No 1. Yes	2. No Family 2. None				
2.	SIGNATURE	S OF PERSONS COMPLETING THE ASSESS	MENT:				
	NANC'	Y SMITH					
	a. Signatu	re of Assessment Coordinator (sign on line above)				
	b. Date Assessment Coordinator signed as complete $\boxed{0 7}_{Month} - \boxed{1 7}_{Day} - \boxed{2 0 0 4}_{Vear}$						
	c. Other Signatures Title Sections Date						
	d.		Date				
	e.		Date				
3.	CASE MIX GROUP						
SECTION T. Preventive Health/Health Behaviors							
1.	PREVENTIVE	(Check all the procedures the resident received	I during the past 12 months)				
	HEATH		reast exam or mammogram				
1		□ b. Hearing assessment □ h. P	ap smear				

	b. Hearing assessment	h. Pap smear
	c. Vision test	i. PSA or rectal exam
	X d. Dental visit	X j. Other (specify)
	X e. Influenza vaccine	PSA
	f. Pneumococcal vaccine	

CONFIDENTIAL 07/13/2004 00

004-28-3220 Soc. Sec. #_

SECTION U. MEDICATIONS LIST

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

1. List the medication name and the dosage

Resident Name:

2. RA (Route of Administration). Use the appropriate code from the following list:

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

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

Date

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

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

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

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

MINIMUM DATA SET (MDS)[©] RESIDENTIAL CARE ASSESSMENT (RCA)

BASIC ASSESSMENT TRACKING FORM

GENERAL INSTRUCTIONS:

Complete this form for all assessments and discharges.

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	Samantha Green				
		a. (First) b. (Middle Initial) c. (Last)	d. (Jr/Sr)			
2.	GENDER	□ 1. Male X 2. Female				
3.	BIRTHDATE	0 2 - 2 5 - 1 9 2 4 Month Day Year				
4.	RACE/ ETHNICITY (Check only one.)	2. Asian/Pacific Islander 5. W	spanic 'hite, not of ispanic origin her			
5.	SOCIAL SECURITY and MEDICARE NUMBERS (C in 1 st box if no med. no.)	a. Social Security Number 0 0 5 2 2 9 4 4 4 b. Medicare number (or comparable railroad insurance nu 0 0 5 2 2 9 4 4 4 A] imber)			
6.	FACILITY NAME AND PROVIDER NO.	a. Facility Name MCBVI b. Provider No. 9 9 9 9 9 9 9 9 9 9				
7.	MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient] 2 4 6 0 3 7 7 0 A	1			
8.	8. SIGNATURE(S) OF PERSON(S) COMPLETING FACE SHEET:					
a. 9	a. Sinarrecy Smith RCA Director Satins 7/28/2004					
b.			Date			
2.	DATE Completed	Record date background information was completed. 0 7				

MINIMUM DATA SET (MDS)[©]

Soc. Sec. #_

Residential Care Assessment (RCA)

DISCHARGE FORM

d. (Jr/Sr)

RESIDENT NAME

 \square

Х

a. (First)

1. Male

Month

4. Hispanic

0 0

0

0 2

6.	FACILITY NAME	a	ı. Fa	cility	Nam	е							
	AND PROVIDER	_			M	СВУ	I						
	NO.												
		k). Pr	ovide	r No								
			9	9	9	9	9	9	9	9	9		
7.	MAINECARE		[Rec	cord	a "+'	' if pe	ndin	g, "N	l" if I	not a	Mair	neCare recipient]	
	NO.	[-					L _	- 1			7	
			2	4	6	0	3	7	7	0	Α		
8.	REASON FOR	(1	VOT	'E: 0	ther	code	s do	not a	apply	to t	his fo	orm)	
0.	ASSESSMENT		6	Disc	haro	he							
					0								
			7.	Disc	harge	ed pri	or to	com	pletin	g initi	al as	sessement	6

SECTION D2. DEMOGRAPHIC INFORMATION

1.	DATE OF Entry	Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date 0 8 — 0 9 — 1 9 7 1 Month Day Year Year Year Year
2.	ADMITTED FROM (AT ENTRY) (Check only one.)	X1. Private home/apt. 2. Other residential care/assisted living/group home 3. Nursing home 4. Acute care hospital 5. Psychiatric hospital 6. MR/DD facility 7. Rehabilitation hospital 8. Other (specify)

	6
STATUS 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)	
2. DISCHARGE Date of death or discharge	
DATE	
Month Day Year	
3. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:	
	/2004
3. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:	/2004 Date
3. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT: NANCY SMITH RCA DIRECTOR 07/26	
3. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT: NANCY SMITH RCA DIRECTOR 07/26	
SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT: NANCY SMITH RCA DIRECTOR 07/26 a. Signatures Title	Date

Facility Provider #_

SECTION D1. IDENTIFICATION INFORMATION

Resident Name:

1.

2.

3.

4.

5.

GENDER

BIRTHDATE

RACE/ ETHNICITY

(Check only one.)

SOCIAL SECURITY AND MEDICARE NUMBERS

[C in 1st box if

no med. no.]

SAMANTHA GREEN

SAMANTHA

b. (Middle Initial)

2 5

1. American Indian/Alaskan Native

3. Black, not of Hispanic origin

2. Asian/Pacific Islander

a. Social Security Number

0 5

5

Day

2 2

2 2

CONFIDENTIAL 07/25/2004

Date:_

5. White, not of

4 4

Α

6. Other

Hispanic origin

GREEN

c. (Last)

Х

9

4 4

b. Medicare number (or comparable railroad insurance number)

9 4

1 9

2. Female

2 4

4

Year

SECTION D3. ASSESSMENT/DISCHARGE INFORMATION

999999999

MINIMUM DATA SET - RESIDENTIAL CARE ASSESSMENT (MDS-RCA)

CORRECTION REQUEST FORM

Use this form:

- 1. To request correction of error(s) in an MDS-RCA assessment record or error(s) in an MDS-RCA Discharge Tracking
- record that has been previously accepted into the State MDS-RCA database; and
- 2. To identify the inaccurate record.

A correction request can be made to either MODIFY or INACTIVATE a record.

TO MODIFY A RECORD IN THE STATE DATABASE:

- 1. Complete a new corrected assessment or discharge tracking form. Include all the items on the form, not just those in need of correction;
- 2. Complete and attach this Correction Request Form to the corrected assessment or discharge tracking form;
- 3. Place a hard copy of the complete assessment and correction form in the Clinical Record;
- 4. Create a new electronic record including the corrected assessment or tracking form AND the Correction Request Form; and
- 5. Electronically submit the new record (as in #3) to the MDS-RCA database at the State.
- TO INACTIVATE A RECORD IN THE STATE DATABASE:
- 1. Complete this correction request form;
- 2. Create an electronic record of the Correction Request Form;
- 3. Place a hard copy of the complete assessment and correction form in the Clinical Record; and
- 4. Electronically submit this Correction Request record to the MDS-RCA database at the State.

PRIOR RECORD SECTION:

THIS SECTION IDENTIFIES THE ASSESSMENT OR TRACKING FORM THAT IS IN ERROR. (In this section, reproduce the information EXACTLY as it appeared in the erroneous record, even if the information is wrong. This information is necessary in order to locate the record in the State database.)

Prior AA1	RESIDENT NAME	SAMANTHA GREEN	
		a.(First) b.(Middle Initial) c.(Last) d.(Jr/Sr)	
Prior AA2	GENDER	1. Male 2. Female 2	
Prior AA3	BIRTHDATE	02-25-1924 Month Day Year	
Prior AA5a	SOCIAL Security	a. Social Security Number $0 0 5 - 2 2 - 9 4 4 4$]
Prior A6 OR D1.8	REASON FOR ASSESSMENT	ASSESSMENT 1. Admission assessment 2. Annual assessment 3. Significant change in status assessment 4. Semi-Annual 5. Other DISCHARGE TRACKING 6. Discharged 7. Discharged prior to completing initial assessment)
	PRIOR DATE	PRIOR DATE (Complete one only) Complete Prior A5 if Primary Reason (Prior A6) equals 1,2,3,4 or 5 Complete Prior D3.2 if Primary Reason (Prior D1.8) equals 6 or 7	
Prior A5	ASSESSMENT DATE	a. Last day of MDS observation period	_
Prior D3.2	DISCHARGE Date	$ \begin{array}{c c} Date of Discharge \\ \hline 0 7 - 2 5 \\ Month \\ \hline Day \\ Year \end{array} $	

CORRECTION SECTION:

COMPLETE THIS SECTION TO EXPLAIN THE CORRECT REQUEST

AT1.	CORRECTION SEQUENCE NUMBER	(Enter total number of correction for this record, including the present one)	01
AT2.	ACTION REQUESTED	 MODIFY record in error (Attach and submit a COMPLETE assessment or tracking form. Do NOT submit the corrected items ONLY. Proceed to item AT3 below). INACTIVATE record in error. (DO NOT submit an assessment or tracking form. Submit the correction request only. Skip to item AT4). 	1
AT3.	REASONS FOR MODIFICATION	If AT2=1, check at least one of the following reasons; check all that apply, then skip to AT5) a. Transcription error b. Data entry error c. Software product error d. Item coding error e. Other error If "Other" checked, please specify:	a. b. X c. d. e.
AT4.	REASONS FOR INACTIVATION	(If AT2=2, check at least one of the following reasons; check all that apply.) a. Test record submitted as production record b. Event did not occur c. Inadvertent submission of non-required record d. Other reason requiring inactivation If "Other" checked, please specify:	a. b. c. d.

MDS-RCA COORDINATOR SIGNATURE AND DATE COMPLETION

AT5.		NANCY	SMITH	RCA DIRECTOR
		a.(First)	b.(Last)	c.(Title)
	SIGNATURE			
AT6.	CORRECTION DATE	08 Month	0 1	2 0 0 4 Year

MINIMUM DATA SET (MDS)[©] RESIDENTIAL CARE ASSESSMENT (RCA)

BASIC ASSESSMENT TRACKING FORM

GENERAL INSTRUCTIONS:

Complete this form for all assessments and discharges.

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	Samantha Green	
		a. (First) b. (Middle Initial) c. (Last)	d. (Jr/Sr)
2.	GENDER	□ 1. Male X 2. Female	
3.	BIRTHDATE	0 2 - 2 5 - 1 9 2 4 Month Day Year	
4.	RACE/ ETHNICITY (Check only one.)	2. Asian/Pacific Islander 5. W	spanic 'hite, not of ispanic origin her
5.	SOCIAL SECURITY and MEDICARE NUMBERS (C in 1 st box if no med. no.)	a. Social Security Number 0 0 5 2 2 9 4 4 4 b. Medicare number (or comparable railroad insurance nu 0 0 5 2 2 9 4 4 4 A] imber)
6.	FACILITY NAME AND PROVIDER NO.	a. Facility Name MCBVI b. Provider No. 9 9 9 9 9 9 9 9 9 9	
7.	MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient] 2 4 6 0 3 7 7 0 A	1
8.	SIGNATURE(S)	OF PERSON(S) COMPLETING FACE SHEET:	
a. 9	Nancy S	Smith RCAleDirector Sections	7/26/2004
b.			Date
2.	DATE Completed	Record date background information was completed. 0 7	

MINIMUM DATA SET (MDS)[©]

Residential Care Assessment (RCA)

DISCHARGE FORM

d. (Jr/Sr)

6

SECTION D1. IDENTIFICATION INFORMATION

a. (First)

SAMANTHA GREEN

SAMANTHA

GENDER 2. 2. Female 1. Male Х 3. BIRTHDATE 0 2 2 5 2 4 1 9 Month Day Year RACE/ ETHNICITY 4. 1. American Indian/Alaskan Native 5. White, not of 2. Asian/Pacific Islander Hispanic origin (Check only one.) 3. Black, not of Hispanic origin 6. Other Х 4. Hispanic 5. SOCIAL a. Social Security Number SECURITY AND 0 0 5 2 2 9 4 4 4 MEDICARE b. Medicare number (or comparable railroad insurance number) NUMBERS [C in 1st box if 0 5 2 2 0 9 4 4 4 Α no med. no.] FACILITY 6. a. Facility Name NAME AND PROVIDER MCBVI NO. b. Provider No. 99 9 9 9 9 9 9 9 MAINECARE NO. 7. [Record a "+" if pending, "N" if not a MaineCare recipient] 2 4 6 0 3 7 7 Α 0 (NOTE: Other codes do not apply to this form) REASON FOR Assessment 8. 6. Discharged

b. (Middle Initial)

1. DISCHARGE Code for resident disposition upon discharge

SECTION D3. ASSESSMENT/DISCHARGE INFORMATION

005-22-9444

	STATUS	1. Private home/apt. with no home health services 2. Private home/apt. with no 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>)	0
2.	DISCHARGE Date	Date of death or discharge 0 7 Month Day	
3.		S OF PERSONS COMPLETING THE ASSESSMENT: SMITH RCA DIRECTOR Title	07/26/2004 Date Date Date

Facility Provider #_

SECTION D2. DEMOGRAPHIC INFORMATION

1.	DATE OF ENTRY	Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date 0 8 0 9 1 9 7 1 Month Day Year Year Year
(A	DMITTED FROM T ENTRY) Check only one.)	X1. Private home/apt. 2. Other residential care/assisted living/group home 3. Nursing home 4. Acute care hospital 5. Psychiatric hospital 6. MR/DD facility 7. Rehabilitation hospital 8. Other (specify)

7. Discharged prior to completing initial assessement

9999999999

.

1.

RESIDENT NAME Date:_

GREEN

c. (Last)

_____ Soc. Sec. #_

MINIMUM DATA SET (MDS)[©] RESIDENTIAL CARE ASSESSMENT (RCA)

BASIC ASSESSMENT TRACKING FORM

GENERAL INSTRUCTIONS:

Complete this form for all assessments and discharges.

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	Whitehorse	9	Cartwright	
		a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)
2.	GENDER	X 1. Ma	le	2. Female	
3.	BIRTHDATE	09 Month		1 9 0 9 Year	
4.	RACE/ ETHNICITY (Check only one.)	2. Asian	ican Indian/Alaskan Na /Pacific Islander , not of Hispanic origin	5. W	spanic 'hite, not of ispanic origin her
5.	SOCIAL SECURITY and MEDICARE NUMBERS (C in 1 st box if no med. no.)	a. Social Sec 0 8 b. Medicare r 0 8	8 — 9 5 — number (or comparable	- 8 9 8 9 railroad insurance nu 9 8 9 — C	imber)
6.	FACILITY NAME AND PROVIDER NO.	a. Facility Na MCBV b. Provider N 9 9 9	'l Io.	9 9	
7.	MAINECARE NO.	[Record a "+ 9 8 3	" if pending, "N" if not a 5 4 5 6	MaineCare recipientj 7 A	1
8.	SIGNATURE(S))F PERSON(S)	COMPLETING FACE SH	EET:	
a. 5	wancy S	mith	RC ^{Ale} Directo	r ^{Sections} 8	/24/2004
b.					Date
2.	DATE Completed		te background informat 824 nDay	tion was completed. 2 0 0 4 Year	

AA4 = 1 - problem with Acrobat could not do X

Date:_

MINIMUM DATA SET (MDS)[©]

Soc. Sec. #_

Residential Care Assessment (RCA)

DISCHARGE FORM

SECTION D1. IDENTIFICATION INFORMATION CARTWRIGHT 1. RESIDENT NAME WHITEHORSE d. (Jr/Sr) a. (First) b. (Middle Initial) c. (Last) GENDER 2. Х 1. Male \square 2. Female 3. BIRTHDATE 0 9 1 1 1 9 0 9 Month Day Year RACE/ ETHNICITY 4. 1. American Indian/Alaskan Native 5. White, not of Х 2. Asian/Pacific Islander Hispanic origin (Check only one.) 3. Black, not of Hispanic origin 6. Other 4. Hispanic SOCIAL SECURITY 5. a. Social Security Number 8 8 0 9 5 8 9 8 9 AND MEDICARE b. Medicare number (or comparable railroad insurance number) NUMBERS [C in 1st box if С 0 8 8 9 5 8 9 8 9 1 no med. no.] FACILITY 6. a. Facility Name NAME MCBVI AND PROVIDER NO. b. Provider No. 9 9 9 9 9 9 9 9 9 MAINECARE NO. 7. [Record a "+" if pending, "N" if not a MaineCare recipient] 9 3 5 4 5 6 7 Α 8 (NOTE: Other codes do not apply to this form) REASON FOR Assessment 8. 6. Discharged 7 7. Discharged prior to completing initial assessement

SECTION D2. DEMOGRAPHIC INFORMATION

1.	DATE Of Entry	Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date 0 8 2 2 0 4 Month Day Year
2.	ADMITTED FROM (AT ENTRY) (Check only one.)	 1. Private home/apt. 2. Other residential care/assisted living/group home 3. Nursing home X 4. Acute care hospital 5. Psychiatric hospital 6. MR/DD facility 7. Rehabilitation hospital 8. Other (<i>specify</i>)

SECTION D3.	ASSESSMENT/DISCHARGE INFORMATION	

1.	DISCHARGE	Code for resident disposition upon discharge	5
	STATUS	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)	
2.	DISCHARGE	Date of death or discharge	
	DATE		
		0 8 - 2 4 - 2 0 0 4	
		Month Day Year	
3.	SIGNATURES	S OF PERSONS COMPLETING THE ASSESSMENT:	
	NANCY	SMITH RCA DIRECTOR 08/2	4/2004
	a. Signatures	Title	Date
	al eignatairee		Dailo
	b.		Date
	C.		Date

MINIMUM DATA SET (MDS)[©] RESIDENTIAL CARE ASSESSMENT (RCA)

BASIC ASSESSMENT TRACKING FORM

GENERAL INSTRUCTIONS:

Complete this form for all assessments and discharges.

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	LAURA B BAKER	
		a. (First) b. (Middle Initial) c. (Last)	d. (Jr/Sr)
2.	GENDER	I. MaleX2. Female	
3.	BIRTHDATE	$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$	
4.	RACE/ ETHNICITY (Check only one.)	2. Asian/Pacific Islander 5. Wi 3. Black, not of Hispanic origin Hispanic origin	panic nite, not of spanic origin tther
5.	SOCIAL SECURITY and MEDICARE NUMBERS (C in 1 st box if no med. no.)	a. Social Security Number 0 0 2 4 2 4 3 1 4 b. Medicare number (or comparable railroad insurance nu 0 0 1 0 5 6 9 4 4 C	mber) 1
6.	FACILITY NAME AND PROVIDER NO.	a. Facility Name MCBVI b. Provider No. 9 <th></th>	
7.	MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient] 9 5 4 5 8 0 3 1 A	
8.	SIGNATURE(S)	DF PERSON(S) COMPLETING FACE SHEET:	
a . S	Signatures	Title Sections	Date
b.			Date
C.	DATE Completed	Record date background information was completed. 0 7 1 5 2 0 0 4 Month Day Year	

MINIMUM DATA SET (MDS)[®] RESIDENTIAL CARE ASSESSMENT (RCA)

FACE SHEET: BACKGROUND INFORMATION ONLY AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1.	DATE OF ENTRY	Date the stay began. (Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date.)
		0 7 - 0 6 - 2 0 0 4
		Month Day Year
2.	ADMITTED FROM (AT ENTRY) (Check only one.)	 1. Private home/apt. 2. Other board and care/assisted living/group home X 3. Nursing home 4. Acute care hospital 5. Psychiatric hospital 6. MR/DD facility 7. Rehabilitation hospital 8. Other (<i>specify</i>)
3.	LIVED ALONE (PRIOR TO ENTRY) (Check only one.)	X 0. No □ 1. Yes □ 2. In other facility
4.	PRIOR PRIMARY RESIDENCE	Provide town, state, zip code for Resident's primary residence prior to admission DEERFIELD NH 0 3 2 6 1
	BEAUBE	Town State Zip Code
5.	RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	 (Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above) a. Prior stay at this home X b. Nursing home C. Other residential facility—board and care home, assisted living, group home d. MH/psychiatric hospital e. MR/DD facility f. NONE OF ABOVE
6.	LIFETIME OCCUPATION	Put a "/" between two occupations. P R O D U C T I O N W O R K E R I
7.	EDUCATION (Highest Level Completed) (Check only one.)	1. No schooling 5. Technical or trade school X 2. 8th grade or less 6. Some college 3. 9–11 grades 7. Bachelor's degree 4. High school 8. Graduate degree
8.	PRIMARY LANGUAGE (Check only one.)	X 0. English 2. French 1. Spanish 3. Other (specify)
9.	MENTAL Health History	Does resident's RECORD indicate any history of the following? a. Mental retardation 0. No X 1. Yes b. Mental illness 0. No X 1. Yes c. Developmental disability 0. No X 1. Yes
10.	CONDITIONS	(Check all conditions that are related to MR/DD status that were
	RELATED TO	manifested before age 22, and are likely to continue indefinitely) a. Not applicable—no MR/DD (<i>Skip to AB11</i>)
	MR/DD Status	MR/DD with organic condition
		b. Down's syndrome X e . Cerebral palsy
		c. Autism f. Other organic condition related to MR/DD
11		X d. Epilepsy 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 1. Yes b. Dementia other than Alzheimer's disease X 0. No 1. Yes

SECTION AC. CUSTOMARY ROUTINE

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

END

SECTION AD. FACE SHEET SIGNATURES and DATES

1. SI	GNATURE(S) OF	PERSON(S) COMPLETING FACE SHEET:	
a. Się	gnatures	Title Sections	Date 07/15/2004
b.			Date
2.	DATE	Record date background information was completed.	
2.	COMPLETED		
		0 7 1 5 2 0 0 4 Month Day Year	

CONFIDENTIAL MINIMUM DATA SET (MDS)[®] RESIDENTIAL CARE ASSESSMENT (RCA)

(STATUS IN LAST 7 DAYS UNLESS OTHERWISE NOTED)

954		DENTIFICATION and BACKGROUND INFORMATION			COMMUNICATION/HEARING PATTERNS
5E	RESIDENT	LAURA B BAKER	1.	HEARING	(With hearing appliance, if used)
2.	NAME SOCIAL SECURITY and MEDICARE NUMBERS (C in 1 st box if	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr) a. Social Security Number 0 0 2 4 2 4 3 1 4 b. Medicare number (or comparable railroad insurance number) 0 <		(Check only one.)	 O. HEARS ADEQUATELY—normal talk, TV, phone O. HEARS ADEQUATELY—normal talk, TV, phone X 1. MINIMAL DIFFICULTY when not in quiet setting 2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly 3. HIGHLY IMPAIRED –absence of useful hearing
3.	FACILITY FACILITY NAME AND PROVIDER NO.	0 0 1 0 5 6 9 4 4 — C 1 a. Facility Name MCBVI b. Provider No. 9 9 9 9 9 9 9 9	2.	COMMUNICA- Tion Devices/ Techniques	 (Check all that apply during last 7 days.) a. Hearing aid, present and used b. Hearing aid, present and not used regularly c. Other receptive communication techniques used (e.g., lip reading) X d. NONE OF ABOVE
4.	MAINECARE No.	[Record a "+" if pending, "N" if not a MaineCare recipient] 9 5 4 5 8 0 3 1 A	3.	MAKING SELF UNDERSTOOD (Check only one.)	 (Expressing information content—however able) X 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts
5.	ASSESSMENT DATE	Last day of observation period 0 7 1 3 2 0 0 4 Month Day Year			2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY/NEVER UNDERSTOOD
6.	REASON FOR ASSESSMENT	(Check primary reason for assessment) 4. Semi-Annual X 1. Admission assessment 5. Other (specify) 3. Significant change in status assessment	4.	ABILITY TO UNDERSTAND OTHERS (Check only one.)	 (Understanding information content—however able) X 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part / intent of message a. OUTETUTE UNDERSTANDS
7.	MARITAL STATUS (Check only one.)	X 1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated			 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY/NEVER UNDERSTANDS
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 e. Private pay X b. SSI f. Private insurance c. VA (including co-payment)	5.	COMMUNICA- TION (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. Image: Description of the state
		d. Social Security g. SSDI	SE	CTION D.	VISION PATTERNS
9.	RESPONSI- BILITY/ Legal Guardian	h. Other (specify)	1.	VISION (Check only one.)	 (Ability to see in adequate light and with glasses if used) 0. ADEQUATE—sees fine detail, including regular print in newspapers/books 1. IMPAIRED—sees large print, but not regular print in newspapers/books X 2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY IMPAIRED—object identification in question, but eves
10.	ADVANCED Directives	Does resident have any of the following advanced directives in place? a. Living Will X 0. No 1. Yes b. Do not resuscitate (DNR) X 0. No 1. Yes c. Do not hospitalize X 0. No 1. Yes			3. FIGHLY INFAIRED—object identification in question, but eyes appear to follow objects 4. SEVERELY IMPAIRED—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects
		d. Organ donation X 0. □ 1. Yes e. Other X 0. No □ 1. Yes (If "yes," specify) X 0. No □ 1. Yes	2.	VISUAL APPLIANCES	a. Glasses, contact lenses 0. No X 1. Yes b. Artificial eye X 0. No 1. Yes
SE		COGNITIVE PATTERNS	SE	INDICATORS	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s)
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 1. Memory problem 		OF DEPRESSION, ANXIETY, SAD MOOD	 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)
2.	MEMORY/ Recall Ability	b. Long-term memory OK—seems/appears to recall long past X 0. Memory OK 1. Memory problem (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 e. NONE OF ABOVE are recalled X c. Staff names/faces			VERBAL EXPRESSIONS OF DISTRESS _0a. 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")
3.	COGNITIVE SKILLS FOR DAILY DECISION- MAKING (Check only one.)	 (Made decisions regarding tasks of daily life) X 0. INDEPENDENT—decisions consistent/reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues/ supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions 			0 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 or being abandoned, left alone, being with others 0 g. Recurrent statements that something terrible is about to happer
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			 -e.g., believes he or she is about to die, have a heart attack h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions i. Repetitive anxious complaints/concerns (non-health related)
		1. Improved 2. Declined			e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues (continued next page)

	LAURA	В	BAKER	CONI 07/13/2004	FIDENTIAL 002-42-4314		9999999999
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 symplin 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/w SLEEP-CYCLE ISSUES _0			erved	1.	SENSE OF INITIATIVE/ INVOLVEMENT (Check all that apply)	X a. At ease interact X b. At ease doing X c. At ease doing X d. Establishes ow X e. Pursues involved involved in gr assists at reli X f. Accepts invital g. NONE OF AU
		0_ I. Sad, pained, worried facial expressions—e.g., 0_ m. Crying, tearfulness 0_ n. Repetitive physical movements—e.g., pacing, restlessness, fidgeting, picking LOSS OF INTEREST 0_ o. Withdrawal from activities of interest—e.g., no i standing activities or being with family/friends	hand	wring	ging,	2.	UNSETTLED RELATION- SHIPS (Check all that apply)	a. Covert/open b. Unhappy wit c. Unhappy wit d. Openly expra e. Absence of p f. Recent loss g. Does not adj
		0 p. Reduced social interaction INDICATORS OF MANIA _1q. Inflated self-worth, exaggerated self-opinion; in about one's own ability, etc. r. Excited behavior, motor excitation (e.g., heighter activity; excited, loud or pressured speech; increments.)	ned p	hysic	al	3	LIFE- EVENTS HISTORY (Check all that apply.)	X h. NONE OF AE Events in past 2 year a. Serious accid b. Health conce c. Death of fam d. Trouble with
2	Check only one.)	Check if one or more indicators of depressed, sad or anxiou (above) were not easily altered by attempts to "cheer up", or reassure the resident over last 7 days . X 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	is ma consc	ood ole, or			ιπαι αμριγ.)	e. Robbed/phys X f. Conflict laden g. Loss of incon h. Sexual assau i. Child custody
3	Check only one.)	Resident's current mood status compared to resident's statu (or since admission if less than 180 days): X 0. No change 1. Improved 2. Decl) day:	s ago			j. Change in m k. Review hearing I. NONE OF And
4	• BEHAVIORAL SYMPTOMS	(COLUMN A CODES: Record the appropriate code for the frequency of the symptom in last 7 days (COLUMN B Alterability of symptoms in last 7 days 0. Behavior not exhibited in last 7 days 0. Not preser 1. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 1. Behavior not this type occurred 4 to 6 days but less than daily	f beha last nt or e lot eas A	<i>T days</i> asily a sily alt B	altered ered C	SE 1.	(A) ADL SEL 0. INDEPENDE during last 1. SUPERVISI days —OF	PHYSICAL FUNC F-PERFORMANCE M—No help or oversigh 7 days M—Oversight, encoura C—Supervision (3 or mo gi last 7 days
		(COLUMN C CODES: <u>History of this behavior in the last 6 months</u>) 0. No 1. Yes	FREQUENCY	ALTERABILITY	HISTORY		2. LIMITED AS maneuveri	<i>SISTANCE</i> —Resident hig ng of limbs or other non- sistance (3 or more time
a	. WANDERING	(moved with no rational purpose, seemingly oblivious to y)	0	0	0		3. EXTENSIVE	ASSISTANCE—While resi pwing type(s) provided 3
b		BUSIVE BEHAVIORAL SYMPTOMS (others were reamed at, cursed at)	0	0	0		- Weight-	bearing support f performance during pa
c	. PHYSICALLY	ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shed, sexually abused, gross physical assault)	0	0	0		4. TOTAL DEPI	ENDENCE—Full staff perfo
d	SOCIALLY IN SYMPTOMS public, smear	APPROPRIATE/DISRUPTIVE BEHAVIORAL (made disruptive sounds, sexual behavior, disrobing in ad/threw food/feces, hoarding, rummaged through others' ealing, self-abusive acts, substance abuse, self-mutilation)	0	0	0		HOUR PERIO	PPORT CODES (COD OD) during last 7 days; ance classification.
е	. RESISTS CA assistance, or	RE (resisted taking medications/ injections, ADL eating)	0	0	0		1. Setup h	p or physical help from elp only rson physical assist
f.	-	G BEHAVIOR (made others feel unsafe, at risk, privacy	0	0	0		3. Two+ pe 8. Activity of	erson's physical assist did not occur during ent
g			0	0	0	a.		TY– How resident move tions body while in bed
h i.	Dangerous no	n-violent behavior (e.g., falling asleep while smoking)	0 0	0	0	b.	TRANSFER -	- How resident moves b
j.	FIRE SETTIN		0	0	0	c.		anding position (EXCLU DN – How resident move
5		Resident demonstrated suicidal thoughts or actions in the la	st 30	day:	s:		areas set asid	le for dining, activities, c moves to and from dista
	IDEATION	□ 0. No X 1. Yes					sufficiency on	ce in chair
6	SLEEP PROBLEMS	Check all present on 2 or more days during last 7 days a. Inability to awaken when desired b. Difficulty falling asleep X c. Restless or non-restful sleep				d. e. f.	clothing, inclu EATING – Ho nourishment b TOILET USE	How resident puts on, uding donning/removing w resident eats and drir by other means (e.g., tul – How resident uses th
7	, INSIGHT INTO MENTAL HEALTH	Resident has insight about his/her mental problem Image:	alth p	oroble	ems	g.	catheter, adjust PERSONAL I combing hair,	HYGIENE – How resid brushing teeth, shaving
8	BEHAVIORS (Check only one.)	Resident's current behavior status compared to resident's statadays ago (or since admission if less than 180 days): X 0. No change 1. Improved 2. D	tus 1 ecline			h.		erineum (EXCLUDE bai w resident climbs stairs

SE	CTION F. P	SYCHOSOCIAL WELL-BEING		
1.	SENSE OF	X a. At ease interacting with others		
	INITIATIVE/	X b. At ease doing planned or structured activities		
	INVOLVEMENT	X c. At ease doing self-initiated activities		
	(Check all that apply)	X d. Establishes own goals		
	арруу	X e. Pursues involvement in life of facility (e.g., makes/keeps frie		
		involved in group activities; responds positively to new acti assists at religious services)	vities;	
		X f. Accepts invitations into most group activities		
		g. NONE OF ABOVE		
-				
2.	UNSETTLED Relation-	a. Covert/open conflict with or repeated criticism of staff		
	SHIPS	 b. Unhappy with roommate c. Unhappy with residents other than roommate 		
	(Check all that apply)	d. Openly expresses conflict/anger with family/friends		
	uppiy)	e. Absence of personal contact with family/friends		
		f. Recent loss of close family member/friend		
		g. Does not adjust easily to change in routines		
		X h. NONE OF ABOVE		
3.	LIFE-	Events in past 2 years		
	EVENTS HISTORY	a. Serious accident or physical illness		
	nistont	b. Health concerns for other person		
	(Check all	c. Death of family member or close friend d. Trouble with the law		
	that apply.)	e. Robbed/physically attacked		
		X f. Conflict laden or severed relationship		
		g. Loss of income leading to change in lifestyle		
		h. Sexual assault/abuse		
		i. Child custody issues		
		j. Change in marital/partner status		
		k. Review hearings (e.g., forensic, certification, capacity hear	ring)	
		I. NONE OF ABOVE		
SE	CTION G. I	PHYSICAL FUNCTIONING		
1.	· · /	F-PERFORMANCE		
	<i>0. INDEPENDE</i> during last	NT—No help or oversight —OR— Help/oversight provided only 1 or 2 ti 7 days	mes	
		DN —Oversight, encouragement or cueing provided 3 or more times dur	ing las	t 7
	days —OR	R— Supervision (3 or more times) plus physical assistance provided only	y 1 or :	2
		g last 7 days SISTANCE—Resident highly involved in activity; received physical help ir	auida	d
		ng of limbs or other non-weight bearing assistance 3 or more times —C		u
		sistance (3 or more times,) plus weight-bearing support provided 1 or 2		
	3. EXTENSIVE	ASSISTANCE—While resident performed part of activity, over last 7-day powing type(s) provided 3 or more times:	period,	
		bearing support		
	•	f performance during part (but not all) of last 7 days		
		ENDENCE—Full staff performance of activity during last 7 days		
	8. ACTIVITY DI	ID NOT OCCUR DURING LAST 7 DAYS		
		PPORT CODES (CODE for MOST SUPPORT PROVIDED OVER E	ACH 2	4
		OD) during last 7 days; code regardless of person's ance classification.	А	В
		p or physical help from staff	SELF- PERFORMANCE	
	1. Setup he		MAN	⊢
		rson physical assist	- GRI	Ю
		ersons physical assist did not occur during entire 7 days		SUPPORT
a.	,	TY – How resident moves to and from lying position, turns side to		S
u.		tions body while in bed	0	0
b.		- How resident moves between surfaces—to/from: bed, chair,	0	C
		anding position (EXCLUDE to/from bath/toilet)		
c.		N – How resident moves to and returns from other locations (e.g., e for dining, activities, or treatments). If facility has only one floor,		
	how resident r	noves to and from distant areas on the floor. If in wheelchair, self-	0	0
	sufficiency on			
d.		How resident puts on, fastens, and takes off all items of street uding donning/removing prosthesis	0	0
e.	EATING - Ho	w resident eats and drinks (regardless of skill). Includes intake of	0	0
_		by other means (e.g., tube feeding, total parenteral nutrition)	Ľ	
f.		 How resident uses the toilet room (or commode, bed- pan, 		0
1	uniul, ualiste	r on/off toilet cleanses changes had manages octomy or		ı U
	catheter, adjus	er on/off toilet, cleanses, changes pad, manages ostomy or sts clothes	0	
g.	catheter, adjust		0	0

0 0

LAURA	в	BAKER
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CONFIDENTIAL 07/13/2004

002-42-4314

Resi	dent Name:	Date:		Soc	. Sec. #	Facility Provider #
SEC	TION G. P	HYSICAL FUNCTIONING (cont.)		SE	CTION G.	PHYSICAL FUNCTIONING (cont.)
2. 3A.	BATHING SELF- PERFORMANCE MODES OF	How resident takes full-body bath/shower, sponge bath, and transfers of tub/shower (EXCLUDE washing of back and hair.) Check for most dependent in self-performance during last 7 days. X 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 (Check all that apply during last 7 days)	in/out <u>t</u>			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
	LOCOMOTION	 a. Cane/walker/crutch b. Wheeled self c. Other person wheeled X d. 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 b. Hearing aid (e.g., button hook, velcro closings) c. Cane or walker g. Dentures
3B.	MAIN Mode of Locomotion	Was wheelchair the primary mode of locomotion during the last 7 day X 0. No I Yes	rs?			d. Wheelchair h. Other (specify) e. Assistive feeding devices (e.g., plate X i. NONE OF ABOVE
3C.	BEDFAST/ Chairfast	 (Check if health condition keeps resident in his/her room 22+ hours per in last 7 days) a. Bedfast all or most of time b. Chairfast all or most of the time X c. NONE OF ABOVE 	er day	8.	SELF- Performance in Iadls	0. No change X1. Improved 2. Declined
4.	SELF- PERFORMANCE IN ADLs (Check only one.)	 Resident's current ADL status or abilities compared to resident's statudays ago (or since admission if less than 180 days): 0. No change X 1. Improved 2. Declined 	ıs 180	SE 1	CONTINENT (Code for res 0. CONTIN ostomy d	CONTINENCE IN LAST 14 DAYS CE SELF-CONTROL CATEGORIES <i>ident's PERFORMANCE OVER ALL SHIFTS)</i> /ENT—Complete control (includes use of indwelling urinary catheter or evice that does not leak urine or stool)
5A.	IADL SELF- Perfor- Mance	 Code for level of independence in the last 30 days based on resident involvement in the activity. SELF-PERFORMANCE CODES: INDEPENDENT : (with/without assistive devices)—No help preserved. DONE WITH HELP: Resident involved in activity but help (inclusive) supervision, reminders, and/or physical help) is provided. DONE BY OTHERS: Full performance of the activity is done by others. The resident is involved at all when the activity is performed. 	ovided. uding	a.	BOWEL, 2. OCCASI daily; BO 3. FREQUE some cor 4. INCONTI all (or alm	Y CONTINENT—BLADDER, Incontinent episodes once a week or less; less than weekly ONALLY INCONTINENT—BLADDER, 2 or more times a week but not WEL, once a week ENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but throl present (e.g. on day shift); BOWEL, 2-3 times a week NENT—Had inadequate control BLADDER, multiple daily episodes; BOWEL, ost all) of the time Control of bowel movement, with appliance or bowel continence programs, if employed
		 Activity did not occur in the last 30 days. 	ų	b.	BLADDER CONTINENCE	Control of urinary bladder function with appliances (e.g. foley) or 0 continence programs, if employed
		IADL	SELF- PERFORMANCE	2.	BOWEL Elimination Pattern	Bowel elimination pattern regular—at least one movement every three days Diarrhea c. a. X Fecal Impaction d. Resident is Independent VONF OF ABOVE e.
		a. Resident arranged for shopping for clothing, snacks, other incidentals.	0	3.	APPLIANCES	Constipation b. NONE OF ABOVE f. Any scheduled toileting plan a. Did not use toilet room/ Image: Constipation of the schedule
		 b. Resident shopped for clothing, snacks, or other incidentals. c. Resident arranged for suitable transportation to get to appointments, outings, necessary engagements. 	0		and PROGRAMS	Bladder retraining program b. commode/urinal f. External (condom) catheter c. Pads/briefs used g. In the urity of
		 Resident managed finances including banking, handling checkbook, or paying bills. 	1			Intermittent catheter e. Ostomy present i.
		 e. Resident managed cash, personal needs allowance. f. Resident prepared snacks, light meals. 	0	4	USE OF	NONE OF ABOVE J. X Resident's management of incontinence supplies (pads, briefs, ostomy,
		g. Resident used phone.	0		INCONTINENC SUPPLIES	E catheter) in <u>last 14 days.</u> X 0. Always continent
		 h. Resident did light housework such as making own bed, dusting, or taking care of belongings. i. Resident sorted, folded, or washed own laundry. 	0		(Check only one.)	
5B.	TRANSPOR- TATION	Check all that apply for level of independence in the last 30 days base on resident's involvement in the activity.	ed			 A Resident incontinent and receives assistance with managing incontinence supplies. 3. Resident incontinent and does not use incontinence supplies.
		 X a. Resident drove car or used public transportation independently get to medical, dental appointments, necessary engagements, other activities. X b. Resident rode to destination with staff, family, others (in car, van 	or	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): X 0. No change 1. Improved 2. Deteriorated
		public transportation) but was not accompanied to medical, dental appointments, necessary engagements, or other activiti	es.	SE	CTION I. D	IAGNOSES
		 X c. Resident rode to destination with staff, family, others (in car, van public transportation) and <u>was accompanied</u> to medical, dent appointments, necessary engagements, or other activities. 		anc	l behavior statu	diagnoses that have a relationship to current ADL status, cognitive status, mood is, medical treatments, nurse monitoring, or risk of death. (Do not list inactive e apply, CHECK item xx. <i>NONE OF ABOVE</i>)
6.	ADL AND IADL FUNCTIONAL REHABILI- TATION OR IMPROVE- MENT POTENTIAL (Check all that apply.)	 d. Activity did not occur. X a. Resident believes he/she is capable of increased independence at least some ADLs or IADLs. X b. Direct care staff believes resident is capable of increased independence in at least some ADLs or IADLs. X c. Resident able to perform tasks/activity but is very slow d. Difference in ADL/IADL Self-Performance comparing mornings evenings e. Resident requires or only understands a one-step direction. (continued in next column) 		1.	DIAGNOSES	ENDOCRINE/METABOLIC/ NUTRITIONAL HEART/CIRCULATION X a. Diabetes mellitus d. Arteriosclerotic heart disease (ASHD) b. Hyperthyroidism e. Cardiac dysrhythmia c. Hypothyroidism f. Congestive heart failure g. Deep vein thrombosis h. Hypertension i. Hypotension j. Peripheral vascular disease k. Other cardiovascular disease (continued on next page)

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200		LAURA B BAKER 7/13/2004 Date:					
	ident Name: _	Date NOSES (cont.)					
		MUSCULOSKELETAL ff. Manic depressive (Bipolar)					
		I. Arthritis gg. Schizophrenia					
		In. Missing limb (e.g., amputation) Asthma o. Osteoporosis In. Asthma ii. Emphysema/COPD					
		p. Pathological bone SENSORY					
		NEUROLOGICAL ji, Cataracts kk. Diabetic retinopathy q. Alzheimer's X. II. Glaucoma disease m. Macular degeneration					
		Aphasia S. Cerebral palsy t. Cerebrovascular accident (stroke) U					
		than Alzheimer's qq. Renal failure disease rr. Tuberculosis-TB v. Hemiplegia/ ss. HIV					
		hemiparesis X tt. Mental retardation(e.g., Down w. Multiple sclerosis x. Paraplegia y. Parkinson's disease z. Quadriplegia X tt. Mental retardation(e.g., Down Syndrome, Autism, or other organic condition related to Developmental disability (MR/ DD)	's				
		X. aa. Seizure disorder uu. Substance abuse (alcohol or drug) bb. Transient ischemic attack (TIA) vv. Other psychiatric diagnosis (e.g., paranoia, phobias,					
		C. Traumatic brain injury Synchiat Strain (Infy) Gerege personality disorder) Ww. Explicit terminal prognosis Xx. NONE OF ABOVE dd. Anxiety disorder					
		ee. Depression					
2.	OTHER Current Diagnosis And Icd-9	a 820.21]				
	CODES	c					
1.	PROBLEM	(Check all problems present in last 7 days unless other time frame is indicated)					
	CONDITIONS	a. Inability to lie flat due to shortness of breath j. Numbness/tingling					
		b. Shortness of breath k . Blurred vision					
		C. Edema I. Dry mouth d. Dizziness/vertigo m. Excessive salivation or					
		e. Delusions drooling					
		Image: Installation Image: Installation Image:)				
		h. Suspiciousness X p. NONE OF ABOVE					
2.	EXTRA- Pyramidal Signs and Symptoms	Check all present at any point during last 3 days INCREASE IN MOTOR ACTIVITY a. Akathisia-resident reports subjective feeling of restlessness or					
		 need for movement b. Dyskinesia–chewing, puckering movements of mouth; abnormal irregular movements of lips; or rocking or writhing of trunk 					
		C. Tremor–regular rhythmic movements of the fingers, limbs, head, mouth. or tongue	uth; abnormal if trunk , limbs, head,				
		DECREASE IN MOTOR ACTIVITY d. Rigidity-resistance to flexion and extension of muscles (e.g.,	n or mability (MR/ (alcohol or diagnosis obias, ser) ognosis E 2 0 . 2 1 2 0				
		 continuous or cogwheeling rigidity) e. Slow shuffling gait–reduction in speed and stride length of gait, 	is indicated) gling vation or mal appetite) <i>VE</i> ssness or y abnormal unk mbs, head, s (e.g., th of gait, e.g., reduced res, speech)				
		usually with a decrease in pendular arm movement f. Bradykinesis–decrease in spontaneous movements (e.g., reduce					
		body movement or <i>poverty of</i> facial expression, gestures, speech MUSCLE CONTRACTIONS g. Dystonia–muscle hypertonicity (e.g., muscle spasms or stiffness,)				
		protruding tongue, upward deviation of the eyes) X h. NONE OF ABOVE					
3.	PAIN Symptoms	(Code the highest level of resident's pain present in the last 7 days) On a scale of 1 to 10, where 1 is the least and 10 is the most,					
		how would you rate your pain? (If no pain, code 0 and skip to J7)					
4.	PAIN SITE	(If pain is present in the last 7 days)					
		X a. Back pain f. Incisional pain b. Bone pain g. Joint pain (other than hip)					
		b. Bone pain g. Joint pain (other than hip) c. Chest pain while doing h. Soft tissue pain (e.g., lesion,					
		usual activities muscle)					

SEC	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 r normal activities such as visiting with friends, going out, and so on? 1. All of the time 3. Little of the time 2. Some of the time X 4. None of the time	esident's		
6.	PAIN Manage- Ment	X 1. No pain treatment Image: Sector Se	ontrol		
7.	ACCIDENTS (Check all that apply)	a. Fell in past 30 days d. Other fracture in last 180 b. Fell in past 31-180 days X e. NONE OF ABOVE c. Hip fracture in last 180 days	days		
8.	DANGER OF FALL (Check all that apply)	 a. Has unsteady gait b. Has balance problems when standing c. Limits activity because resident or family fearful of resident falling d. Unstable transition from seated to standing e. Other (<i>specify</i>) X f. NONE OF ABOVE 			
SEC		L/NUTRITIONAL STATUS			
1.	ORAL PROBLEMS (Check all that apply)	a. Mouth is "dry"when eating a meal d. Mouth Pain b. Chewing Problem X e. NONE OF ABOU c. Swallowing Problem X	/E		
2.	HEIGHT AND WEIGHT	Record (a.) height in inches and (b.) weight in pounds. Base weight on most measure in last 30 days; measure weight consistently in accord with standard practice-e.g., in a.m. after voiding, before meal, with shoes off, and in nightcle a. HT (in.) 6 2 b. WT (ib.) 1 2	l facility		
3.	WEIGHT Change	 a. Unintended weight loss-5% or more in last 30 days; or 10% more in last 180 days X 0. No I. Yes b. Unintended weight gain-5% or more in last 30 days; or 10% more in last 180 days X 0. No I. Yes 			
4.	NUTRI- TIONAL PROBLEMS OR AP- PROACHES (Check all that apply)	 a. Complains about the taste of many foods b. Regular or repetitive complaints of hunger c. Leaves 25% of food uneaten at most meals d. Therapeutic diet e. Mechanically altered (or pureed) diet f. Noncompliance with d g. Eating disorders h. Food allergies (specify) i. Restrictions (specify) X j. NONE OF ABOVE 	iet		
SECTION L. ORAL/DENTAL STATUS					
1.	ORAL STATUS AND DISEASE PREVENTION (check all that apply)	 a. Has dentures or removable bridge b. Some/all natural teeth lost-does not have or does not use de (or partial plates) c. Broken, loose or carious teeth d. Inflamed gums (gingiva); swollen or bleeding gums; oral abs ulcers or rashes e. Daily cleaning of teeth/dentures or daily mouth care-by reside staff f. Resident has difficulty brushing teeth or dentures 	cesses;		
	X g. NONE OF ABOVE				
	TION M. SKIN				
1.	SKIN PROBLEMS (Check all that apply)	Any troubling skin conditions or changes in the last 7 days? a. Abrasions (scrapes) or cuts b. Burns (2nd or 3rd degree) c. Bruises d. Rashes, itchiness, body lice X g. NONE OF ABOVE	IS		
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 reliaved	Number at Stage		
		the skin) that does not disappear when pressure is relieved.			
		 b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater. c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues-presents as a deep crater with or without 	0		
		undermining adjacent tissue. d. Stage 4. A full thickness of skin and subcutaneous tissue is lost,	0		
		exposing muscle or bone.	0		

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

d. Headachee. Hip pain

i. Stomach pain j. Other (*specify*)_

LAURA B BAKER	AKER
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Resi	dent Name:	Date:	S	Soc. S	ec #	Facility Provider #
SEC	TION M. SKIN	CONDITION	s	SECT	ION O. MEDI	ICATIONS (cont.)
3.	FOOT PROBLEMS	 a. Resident or someone else inspects resident's feet on a regular basis? D. No X 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? 	-	4A.	DAYS RECEIVED THE FOLLOWING MEDICATION PRN	(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 _7_g. Insulin 0 b. Antianxiety _0_e. Diuretic
SEC	TION N. ACTI	X 0. No L 1. Yes			MEDICATIONS	emotional or nervous condition, or behavioral problem? X 0. No
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: X a. Morning D d. Night (Bedtime to A.M.) X b. Afternoon X e. NONE OF ABOVE		N	SELF- DMINSTERED IEDICATIONS Check all that apply.)	Did resident self-administer any of the following in the last 7 days: a. Insulin e. Glucosan b. Oxygen X f. Over-the-counter Meds c. Nebulizers X g. Other (specify) IRON PILLS d. Nitropatch h. NONE OF ABOVE
2.	AVERAGE TIME INVOLVED IN ACTIVITIES (Check only one.)	X c. Evening (When awake and not receiving treatments or ADL care) X 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		P	MEDICATION Preparation Administra- Tion	 Did resident prepare and administer his/her own medications in last 7 days? (<i>Check only one.</i>) 0. No Meds 1. Resident prepared and administrated <u>NONE</u> of his/her own medications. X 2. Resident prepared and administrated <u>SOME</u> of his/her own medications. 3. Resident prepared and administrated <u>ALL</u> of his/her own medications.
3.	PREFERRED Activity Settings	(Check all settings in which activities are preferred) X a. Own room X d. Away from facility X b. Day/activity room □ e. NONE OF ABOVE X c. Outside facility (e.g., in yard)	_		MEDICATION COMPLIANCE (Check one)	Resident's level of compliance with medications prescribed by a physician/ psychiatrist during last 30 days: 0. No Meds
4.	GENERAL ACTIVITY PREFER- ENCES (Adapted to	(Check all PREFERENCES whether or not activity is currently available to resident) X a. Cards/other games X k. Gardening or plants D b. Crafts/arts X I. Talking or conversing X c. Exercise/sports X m. Helping others				 2. Always compliant with reminder, verbal prompts 3. Compliant some of the time (80% of time or more often) or with some medications X 4. Rarely or never compliant
	resident's current abilities)	X d. Dancing X n. Doing chores around the house/facility X e. Music house/facility I f. Reading/writing X o. Cooking/baking			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) \Box 0. No X 1. Yes
		X g. Spiritual/religious activity p. Computer activities X h. Trips/shopping q. Volunteering X i. Walking/wheeling outdoors r. Other (specify) X j. Watching TV s. NONE OF ABOVE	Г	1.	TION P. SPEC SPECIAL TREATMENTS, PROCE- DURES,	IAL TREATMENTS AND PROCEDURES a. SPECIAL CARE-Check treatments or programs received during the last 14 days [Note-count only post admission treatments] TREATMEMTS a. Chemotherapy or X i. Training in skills required to return
5.	PREFERRED ACTIVITY SIZE	(Check all that apply) a. Individual c. Larger group b. Small group X d. No preference			AND Programs	radiation to the community (e.g., taking medications, house work, b. Oxygen therapy shopping, transportation, ADLs) c. Dialysis i. Case management
6.	PREFER- ENCES IN DAILY ROUTINE (Check all	 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 				PROGRAMS , b construction d. Alcohol/drug treatment program k. Day treatment program e. Alzheimer's/dementia special care unit X m. Job training n. Transportation n. Transportation
	that apply)	 d. Resident prefers activity at different time of day X e. Resident prefers stability in daily routine f. NONE OF ABOVE 				f. Hospice care X o. Psychological rehabilitation g. Home health X p. Formal education h. Home care g. 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 4. Once a week facility 5. 2 or 3 times a week but not daily 2. None daily 	÷			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
		 X 3. 1-3 times/month How often has resident talked by telephone with family and friends in the last 30 days? (check only one) 				Check C if therapy was received out-of-home or facility (A) A B a. Speech-language pathology and auditory services 0 b. Occupational therapy 0
		□ 1. No family or friends outside facility □ 4. Once a week □ 1. No family or friends outside facility □ 5. 2 or 3 times a week but not daily □ 2. None daily X 3. 1-3 times/month □ 6. Daily				c. Physical therapy 0 d. Respiratory therapy 0 e. Psychological therapy (by any licensed mental health professional) 0
8.	VOTING	Is resident registered to vote? X 0. No I 1. Yes	┝		WITES	(Check all interventions or strategies used in the last 7 days unless other time
9.	SOCIAL ACTIVITES (Check only one.)	Resident's current level of participation in social, religious or other personal activities compared to resident's status 180 days ago (since admission if less than 180 days): 0. No change X 1. Improved 2. Declined			INTER- VENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	 specified-no matter where received) a. Special behavior symptom evaluation program b. Special behavior
SEC	TION O. MEDI	CATIONS				management program
1.	NUMBER OF MEDICATIONS NEW	(Record the number of different medications used in the last 7 days;				c. Evaluation by a licensed mental health specialist in last 90 days g. Validation/Redirection h. Crisis intervention in facility i. Crisis stabilization unit in last
2.	MEDICATIONS	X 0.N0 I 1. Yes				d. Group therapy 90 days
3.	INJECTIONS	(Record the number of DAYS injections of any type received during 0 0				e. Resident-specific j. Other (specify) deliberate changes in the X k. NONE OF ABOVE

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Re	sident Name:		Date:	_ Soc. Sec	:#	Facility Provider #
SE	ECTION P. SPEC	IAL TREATMENTS AND PROCEDUR	ES (cont.)	SE	ECTION Q. SE	RVICE PLANNING
3	ON-GOING MONITORING		 RCF Other Staff Home health nurse <u>0</u> b. New treatment/media 		I. RESIDENT GOALS (Check all areas in whi resident ha self-identifie goals)	a. Headin promotion/wearless exercise b. Social involvement/making friends ch c. Activities/hobbies/adult learning g d. Rehabilitation-skilled
4	RESTORATIVE CARE	techniques or practices was provided to the minutes per day in the last 7 days (Enter 0 $\frac{0}{2}$ a. Range of motion (passive) $\frac{0}{2}$ b. Range of motion (active) $\frac{0}{2}$ c. Splint or brace assistance	e resident for more than or equal to a	15	CONFLICT	X hNo goals 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 Yes Yes
		TRAINING/SKILL PRACTICE IN:		SE	CTION R. DIS	SCHARGE POTENTIAL
		0 Transfor	0 j. Communication 0 j. Communication 0 k. Time management 7 I. Other (specify)		1. DISCHARG Potentia	
5	5. SKILL Training	Record the number of days , in the last 3 were performed with assistance from sta the resident's service plan. <u>0</u> a. Meal Preparation (snacks,	aff as a skill training activity identified	ADLs ed in		since admission, if less than 6 months?
		0 b. Telephone Use	(makes list, acquires		ECTION S. AS	SESSMENT INFORMATION
		b. Telephone Use c. Light Housework (makes	i. Shopping (for grocer	ries,	1. PARTICIPA- Tion	a. Resident: 0. No X 1. Yes
		own bed, takes care of	clothes, or other incidentals)		IN	b. Family: X 0. No 1. Yes 2. No Family
		0 beiorigings) d. Laundry (sorts, folds, or	d Laundry (sorts folds or j. Transportation (travel by		ASSESS- MENT	c. Other Non-Staff: X 0. No I 1. Yes 2. None
		0 e. Managing Incontinence Supplies (pads, briefs,	various means to get medical appointment other necessary			RES OF PERSONS COMPLETING THE ASSESSMENT: CY SMITH
		f. Managing Cash (handles cash, makes purchases) g. Managing Finances	30 engagements) 		b. Date A	ture of Assessment Coordinator (sign on line above) Assessment Coordinator signed as complete
		(banking, handling checkbook, or paying bills)	HAIR CUTTING	-	c. Other Si	gnatures Title Sections Date

	ADHERENCE With Treatments/ Therapies/	In the last 6 months, compliant all or most of the time with special treatment therapies and programs: X 0Always compliant 3. No treatments or programs:		d. 		
	PROGRAMS	1. Compliant 80% of time 8. Unknown			3.	
		2. Compliant less than 80% of the time			5.	GROUP
	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.)	0	0	SEC	TION T. Prev
		(Enter "0" if no hospital admissions)			1.	PREVENTIVE
	EMERGENCY ROOM (ER)	Record number of times resident visited ER without an overnight stay in last 6 months (or since last assessment if less than 6	0	0		HEATH
	VISIT(S)	months.) (Enter "0" if no ER visits)				
	PHYSICIAN Visits	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	4		
	PHYSICIAN	In the last 14 days (or since admission if less than 14 days in				
	ORDERS	facility) how many days has the physician (or authorized assistant or	0	1		
		practitioner) changed the resident's orders? Do not include order	U	1		
		renewals without change. (Enter "0" if none)				
	ABNORMAL	Has the resident had any abnormal lab values during the last 90				
	LAB VALUES	days (or since admission if less than 90 days)? \Box 0. No \Box 1. Yes			P11 =	:0
PS	PSYCHIATRIC	Record number of times resident was admitted to a psychiatric				
HOSPITAL STAY(S)		hospital with an overnight stay in the last 6 months (or since last assessment if less than 6 months.) (Enter "0" if no psychiatric	0	0		
		hospital admissions)				

			Month Month
	c. Other Signatures	Title	Sections
	d.		

N T. Preventive Health/Health Behaviors

EVENTIVE HEATH (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)

Date

Date

g. Breast exam or mammogram

X h. Pap smear X i. PSA or rectal exam

j. Other (specify)

SECTION P. SPECIAL	TREATMENTS AND	PROCEDURE

6.

7.

8.

9.

10.

11.

12	1211		

LAUR	ABB	AKER
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Resident Name:		Date:	Soc. Sec. #	Facility Provid	der #						
	SECTION U. MEDICATIONS LIST										
	List all medications given during the last 7 days. Include medications used regularly less than weekly as part of the resident's treatment regimen.										
	 List the medication name and the dosage RA (Route of Administration). Use the appropriate code from the following list: 										
	1 = by mouth (PO) 2 = sublingual (SL)	3 = intramuscular (IM) 4 = intravenous (IV)	5 = subcutaneous (SubQ) 6 = rectally	7 = topical 8 = inhalation	9 = enteral tube 10 = other						

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

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

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

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

1. Medication Name and Dosage	2. RA	3. Freq	4. PRN-n	5. NDC Codes										
EXAMPLE: Coumadin 2.5 mg Digoxin 0.125 mg Humulin R 25 Units Robitussin 15cc	1 1 5 1	1W 1D 1D PR	2											
MILK OF MAGNESEA 15 CC	01	QO		9	9	9	9	9	4	4	4	4	0	0
PAMELOR 50 MG	01	1D		0	0	0	7	8	0	0	7	8	0	5
HYDROCH LORTHIA2	01	1D		0	0	3	4	9	2	0	7	0	 	1 0
INSULIN	03	1D		5	4	3	2	1	5	6	7	ـــــــــــــــــــــــــــــــــــــ	3	9 (
													L	1

MINIMUM DATA SET - RESIDENTIAL CARE ASSESSMENT (MDS-RCA)

CORRECTION REQUEST FORM

Use this form:

- 1. To request correction of error(s) in an MDS-RCA assessment record or error(s) in an MDS-RCA Discharge Tracking
- record that has been previously accepted into the State MDS-RCA database; and
- 2. To identify the inaccurate record.

A correction request can be made to either MODIFY or INACTIVATE a record.

TO MODIFY A RECORD IN THE STATE DATABASE:

- 1. Complete a new corrected assessment or discharge tracking form. Include all the items on the form, not just those in need of correction;
- 2. Complete and attach this Correction Request Form to the corrected assessment or discharge tracking form;
- 3. Place a hard copy of the complete assessment and correction form in the Clinical Record;
- 4. Create a new electronic record including the corrected assessment or tracking form AND the Correction Request Form; and
- 5. Electronically submit the new record (as in #3) to the MDS-RCA database at the State.
- TO INACTIVATE A RECORD IN THE STATE DATABASE:
- 1. Complete this correction request form;
- 2. Create an electronic record of the Correction Request Form;
- 3. Place a hard copy of the complete assessment and correction form in the Clinical Record; and
- 4. Electronically submit this Correction Request record to the MDS-RCA database at the State.

PRIOR RECORD SECTION:

THIS SECTION IDENTIFIES THE ASSESSMENT OR TRACKING FORM THAT IS IN ERROR. (In this section, reproduce the information EXACTLY as it appeared in the erroneous record, even if the information is wrong. This information is necessary in order to locate the record in the State database.)

Prior AA1	RESIDENT NAME	LAURA B BAKER							
		a.(First) b.(Middle Initial) c.(Last) d.(Jr/Sr)							
Prior AA2	GENDER	1. Male 2. Female 2							
Prior AA3	BIRTHDATE	0 7 1 9 1 9 5 9 Month Day Year							
Prior AA5a	SOCIAL Security	a. Social Security Number 0 0 2 4 2 4 3 1 4							
Prior A6 OR D1.8	REASON FOR Assessment	ASSESSMENT 1 1. Admission assessment 2. Annual assessment 3. Significant change in status assessment 4. Semi-Annual 5. Other DISCHARGE TRACKING 6. Discharged 7. Discharged prior to completing initial assessment							
	PRIOR DATE	PRIOR DATE (Complete one only) Complete Prior A5 if Primary Reason (Prior A6) equals 1,2,3,4 or 5 Complete Prior D3.2 if Primary Reason (Prior D1.8) equals 6 or 7							
Prior A5	ASSESSMENT DATE	a. Last day of MDS observation period 0 7 1 3 2 0 0 Month Day Year							
Prior D3.2	DISCHARGE Date	Date of Discharge							

CORRECTION SECTION:

COMPLETE THIS SECTION TO EXPLAIN THE CORRECT REQUEST

AT1.	CORRECTION Sequence Number	(Enter total number of correction for this record, including the present one)	01
AT2.	ACTION REQUESTED	 MODIFY record in error (Attach and submit a COMPLETE assessment or tracking form. Do NOT submit the corrected items ONLY. Proceed to item AT3 below). INACTIVE record in error. (Don NOT submit an assessment or tracking form. Submit the correction request only. Skip to item AT4). 	2
AT3.	REASONS FOR Modification	If AT2=1, check at least one of the following reasons; check all that apply, then skip to AT5) a. Transcription error b. Data entry error c. Software product error d. Item coding error e. Other error If "Other checked, please specify:	a. b. c. d. e.
AT4.	REASONS FOR INACTIVATION	 (If At2=2, check at least one of the following reasons; check all that apply.) a. Test record submitted as production record b. Event did not occur c. Inadvertent submission of non-required record d. Other reason requiring inactivation If "Other" checked, please specify: 	a. x b. c. d.

MDS-RCA COORDINATOR SIGNATURE AND DATE COMPLETION

AT5.	INDIVIDUAL NAME	Nancy Smith		RCA Director		
		a.(First)	b.(Last)	c.(Title)		
	SIGNATURE					
AT6.	CORRECTION DATE	0 7 — Month	1 6 — 2 Day	0 0 4 Year		

MINIMUM DATA SET (MDS)[©] RESIDENTIAL CARE ASSESSMENT (RCA)

BASIC ASSESSMENT TRACKING FORM

GENERAL INSTRUCTIONS:

Complete this form for all assessments and discharges.

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME	LAURA B BAKER	
		a. (First) b. (Middle Initial) c. (Last)	d. (Jr/Sr)
2.	GENDER	I. MaleX2. Female	
3.	BIRTHDATE	$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$	
4.	RACE/ ETHNICITY (Check only one.)	2. Asian/Pacific Islander 5. Wi 3. Black, not of Hispanic origin Hispanic origin	panic nite, not of spanic origin tther
5.	SOCIAL SECURITY and MEDICARE NUMBERS (C in 1 st box if no med. no.)	a. Social Security Number 0 0 2 4 2 4 3 1 4 b. Medicare number (or comparable railroad insurance nu 0 0 1 0 5 6 9 4 4 C	mber) 1
6.	FACILITY NAME AND PROVIDER NO.	a. Facility Name MCBVI b. Provider No. 9 <th></th>	
7.	MAINECARE NO.	[Record a "+" if pending, "N" if not a MaineCare recipient] 9 5 4 5 8 0 3 1 A	
8.	SIGNATURE(S)	DF PERSON(S) COMPLETING FACE SHEET:	
a . S	Signatures	Title Sections	Date
b.			Date
C.	DATE Completed	Record date background information was completed. 0 7 1 5 2 0 0 4 Month Day Year	

MINIMUM DATA SET (MDS)[®] RESIDENTIAL CARE ASSESSMENT (RCA)

FACE SHEET: BACKGROUND INFORMATION ONLY AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1.	DATE OF ENTRY	Date the stay began. (Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date.)
		0 7 - 0 6 - 2 0 0 4
		Month Day Year
2.	ADMITTED FROM (AT ENTRY) (Check only one.)	 1. Private home/apt. 2. Other board and care/assisted living/group home X 3. Nursing home 4. Acute care hospital 5. Psychiatric hospital 6. MR/DD facility 7. Rehabilitation hospital 8. Other (<i>specify</i>)
3.	LIVED ALONE (PRIOR TO ENTRY) (Check only one.)	X 0. No □ 1. Yes □ 2. In other facility
4.	PRIOR PRIMARY RESIDENCE	Provide town, state, zip code for Resident's primary residence prior to admission DEERFIELD NH 0 3 2 6 1
	BEAUBE	Town State Zip Code
5.	RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	 (Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above) a. Prior stay at this home X b. Nursing home C. Other residential facility—board and care home, assisted living, group home d. MH/psychiatric hospital e. MR/DD facility f. NONE OF ABOVE
6.	LIFETIME OCCUPATION	Put a "/" between two occupations. P R O D U C T I O N W O R K E R I
7.	EDUCATION (Highest Level Completed) (Check only one.)	1. No schooling 5. Technical or trade school X 2. 8th grade or less 6. Some college 3. 9–11 grades 7. Bachelor's degree 4. High school 8. Graduate degree
8.	PRIMARY LANGUAGE (Check only one.)	X 0. English 2. French 1. Spanish 3. Other (specify)
9.	MENTAL Health History	Does resident's RECORD indicate any history of the following? a. Mental retardation 0. No X 1. Yes b. Mental illness 0. No X 1. Yes c. Developmental disability 0. No X 1. Yes
10.	CONDITIONS	(Check all conditions that are related to MR/DD status that were
	RELATED TO	manifested before age 22, and are likely to continue indefinitely) a. Not applicable—no MR/DD (<i>Skip to AB11</i>)
	MR/DD Status	MR/DD with organic condition
		b. Down's syndrome X e . Cerebral palsy
		c. Autism f. Other organic condition related to MR/DD
11		X d. Epilepsy 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 1. Yes b. Dementia other than Alzheimer's disease X 0. No 1. Yes

SECTION AC. CUSTOMARY ROUTINE

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

END

SECTION AD. FACE SHEET SIGNATURES and DATES

1. SI	1. SIGNATURE(S) OF PERSON(S) COMPLETING FACE SHEET:								
a. Się	gnatures	Title Sections	Date 07/15/2004						
b.			Date						
2.	DATE	Record date background information was completed.							
2.	COMPLETED								
		0 7 1 5 2 0 0 4 Month Day Year							

CONFIDENTIAL MINIMUM DATA SET (MDS)[®] RESIDENTIAL CARE ASSESSMENT (RCA)

(STATUS IN LAST 7 DAYS UNLESS OTHERWISE NOTED)

954		DENTIFICATION and BACKGROUND INFORMATION			COMMUNICATION/HEARING PATTERNS
5E	RESIDENT	LAURA B BAKER	1.	HEARING	(With hearing appliance, if used)
2.	NAME SOCIAL SECURITY and MEDICARE NUMBERS (C in 1 st box if	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr) a. Social Security Number 0 0 2 4 2 4 3 1 4 b. Medicare number (or comparable railroad insurance number) 0 <		(Check only one.)	 O. HEARS ADEQUATELY—normal talk, TV, phone O. HEARS ADEQUATELY—normal talk, TV, phone X 1. MINIMAL DIFFICULTY when not in quiet setting 2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly 3. HIGHLY IMPAIRED –absence of useful hearing
3.	FACILITY FACILITY NAME AND PROVIDER NO.	0 0 1 0 5 6 9 4 4 — C 1 a. Facility Name MCBVI b. Provider No. 9 9 9 9 9 9 9 9	2.	COMMUNICA- Tion Devices/ Techniques	 (Check all that apply during last 7 days.) a. Hearing aid, present and used b. Hearing aid, present and not used regularly c. Other receptive communication techniques used (e.g., lip reading) X d. NONE OF ABOVE
4.	MAINECARE No.	[Record a "+" if pending, "N" if not a MaineCare recipient] 9 5 4 5 8 0 3 1 A	3.	MAKING SELF UNDERSTOOD (Check only one.)	 (Expressing information content—however able) X 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts
5.	ASSESSMENT DATE	Last day of observation period 0 7 1 3 2 0 0 4 Month Day Year			2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY/NEVER UNDERSTOOD
6.	REASON FOR ASSESSMENT	(Check primary reason for assessment) 4. Semi-Annual X 1. Admission assessment 5. Other (specify) 3. Significant change in status assessment	4.	ABILITY TO UNDERSTAND OTHERS (Check only one.)	 (Understanding information content—however able) X 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part / intent of message a. OUTETUTE UNDERSTANDS
7.	MARITAL STATUS (Check only one.)	X 1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated			 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY/NEVER UNDERSTANDS
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 e. Private pay X b. SSI f. Private insurance c. VA (including co-payment)	5.	COMMUNICA- TION (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. Image: Description of the state
		d. Social Security g. SSDI	SE	CTION D.	VISION PATTERNS
9.	RESPONSI- BILITY/ Legal Guardian	h. Other (specify)	1.	VISION (Check only one.)	 (Ability to see in adequate light and with glasses if used) 0. ADEQUATE—sees fine detail, including regular print in newspapers/books 1. IMPAIRED—sees large print, but not regular print in newspapers/books X 2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY IMPAIRED—object identification in question, but eves
10.	ADVANCED Directives	Does resident have any of the following advanced directives in place? a. Living Will X 0. No 1. Yes b. Do not resuscitate (DNR) X 0. No 1. Yes c. Do not hospitalize X 0. No 1. Yes			3. FIGHLY INFAIRED—object identification in question, but eyes appear to follow objects 4. SEVERELY IMPAIRED—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects
		d. Organ donation X 0. □ 1. Yes e. Other X 0. No □ 1. Yes (If "yes," specify) X 0. No □ 1. Yes	2.	VISUAL APPLIANCES	a. Glasses, contact lenses 0. No X 1. Yes b. Artificial eye X 0. No 1. Yes
SE		COGNITIVE PATTERNS	SE	INDICATORS	MOOD AND BEHAVIOR PATTERNS (CODE: Record the appropriate code for the frequency of the symptom(s)
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 1. Memory problem 		OF DEPRESSION, ANXIETY, SAD MOOD	 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)
2.	MEMORY/ Recall Ability	b. Long-term memory OK—seems/appears to recall long past X 0. Memory OK 1. Memory problem (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 e. NONE OF ABOVE are recalled X c. Staff names/faces			VERBAL EXPRESSIONS OF DISTRESS _0a. 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")
3.	COGNITIVE SKILLS FOR DAILY DECISION- MAKING (Check only one.)	 (Made decisions regarding tasks of daily life) X 0. INDEPENDENT—decisions consistent/reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues/ supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions 			0 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 or being abandoned, left alone, being with others 0 g. Recurrent statements that something terrible is about to happer
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			 -e.g., believes he or she is about to die, have a heart attack h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions i. Repetitive anxious complaints/concerns (non-health related)
		1. Improved 2. Declined			e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues (continued next page)

	LAURA	В	BAKER	CONI 07/13/2004	FIDENTIAL 002-42-4314		9999999999
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 symplin 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/w SLEEP-CYCLE ISSUES _0	1.	SENSE OF INITIATIVE/ INVOLVEMENT (Check all that apply)	X a. At ease interact X b. At ease doing X c. At ease doing X d. Establishes ow X e. Pursues involved involved in gr assists at reli X f. Accepts invital g. NONE OF AU				
		0_ I. Sad, pained, worried facial expressions—e.g., 0_ m. Crying, tearfulness 0_ n. Repetitive physical movements—e.g., pacing, restlessness, fidgeting, picking LOSS OF INTEREST 0_ o. Withdrawal from activities of interest—e.g., no i standing activities or being with family/friends	2.	UNSETTLED RELATION- SHIPS (Check all that apply)	a. Covert/open b. Unhappy wit c. Unhappy wit d. Openly expra e. Absence of p f. Recent loss g. Does not adj				
		0 p. Reduced social interaction INDICATORS OF MANIA _1q. Inflated self-worth, exaggerated self-opinion; in about one's own ability, etc. r. Excited behavior, motor excitation (e.g., heighter activity; excited, loud or pressured speech; incre	ned p	hysic	al	3	LIFE- EVENTS HISTORY (Check all that apply.)	X h. NONE OF AE Events in past 2 year a. Serious accid b. Health conce c. Death of fam d. Trouble with	
2	Check only one.)	Check if one or more indicators of depressed, sad or anxiou (above) were not easily altered by attempts to "cheer up", or reassure the resident over last 7 days . X 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	is ma consc	ood ole, or			ιπαι αμριγ.)	e. Robbed/phys X f. Conflict laden g. Loss of incon h. Sexual assau i. Child custody	
3	Check only one.)	Resident's current mood status compared to resident's statu (or since admission if less than 180 days): X 0. No change 1. Improved 2. Decl) day:	s ago			j. Change in m k. Review hearing I. NONE OF And	
4	• BEHAVIORAL SYMPTOMS	BEHAVIORAL SYMPTOMS (COLUMN A CODES: Record the appropriate code for the frequency of the symptom in last 7 days) (COLUMN B CODE Alterability of beha symptoms in last 0. Behavior of this type occurred 1 to 3 days in last 7 days 0. Behavior of this type occurred 1 to 3 days in last 7 days 0. Not present or eas 1. Behavior of this type occurred 4 to 6 days but less than daily					(A) ADL SEL 0. INDEPENDE during last 1. SUPERVISI days —OF	PHYSICAL FUNC F-PERFORMANCE M—No help or oversigh 7 days M—Oversight, encoura C—Supervision (3 or mo gi last 7 days	
		 3. Behavior of this type occurred daily (COLUMN C CODES: <u>History of this behavior in the last 6 months</u>) 0. No 1. Yes 	FREQUENCY	ALTERABILITY	HISTORY		LIMITED ASSISTANCE—Residen maneuvering of limbs or other r Limited assistance (3 or more		
a	. WANDERING	(moved with no rational purpose, seemingly oblivious to y)	0	0	0		3. EXTENSIVE	ASSISTANCE—While resi pwing type(s) provided 3	
b		BUSIVE BEHAVIORAL SYMPTOMS (others were reamed at, cursed at)	0	0	0		- Weight-	bearing support f performance during pa	
c	. PHYSICALLY	ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shed, sexually abused, gross physical assault)	0	0	0		4. TOTAL DEPI	ENDENCE—Full staff perfo	
d	SOCIALLY IN SYMPTOMS public, smear	APPROPRIATE/DISRUPTIVE BEHAVIORAL (made disruptive sounds, sexual behavior, disrobing in ad/threw food/feces, hoarding, rummaged through others' ealing, self-abusive acts, substance abuse, self-mutilation)	0	0	0		HOUR PERIO	PPORT CODES (COD OD) during last 7 days; ance classification.	
е	. RESISTS CA assistance, or	RE (resisted taking medications/ injections, ADL eating)	0	0	0		1. Setup h	p or physical help from elp only rson physical assist	
f.	-	G BEHAVIOR (made others feel unsafe, at risk, privacy	0	0	0		3. Two+ pe 8. Activity of	erson's physical assist did not occur during ent	
g			0	0	0	a.		TY– How resident move tions body while in bed	
h i.	Dangerous no	n-violent behavior (e.g., falling asleep while smoking)	0 0	0	0	b.	TRANSFER -	- How resident moves b	
j.	FIRE SETTIN		0	0	0	c.		anding position (EXCLU DN – How resident move	
5		Resident demonstrated suicidal thoughts or actions in the la	st 30	day:	s:		areas set asid	le for dining, activities, c moves to and from dista	
	IDEATION	□ 0. No X 1. Yes					sufficiency on	ce in chair	
6	SLEEP PROBLEMS	Check all present on 2 or more days during last 7 days a. Inability to awaken when desired b. Difficulty falling asleep X c. Restless or non-restful sleep	d. e. f.	clothing, inclu EATING – Ho nourishment b TOILET USE	How resident puts on, uding donning/removing w resident eats and drir by other means (e.g., tul – How resident uses th				
7	, INSIGHT INTO MENTAL HEALTH	Resident has insight about his/her mental problem Image:	alth p	oroble	ems	g.	catheter, adjust PERSONAL I combing hair,	HYGIENE – How resid brushing teeth, shaving	
8	BEHAVIORS (Check only one.)	Resident's current behavior status compared to resident's statadays ago (or since admission if less than 180 days): X 0. No change 1. Improved 2. D	h.		erineum (EXCLUDE bai w resident climbs stairs				

SE	CTION F. P	SYCHOSOCIAL WELL-BEING						
1.	SENSE OF	X a. At ease interacting with others						
	INITIATIVE/	X b. At ease doing planned or structured activities						
	INVOLVEMENT	X c. At ease doing self-initiated activities						
	(Check all that apply)	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							
		g. NONE OF ABOVE						
-								
2.	UNSETTLED Relation-	a. Covert/open conflict with or repeated criticism of staff						
	SHIPS	 b. Unhappy with roommate c. Unhappy with residents other than roommate 						
	(Check all that apply)	d. Openly expresses conflict/anger with family/friends						
	uppiy)	e. Absence of personal contact with family/friends						
		f. Recent loss of close family member/friend						
		g. Does not adjust easily to change in routines						
		X h. NONE OF ABOVE						
3.	LIFE-	Events in past 2 years						
	EVENTS HISTORY	a. Serious accident or physical illness						
	nistont	b. Health concerns for other person						
	(Check all	c. Death of family member or close friend d. Trouble with the law						
	that apply.)	e. Robbed/physically attacked						
		X f. Conflict laden or severed relationship						
		g. Loss of income leading to change in lifestyle						
		h. Sexual assault/abuse						
		i. Child custody issues						
		j. Change in marital/partner status						
		k. Review hearings (e.g., forensic, certification, capacity hear	ring)					
		I. NONE OF ABOVE						
SE	CTION G. I	PHYSICAL FUNCTIONING						
1.	· · /	F-PERFORMANCE						
	<i>0. INDEPENDE</i> during last	NT—No help or oversight —OR— Help/oversight provided only 1 or 2 ti 7 days	mes					
		DN —Oversight, encouragement or cueing provided 3 or more times dur	ing las	t 7				
	days —OR	R— Supervision (3 or more times) plus physical assistance provided only	y 1 or :	2				
		g last 7 days SISTANCE—Resident highly involved in activity; received physical help ir	auida	d				
		ng of limbs or other non-weight bearing assistance 3 or more times —C		u				
		sistance (3 or more times,) plus weight-bearing support provided 1 or 2						
	3. EXTENSIVE	ASSISTANCE—While resident performed part of activity, over last 7-day powing type(s) provided 3 or more times:	period,					
		bearing support						
	•	f performance during part (but not all) of last 7 days						
		ENDENCE—Full staff performance of activity during last 7 days						
	8. ACTIVITY DI	ID NOT OCCUR DURING LAST 7 DAYS						
		PPORT CODES (CODE for MOST SUPPORT PROVIDED OVER E	ACH 2	4				
		OD) during last 7 days; code regardless of person's ance classification.	А	В				
		p or physical help from staff	SELF- PERFORMANCE					
	1. Setup he		MAN	⊢				
		rson physical assist	- GRI	Ю				
		ersons physical assist did not occur during entire 7 days		SUPPORT				
a.								
u.		tions body while in bed	0	0				
b.		- How resident moves between surfaces—to/from: bed, chair,	0	C				
	wheelchair, standing position (EXCLUDE to/from bath/toilet)							
c.	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 - Ho	w resident eats and drinks (regardless of skill). Includes intake of	0	0				
_	nourishment by other means (e.g., tube feeding, total parenteral nutrition)							
f.								
1	urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or 0 catheter, adjusts clothes							
		er on/off toilet, cleanses, changes pad, manages ostomy or sts clothes	0					
g.	catheter, adjust		0	0				

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Resi	dent Name:	Date:		Soc	. Sec. #	Facility Provider #
SEC	TION G. P	HYSICAL FUNCTIONING (cont.)		SE	CTION G.	PHYSICAL FUNCTIONING (cont.)
2. 3A.	BATHING SELF- PERFORMANCE MODES OF	How resident takes full-body bath/shower, sponge bath, and transfers of tub/shower (EXCLUDE washing of back and hair.) Check for most dependent in self-performance during last 7 days. X 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 (Check all that apply during last 7 days)	in/out <u>t</u>			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
	LOCOMOTION	 a. Cane/walker/crutch b. Wheeled self c. Other person wheeled X d. 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 b. Hearing aid (e.g., button hook, velcro closings) c. Cane or walker g. Dentures
3B.	MAIN Mode of Locomotion	Was wheelchair the primary mode of locomotion during the last 7 day X 0. No I Yes	rs?			d. Wheelchair h. Other (specify) e. Assistive feeding devices (e.g., plate X i. NONE OF ABOVE
3C.	BEDFAST/ Chairfast	 (Check if health condition keeps resident in his/her room 22+ hours per in last 7 days) a. Bedfast all or most of time b. Chairfast all or most of the time X c. NONE OF ABOVE 	er day	8.	SELF- Performance in Iadls	0. No change X1. Improved 2. Declined
4.	SELF- PERFORMANCE IN ADLs (Check only one.)	 Resident's current ADL status or abilities compared to resident's statudays ago (or since admission if less than 180 days): 0. No change X 1. Improved 2. Declined 	is 180	SE 1	CONTINENT (Code for res 0. CONTIN ostomy d	CONTINENCE IN LAST 14 DAYS CE SELF-CONTROL CATEGORIES <i>ident's PERFORMANCE OVER ALL SHIFTS)</i> /ENT—Complete control (includes use of indwelling urinary catheter or evice that does not leak urine or stool)
5A.	IADL SELF- Perfor- Mance	 Code for level of independence in the last 30 days based on resident involvement in the activity. SELF-PERFORMANCE CODES: INDEPENDENT : (with/without assistive devices)—No help preserved. DONE WITH HELP: Resident involved in activity but help (inclusive) supervision, reminders, and/or physical help) is provided. DONE BY OTHERS: Full performance of the activity is done by others. The resident is involved at all when the activity is performed. 	ovided. uding	a.	BOWEL, 2. OCCASI daily; BO 3. FREQUE some cor 4. INCONTI all (or alm	Y CONTINENT—BLADDER, Incontinent episodes once a week or less; less than weekly ONALLY INCONTINENT—BLADDER, 2 or more times a week but not WEL, once a week ENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but throl present (e.g. on day shift); BOWEL, 2-3 times a week NENT—Had inadequate control BLADDER, multiple daily episodes; BOWEL, ost all) of the time Control of bowel movement, with appliance or bowel continence programs, if employed
		 Activity did not occur in the last 30 days. 	ų	b.	BLADDER CONTINENCE	Control of urinary bladder function with appliances (e.g. foley) or 0 continence programs, if employed
		IADL	SELF- PERFORMANCE	2.	BOWEL Elimination Pattern	Bowel elimination pattern regular—at least one movement every three days Diarrhea c. a. X Fecal Impaction d. Resident is Independent VONF OF ABOVE e.
		a. Resident arranged for shopping for clothing, snacks, other incidentals.	0	3.	APPLIANCES	Constipation b. NONE OF ABOVE f. Any scheduled toileting plan a. Did not use toilet room/ Image: Constipation of the schedule
		 b. Resident shopped for clothing, snacks, or other incidentals. c. Resident arranged for suitable transportation to get to appointments, outings, necessary engagements. 	0		and PROGRAMS	Bladder retraining program b. commode/urinal f. External (condom) catheter c. Pads/briefs used g. In the urity of
		 Resident managed finances including banking, handling checkbook, or paying bills. 	1			Intermittent catheter e. Ostomy present i.
		 e. Resident managed cash, personal needs allowance. f. Resident prepared snacks, light meals. 	0	4	USE OF	NONE OF ABOVE J. X Resident's management of incontinence supplies (pads, briefs, ostomy,
		g. Resident used phone.	0		INCONTINENC SUPPLIES	E catheter) in <u>last 14 days.</u> X 0. Always continent
		 h. Resident did light housework such as making own bed, dusting, or taking care of belongings. i. Resident sorted, folded, or washed own laundry. 	0		(Check only one.)	
5B.	TRANSPOR- TATION	Check all that apply for level of independence in the last 30 days base on resident's involvement in the activity.	ed			 A Resident incontinent and receives assistance with managing incontinence supplies. 3. Resident incontinent and does not use incontinence supplies.
		 X a. Resident drove car or used public transportation independently get to medical, dental appointments, necessary engagements, other activities. X b. Resident rode to destination with staff, family, others (in car, van 	or	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): X 0. No change 1. Improved 2. Deteriorated
		public transportation) but was not accompanied to medical, dental appointments, necessary engagements, or other activiti	es.	SE	CTION I. D	IAGNOSES
		 X c. Resident rode to destination with staff, family, others (in car, van public transportation) and <u>was accompanied</u> to medical, dent appointments, necessary engagements, or other activities. 		and	l behavior statu	diagnoses that have a relationship to current ADL status, cognitive status, mood is, medical treatments, nurse monitoring, or risk of death. (Do not list inactive ie apply, CHECK item xx. <i>NONE OF ABOVE</i>)
6.	ADL AND IADL FUNCTIONAL REHABILI- TATION OR IMPROVE- MENT POTENTIAL (Check all that apply.)	 d. Activity did not occur. X a. Resident believes he/she is capable of increased independence at least some ADLs or IADLs. X b. Direct care staff believes resident is capable of increased independence in at least some ADLs or IADLs. X c. Resident able to perform tasks/activity but is very slow d. Difference in ADL/IADL Self-Performance comparing mornings evenings e. Resident requires or only understands a one-step direction. (continued in next column) 		1.	DIAGNOSES	ENDOCRINE/METABOLIC/ NUTRITIONAL HEART/CIRCULATION X a. Diabetes mellitus d. Arteriosclerotic heart disease (ASHD) b. Hyperthyroidism e. Cardiac dysrhythmia c. Hypothyroidism f. Congestive heart failure g. Deep vein thrombosis h. Hypertension i. Hypotension j. Peripheral vascular disease k. Other cardiovascular disease (continued on next page)

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1. Arthritis gg. Si m. Missing limb (e.g., amputation) PULMONA amputation) hh. A: amputation hh. A: amputation hi. amputation hi. amputation hi. amputation hi. amputation accident (stroke) u. Dementia other hi. amputation's gg. Stroke amputation's	Date:					
2. OTHER CURRENT DIARONSIS AND ICD-9 CODES MUSCULOSKELETAL I. Arthritis M. Hip fracture Alzheimer's Gease MEUROLOGICAL Gerebrovascular Accident (stroke) Gerebrovascular Accident (stroke) U. Dementia other than Alzheimer's Gisease Cerebrovascular Accident (stroke) U. Dementia other than Alzheimer's Gisease Cr. Adzheimer's Gisease Cr. Adzheimer's Gisease Cr. Adzheimer's Cr. Cr. Adzheimer's Cr. Cr. Cr. Cr. Cr. Cr. Cr. Cr. Cr. Cr.						
. m. Hip fracture m. Missing limb (e.g., arguitation) o. Osteoporosis p. Pathological bone fracture m. Alzheimer's disease m. Aphasia X. S. Cerebral palsy X. Cerebral palsy X. Cerebral palsy X. Cerebral palsy W. Dementia other m. Multiple sclerosis X. T. Aphasia OTHER Q. Dementia other m. Multiple sclerosis X. T. Paraplegia W. Multiple sclerosis X. Transient ischemic disease Z. Quadriplegia W. Multiple sclerosis X. aa. Seizure disorder bb. Transient ischemic disease Z. Quadriplegia W. Multiple sclerosis X. aa. Seizure disorder bb. Transient ischemic disease Z. QUARENT a. Depression 2. OTHER CURRENT a. Inability to lie flat due to shortness of breath j b. Schortness of breath j c. Edema d. Dizziness/vertigo d. Dizziness/vertigo d. Dizziness/vertigo d. Dizziness/vertigo d. Dizziness/vertigo d. Dizzinesisance to flexion and ext shortness of breath j d. Dizziness/vertigo d. Dizziness/vertigo d. Dizziness/vertigo d. Dizziness/vertigo d. D	lanic depressive (Bipolar)					
Q. Alzheimer's disease II. Git disease Q. Alzheimer's disease Imm. M X. Cerebral palsy X. m. A L. Cerebrovascular accident (stroke) O. A Q. U. Dementia other than Alzheimer's disease P. T. TT Q. W. Multiple sclerosis X. tt. N M. Matiple sclerosis X. tt. N M. Multiple sclerosis X. X. N M. Multiple sclerosis X. X. N M. Multiple sclerosis X. X. N PSYCHIATRIC/MOOD M. Axiety disorder e. Depression c. CURRENT DIAGNOSIS AND A. All chalusionations I PROBLEM (Check all problems present in last 7 days unless CONDITI	sthma mphysema/COPD , ataracts					
accident (stroke) 00. P u. Dementia other 00. 4 u. Dementia other 01. 4 u. Dementia other 01. 4 u. Dementia other 01. 4 u. Nemplagia 5. H u. Multiple sclerosis X v. Hemiparesis X tt. N v. Paraplegia 00. 4 v. Parkinson's 00 v. Parkinson's 00 disease 00. 2 00 z. Quadriplegia uu. Si x. Paraplegia uu. Si x. Paraplegia uu. Si x. Paraplegia uu. Si x. Aa. Seizure disorder 00 c. c. Transitechanic v. Aa. Seizure disorder v. ee. Depression 2 CURRENT a. Aa. JAGNOSIS a. a. A. Anxiety disorder ee. c. c. c.	iabetic retinopathy aucoma lacular degeneration Allergies (<i>specify</i>)					
Parkinson's disease D Z. Quadriplegia uu. Si X aa. Seizure disorder vv. O b. Transient ischemic vv. O aatack (TIA) ww. Ei PSYCHIATRIC/MOOD dd. Anxiety disorder e. Depression xx. M PSYCHIATRIC/MOOD dd. Anxiety disorder e. Depression xx. M PSYCHIATRIC/MOOD a. b. Depression xx. M PSYCHIATRIC/MOOD c. c. c. ECTION J. HEALTH CONDITIONS AND POSSIBLE MEDICAT 1. PROBLEM CONDITIONS a. Inability to lie flat due to a. Inability to lie flat due to i shortness of breath j b. Shortness of breath j c. Edema i d. Dizziness/vertigo r g. Hostility c h. Suspiciousness X g. Hostility c h. Suspiciousness X g. Hostility c h. Suspiciousness X g. Hostility c i. Dyskinesia-ch	Anemia					
Image: Synchronic state in the input state inpu	Tental Retardation or levelopmental disability (MR/ D) ubstance abuse (alcohol or rug) ther psychiatric diagnosis .g., paranoia, phobias,					
CURRENT DIAGNOSIS AND ICO-9 CODES ab	ersonality disorder) xplicit terminal prognosis NONE OF ABOVE					
1. PROBLEM CONDITIONS (Check all problems present in last 7 days unless a. Inability to lie flat due to shortness of breath i a. Inability to lie flat due to shortness of breath i b. Shortness of breath j c. Edema i d. Dizziness/vertigo r e. Delusions i f. Hallucinations r g. Hostility d value h. Suspiciousness X g. Hostility d d increase in motora Activity a. Akathisia-resident reports subjective need for movement b. b. Dyskinesia-chewing, puckering mov irregular movements of lips; or rockir mouth, or tongue DECREASE IN MOTOR ACTIVITY d. Rigidity-resistance to flexion and ext continuous or cogwheeling rigidity) e. Slow shuffling gait-reduction in spee	820 . 21					
1. CONDITIONS a. Inability to lie flat due to ishortness of breath j b. Shortness of breath j c. Edema j d. Dizziness/vertigo j e. Delusions j f. Hallucinations j g. Hostility g PYRAMIDAL Check all present at any point during last 3 of increases in MOTOR ACTIVITY a. Akathisia-resident reports subjective need for movement b. Dyskinesia-chewing, puckering movirregular movements of lips; or rocking movirregular movements of lips; or rocking movirregular invormation and ext continuous or cogwheeling rigidity) e. Slow shuffling gait-reduction in spee	TION SIDE EFFECTS					
Image: Symptoms Image: F. Hallucinations Image: F. Hallucinations Image: Symptoms 2. EXTRA- PYRAMIDAL SIGNS AND SYMPTOMS Check all present at any point during last 3 or INCREASE IN MOTOR ACTIVITY Image: Symptoms Check all present at any point during last 3 or INCREASE IN MOTOR ACTIVITY Image: Symptoms A kathisia-resident reports subjective need for movement Image: Display the symptoms Dyskinesia-chewing, puckering moving irregular movements of lips; or rocking mouth, or tongue Image: DECREASE IN MOTOR ACTIVITY Image: Check all present at any point during last at any point during	s other time frame is indicated) i. Headache j. Numbness/tingling k. Blurred vision I. Dry mouth m. Excessive salivation or					
PYRAMIDAL SIGNS AND SYMPTOMS INCREASE IN MOTOR ACTIVITY a. Akathisia-resident reports subjective need for movement b. Dyskinesia-chewing, puckering mov irregular movements of lips; or rockir c. Tremor-regular rhythmic movements mouth, or tongue DECREASE IN MOTOR ACTIVITY d. Rigidity-resistance to flexion and ext continuous or cogwheeling rigidity) e. Slow shuffling gait-reduction in spee	drooling n. Change in normal appetite o. Other (<i>specify</i>) <i>NONE OF ABOVE</i>					
C. Tremor–regular rhythmic movements mouth, or tongue DECREASE IN MOTOR ACTIVITY d. Rigidity–resistance to flexion and ext continuous or cogwheeling rigidity) e. Slow shuffling gait–reduction in spee	e feeling of restlessness or vements of mouth; abnormal					
	DECREASE IN MOTOR ACTIVITY d. Rigidity-resistance to flexion and extension of muscles (e.g., continuous or cogwheeling rigidity)					
f. Bradykinesis-decrease in periodiar a body movement or poverty of facial e MUSCLE CONTRACTIONS g. Dystonia-muscle hypertonicity (e.g., protruding tongue, upward deviation X h. NONE OF ABOVE	arm movement bus movements (e.g., reduced expression, gestures, speech) muscle spasms or stiffness,					
3. PAIN SYMPTOMS (Code the highest level of resident's pain present On a scale of 1 to 10, where 1 is the least and how would you rate your pain? (If no pain, co	d 10 is the most,					
	Incisional pain Joint pain (other than hip)					

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	SECTION J. HEALTH CONDITIONS AND POSSIBLE MEDICATION SIDE EFFECTS (cont.)									
5.	PAIN INTERFERES	During the last 7 days, how much of the time did pain interfere with resident's normal activities such as visiting with friends, going out, and so on? 1. All of the time 3. Little of the time 2. Some of the time X 4. None of the time X								
6.	PAIN Manage- Ment	X 1. No pain treatment 3. Treated, partial control 2. Treated, full control 4. Treated, no or minimal control								
7.	ACCIDENTS (Check all that apply)	a. Fell in past 30 days d. Other fracture in last 180 days b. Fell in past 31-180 days X c. Hip fracture in last 180 days								
8.	DANGER OF FALL (Check all that apply)	 a. Has unsteady gait b. Has balance problems when standing c. Limits activity because resident or family fearful of resident falling d. Unstable transition from seated to standing e. Other (<i>specify</i>) X f. NONE OF ABOVE 								
SEC	TION K. ORA	L/NUTRITIONAL STATUS								
1.	ORAL PROBLEMS (Check all that apply)	a. Mouth is "dry"when eating a meal d. Mouth Pain b. Chewing Problem X e. NONE OF ABOVE c. Swallowing Problem X								
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.								
	WEIGHT	a. HT (in.) b. WT (lb.) 1 2 5. WT (lb.) 1 2 7 a. Unintended weight loss–5% or more in last 30 days; or 10% or								
3.	WEIGHT Change	 a. Online rides weight loss-0 % of more in last 30 days, of 10 % of more in last 180 days X 0. No								
		X 0. No								
4.	NUTRI- TIONAL PROBLEMS OR AP- PROACHES (Check all that apply)	 a. Complains about the taste of many foods b. Regular or repetitive complaints of hunger c. Leaves 25% of food uneaten at most meals d. Therapeutic diet e. Mechanically altered (or pureed) diet f. Noncompliance with diet g. Eating disorders h. Food allergies (specify) i. Restrictions (specify) X j. NONE OF ABOVE 								
SEC	TION L. ORA	L/DENTAL STATUS								
1.	ORAL STATUS AND DISEASE PREVENTION (check all that apply)	 a. Has dentures or removable bridge b. Some/all natural teeth lost-does not have or does not use dentures (or partial plates) c. Broken, loose or carious teeth d. Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes e. Daily cleaning of teeth/dentures or daily mouth care-by resident or staff f. Resident has difficulty brushing teeth or dentures X g. NONE OF ABOVE 								
		I CONDITION								
1.	SKIN PROBLEMS (Check all that apply)	Any troubling skin conditions or changes in the last 7 days? a. Abrasions (scrapes) or cuts e. Open sores or lesions b. Burns (2nd or 3rd degree) f. Other (specify) c. Bruises								
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 relievel the record the record results are the relievel the record to the relievel the relievel the record to the relievel the record to the relievel the record to the relievel to the relievel the record to the relievel to the relievel the relievel to the								
		the skin) that does not disappear when pressure is relieved. 0 b. Stage 2. A partial thickness loss of skin layers that presents								
		clinically as an abrasion, blister, or shallow crater. c. Stage 3. A full thickness of skin is lost, exposing the subcutane- ous tissues-presents as a deep crater with or without								
		undermining adjacent tissue. 0								
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.								

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d. Headache e. Hip pain

i. Stomach pain j. Other (*specify*)_

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Resi	dent Name:	Date:	Soc. Sec # Facility Provider #				
SEC	TION M. SKIN	CONDITION	s	SECT	ION O. MEDI	ICATIONS (cont.)	
3.	FOOT PROBLEMS	 a. Resident or someone else inspects resident's feet on a regular basis? D. No X 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? 	-	4A.	DAYS RECEIVED THE FOLLOWING MEDICATION PRN	(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 _7_g. Insulin 0 b. Antianxiety _0_e. Diuretic	
SEC	TION N. ACTI	X 0. No L 1. Yes			MEDICATIONS	emotional or nervous condition, or behavioral problem? X 0. No	
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: X a. Morning D d. Night (Bedtime to A.M.) X b. Afternoon X e. NONE OF ABOVE		N	SELF- DMINSTERED IEDICATIONS Check all that apply.)	Did resident self-administer any of the following in the last 7 days: a. Insulin e. Glucosan b. Oxygen X f. Over-the-counter Meds c. Nebulizers X g. Other (specify) IRON PILLS d. Nitropatch h. NONE OF ABOVE	
2.	AVERAGE TIME INVOLVED IN ACTIVITIES (Check only one.)	X c. Evening (When awake and not receiving treatments or ADL care) X 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		P	MEDICATION Preparation Administra- Tion	 Did resident prepare and administer his/her own medications in last 7 days? (<i>Check only one.</i>) 0. No Meds 1. Resident prepared and administrated <u>NONE</u> of his/her own medications. X 2. Resident prepared and administrated <u>SOME</u> of his/her own medications. 3. Resident prepared and administrated <u>ALL</u> of his/her own medications. 	
3.	PREFERRED Activity Settings	(Check all settings in which activities are preferred) X a. Own room X d. Away from facility X b. Day/activity room □ e. NONE OF ABOVE X c. Outside facility (e.g., in yard)	_		MEDICATION COMPLIANCE (Check one)	Resident's level of compliance with medications prescribed by a physician/ psychiatrist during last 30 days: 0. No Meds	
4.	GENERAL ACTIVITY PREFER- ENCES (Adapted to	(Check all PREFERENCES whether or not activity is currently available to resident) X a. Cards/other games X k. Gardening or plants D b. Crafts/arts X I. Talking or conversing X c. Exercise/sports X m. Helping others				 2. Always compliant with reminder, verbal prompts 3. Compliant some of the time (80% of time or more often) or with some medications X 4. Rarely or never compliant 	
	resident's current abilities)	X d. Dancing X n. Doing chores around the house/facility X e. Music house/facility I f. Reading/writing X o. Cooking/baking			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) \Box 0. No X 1. Yes	
		X g. Spiritual/religious activity p. Computer activities X h. Trips/shopping q. Volunteering X i. Walking/wheeling outdoors r. Other (specify) X j. Watching TV s. NONE OF ABOVE	Г	1.	TION P. SPEC SPECIAL TREATMENTS, PROCE- DURES,	IAL TREATMENTS AND PROCEDURES a. SPECIAL CARE-Check treatments or programs received during the last 14 days [Note-count only post admission treatments] TREATMEMTS a. Chemotherapy or X i. Training in skills required to return	
5.	PREFERRED ACTIVITY SIZE	(Check all that apply) a. Individual c. Larger group b. Small group X d. No preference			AND Programs	radiation to the community (e.g., taking medications, house work, b. Oxygen therapy shopping, transportation, ADLs) c. Dialysis i. Case management	
6.	PREFER- ENCES IN DAILY ROUTINE (Check all	 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 				PROGRAMS , b Day treatment program d. Alcohol/drug treatment program k. Day treatment program e. Alzheimer's/dementia special care unit X m. Job training n. Transportation	
	that apply)	 d. Resident prefers activity at different time of day X e. Resident prefers stability in daily routine f. NONE OF ABOVE 				f. Hospice care X o. Psychological rehabilitation g. Home health X p. Formal education h. Home care g. 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 4. Once a week facility 5. 2 or 3 times a week but not daily 2. None daily 				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	
		 X 3. 1-3 times/month How often has resident talked by telephone with family and friends in the last 30 days? (check only one) 				Check C if therapy was received out-of-home or facility (A) A B a. Speech-language pathology and auditory services 0 b. Occupational therapy 0	
		□ 1. No family or friends outside facility □ 4. Once a week □ 1. No family or friends outside facility □ 5. 2 or 3 times a week but not daily □ 2. None daily X 3. 1-3 times/month □ 6. Daily				c. Physical therapy 0 d. Respiratory therapy 0 e. Psychological therapy (by any licensed mental health professional) 0	
8.	VOTING	Is resident registered to vote? X 0. No I 1. Yes	╞		WITES	(Check all interventions or strategies used in the last 7 days unless other time	
9.	SOCIAL ACTIVITES (Check only one.)	Resident's current level of participation in social, religious or other personal activities compared to resident's status 180 days ago (since admission if less than 180 days): 0. No change X 1. Improved 2. Declined			INTER- VENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	 specified-no matter where received) a. Special behavior symptom evaluation program b. Special behavior 	
SEC	TION O. MEDI	CATIONS				management program	
1.	NUMBER OF MEDICATIONS NEW	(Record the number of different medications used in the last 7 days;				c. Evaluation by a licensed mental health specialist in last 90 days g. Validation/Redirection h. Crisis intervention in facility i. Crisis stabilization unit in last	
2.	MEDICATIONS	X 0.N0 I 1. Yes				d. Group therapy 90 days	
3.	INJECTIONS	(Record the number of DAYS injections of any type received during 0 0				e. Resident-specific j. Other (specify) deliberate changes in the X k. NONE OF ABOVE	

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SEC	TION P. SPEC	IAL TREATMENTS AND PROCEDURES (cont.)		s	SEC	TION Q. SERV					
3.	NEED FOR ON-GOING MONITORING REHABILITA- TION/ RESTORATIVE CARE	(Code for person responsible for monitoring) 0. No monitoring required 2. RCF Other Staff 1. RCF nurse 3. Home health nurse	7		1. 2.	RESIDENT GOALS (Check all areas in which resident has self-identified goals) CONFLICT					
		0 d. Bed mobility 0 i. Amputation/prosthesis ca 0 e. Transfer 0 j. Communication 0 f. Walking 0 k. Time management 0 g. Dressing or grooming 7 I. Other (specify) 0 h. Eating or swallowing 0 I. Other (specify)			1.	DISCHARGE POTENTIAL	 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. Ye s 				
5.	SKILL Training	Record the number of days , in the last 30 days that each of the following IAD were performed with assistance from staff as a skill training activity identified the resident's service plan. 0 a. Meal Preparation (snacks, 0 h. Arranges Shopping)Ls I in				since admission, if less than 6 months?				
		light meals) (makes list, acquires		s	SEC.	TION S. ASSE	SSMENT INFORMATION				
		2 c. Light Housework (makes i. Shopping (for groceries	۶,		1.	PARTICIPA- TION	a. Resident: 0. No X 1. Yes				
		own bed, takes care of clothes, or other incidentals)				IN I	b. Family: X 0. No □ 1. Yes □ 2. No Family				
		0 belongings) <u>1</u> j. Transportation (travel b	у			ASSESS- MENT	c. Other Non-Staff: X 0. No 🗌 1. Yes 🗌 2. None				
	0 washes own laundry) various means to get to medical appointments or other necessary				2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT: NANCY SMITH						
		1 ostomy, catheter) 30 ergagements) 1 f. Managing Cash (handles cash, makes purchases) k. Medications (preparation and administration of medications) 0 g. Managing Finances 1				0	e of Assessment Coordinator (sign on line above) essment Coordinator signed as complete <u>07</u> - <u>16</u> - <u>2004</u> _{Vear}				
		(banking, handling				c. Other Signa	atures Title Sections Date				
6.	ADHERENCE With Treatments/	In the last 6 months, compliant all or most of the time with special treatments therapies and programs: X 0Always compliant				d.	Date				
	THERAPIES/ Programs	□ 1. Compliant 80% of time □ 8. Unknown				e.	Date				
		2. Compliant less than 80% of the time			3.	CASE MIX GROUP					
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.)	0	s			ntive Health/Health Behaviors				
		(Enter "0" if no hospital admissions)			1.	PREVENTIVE HEATH	(Check all the procedures the resident received during the past 12 months)				
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)	0				X a. Blood pressure monitoring g. Breast exam or mammogram b. Hearing assessment X h. Pap smear c. Vision test X i. PSA or rectal exam				
9.	PHYSICIAN VISITS	practitioner) examined the resident? (Enter "0" if none)	4				X d. Dental visit j. Other (specify) X e. Influenza vaccine				
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)	1				f. Pneumococcal vaccine (ANY time)				
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)? \Box 0. No \Box 1. Yes		Р	11 =	= 0					
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)	0								
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)	0								

Soc. Sec # ___

Date:

LAURA B BAKER

Resident Name:

002-42-4314

LAUR	ABB	AKER
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CONFIDENTIAL 07/13/2004

002-42-4314

999999999 sility Provider #

Resident Name:		Date:	Soc. Sec. #	Facility Provider #		
		SEC	TION U. MEDICATIONS LIST			
	List all medications given during th	e last 7 days. Include medications	s used regularly less than weekly as par	rt of the resident's treatment regimen	J .	
 List the medication name and the dosage RA (Route of Administration). Use the appropriate code from the following list: 						
	1 = by mouth (PO) 2 = sublingual (SL)	3 = intramuscular (IM) 4 = intravenous (IV)	5 = subcutaneous (SubQ) 6 = rectally	7 = topical 8 = inhalation	9 = enteral tube 10 = other	

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

PR = (PRN) as necessary 1H = (qh) every hour 2H = (q2h) every two hours 3H = (q3h) every three hours 4H = (q4h) every four hours 6H = (q6h) every six hours	 8H = (q8h) every eight hours 1D = (qd or hs) once daily 2D = (BID) two times daily (includes every 12 hours) 3D = (TID) three times daily 4D = (QID) four times daily 	5D = five times a day 1W = (QWeek) once every week 2W = twice every week 3W = three times every week QO = every other day 4W = four times every week	5W = five times every week 6W = six times every week 1M = (QMonth) once every month 2M = twice every month C = continuous Q = other
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4. PRN-n (prn — number of doses): If the frequency code is "PR", record the number of times during the past 7 days that each PRN medication was given. Do not use this column for scheduled medications.

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

1. Medication Name and Dosage	2. RA	3. Freq	4. PRN-n	5. NDC Codes										
EXAMPLE: Coumadin 2.5 mg Digoxin 0.125 mg Humulin R 25 Units Robitussin 15cc	1 1 5 1	1W 1D 1D PR	2											
MILK OF MAGNESEA 15 CC	01	QO		9	9	9	9	9	4	4	4	4	0	0
PAMELOR 50 MG	01	1D		0	0	0	7	8	0	0	7	8	0	5
HYDROCH LORTHIA2	01	1D		0	0	3	4	9	2	0	7	0)	1 0
INSULIN	03	1D		5	4	3	2	1	5	6	7	<u>د</u>	3	9 0
													<u> </u>	_
										<u> </u>				
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										1				
					I	1	1	1	1	I	I	1	1	I
								1	1	1		1		