



Oklahoma State Department of Health  
Creating a State of Health

**LONG-TERM CARE FACILITY ADVISORY BOARD**  
**Regular Meeting**  
**January 8, 2014 at 1:30 in Room 1102**  
**Oklahoma State Department of Health, 1000 N.E. 10th Street, Oklahoma City, OK 73117-1299**

**AGENDA**

1. Call to Order.....Dewey Sherbon, Vice-Chair
2. Roll Call.....Natalie Smith
3. Introductions.....Kay Parsons  
*Kay Parsons will begin introduction process for members of the board and Public Attendees.*
4. Board History and Operational Routines.....Dorya Huser  
*Dorya Huser will discuss the history of the board and inform new members how the board operates.*
5. Review and Action to Approve/Amend the January 09, 2013/ April 10, 2013/ July 10, 2013/ October 9, 2013 Regular Meeting minutes..... Kay Parsons
6. Nominating Committee for New Officers.....Esther Houser
7. Bulk Medication Proposed Rule Acceptance.....Dorya Huser  
*Dorya Huser will give an update on the Bulk Medication Proposed Rule acceptance by the board of health.*
8. Statistical Report Update on Protective Service Operations.....Dorya Huser
9. AL Assessment Form and Admission Standards.....Mary Fleming  
*Mary Fleming will discuss the Assisted Living assessment form and admission standards.*
10. Psychotic Drug Usage Reduction Study.....Mary Fleming  
*Mary Fleming will give a status report to the board on the Psychotic Drug Usage Reduction study.*
11. Update to the Implementation of the Fingerprint Based National Background Check.....Walter Jacques  
*Walter Jacques will provide an update on the implementation of the Fingerprint Based National Background Check program.*
12. QIS Update.....Mike Cook  
*Mike Cook will provide the board with an update on the QIS process.*

13. Challenges/ New Business.....Dorya Huser

14. Public Comment

15. Adjournment

 **Oklahoma Statutes Citationized**  
 **Title 63. Public Health and Safety**  
 **Chapter 1**  
 **Public Health Code - Nursing Home Care Act**  
 **Article Article 19**  
 **Section 1-1923 - Long-Term Care Facility Advisory Board**  
Cite as: O.S. §, \_\_ \_\_

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A. There is hereby re-created, to continue until July 1, 2010, in accordance with the provisions of the Oklahoma Sunset Law, a Long-Term Care Facility Advisory Board which shall be composed as follows:

1. The Governor shall appoint a twenty-seven-member Long-Term Care Facility Advisory Board which shall advise the State Commissioner of Health. The Advisory Board shall be comprised of the following persons:

a. one representative from the Office of the State Fire Marshal, designated by the State Fire Marshal,

b. one representative from the Oklahoma Health Care Authority, designated by the Administrator,

c. one representative from the Department of Mental Health and Substance Abuse Services, designated by the Commissioner of Mental Health and Substance Abuse Services,

d. one representative from the Department of Human Services, designated by the Director of Human Services,

e. one member who shall be a licensed general practitioner of the medical profession,

f. one member who shall be a general practitioner of the osteopathic profession,

g. one member who shall be a registered pharmacist,

h. one member who shall be a licensed registered nurse,

i. one member who shall be a licensed practical nurse,

j. three members who shall be of reputable and responsible character and sound physical and mental health and shall be operator-administrators of nursing homes which have current licenses issued pursuant to the Nursing Home Care Act and who shall have had five (5) years' experience in the nursing home profession as operator-administrators,

k. three members who shall be residential care home operator-administrators licensed pursuant to the provisions of the Residential Care Act,

l. three members who shall be adult day care facility owner-operators licensed pursuant to the provisions of the Adult Day Care Act,

m. three members who shall be continuum of care facility or assisted living center owner-operators licensed pursuant to the provisions of the Continuum of Care and Assisted Living Act, and

n. six members who shall be over the age of sixty-five (65) who shall represent the general public;

2. The designated representative from the Office of the State Fire Marshal, the designated representative from the Department of Mental Health and Substance Abuse Services, the designated representative from the Department of Human Services, and the designated representative from the State Department of Health shall serve at the pleasure of their designators;

3. The initial appointments of the Governor shall be for the following terms:

a. the initial term of the member of the medical profession shall be for a three-year term,

b. the initial term of the member of the osteopathic profession shall be for a three-year term,

c. the initial term of the registered pharmacist shall be for a two-year term,

d. the initial term of the licensed registered nurse shall be for a two-year term,

e. the initial term of the licensed practical nurse shall be for a one-year term,

f. of the initial terms for the twelve members who are licensed operator-administrators for facilities pursuant to the Nursing Home Care Act, residential care homes pursuant to the Residential Care Act, adult day care facilities pursuant to the Adult Day Care Act, and continuum of care facilities and assisted living centers pursuant to the Continuum of Care and Assisted Living Act, four shall be for one-year terms, four shall be for two-year terms, and four shall be for three-year terms; provided that representatives for each of the terms shall include one individual representing facilities subject to the provisions of the Nursing Home Care Act, one individual representing residential care homes subject to the Residential Care Act, one individual representing facilities subject to the provisions of the Adult Day Care Act, and one individual representing continuum of care facilities and assisted living centers subject to the provisions of the Continuum of Care and Assisted Living Act, and

g. the initial terms for the six members of the general public over the age of sixty-five (65) shall be for one-, two-, three-, four-, five- and six-year terms respectively.

4. After the initial designations or appointments, the designated representative from the Office of the State Fire Marshal, the designated representative of the Oklahoma Health Care Authority, the designated representative of the Department of Human Services and the designated representative of the Department of Mental Health and Substance Abuse Services shall each serve at the pleasure of their designators. All other terms shall be for a three-year period. In case of a vacancy, the Governor shall appoint individuals to fill the remainder of the term.

B. The State Department of Health shall provide a clerical staff worker to perform designated duties of the Advisory Board. The Department shall also provide space for meetings of the Advisory Board.

C. The Advisory Board shall annually elect a chair, vice-chair and secretary-treasurer, shall meet at least quarterly, and may hold such special meetings as may be necessary. The members of the Advisory Board shall be reimbursed as provided for by the State Travel Reimbursement Act.

D. The Advisory Board shall have the power and duty to:

1. Serve as an advisory body to the Department for the development and improvement of services to and care and treatment of residents of facilities subject to the provisions of the Nursing Home Care Act, homes subject to the provisions of the Residential Care Act and facilities subject to the provisions of the Adult Day Care Act;
2. Review, make recommendations regarding, and approve in its advisory capacity the system of standards developed by the Department;
3. Evaluate and review the standards, practices, and procedures of the Department regarding the administration and enforcement of the provisions of the Nursing Home Care Act, the Residential Care Act and the Adult Day Care Act, and the quality of services and care and treatment provided to residents of facilities and residential care homes and participants in adult day care centers. The Board may make recommendations to the Department as necessary and appropriate;
4. Evaluate and review financial accountability standards, policies and practices of residential care facilities regarding residents' funds for which the facility is the payee, and evaluate and review expenditures made on behalf of the resident by the facility to ensure that such funds are managed appropriately and in the best interests of the resident; and
5. Publish and distribute an annual report of its activities and any recommendations for the improvement of services and care and treatment to residents of facilities and residential care homes and participants in adult day care centers on or before January 1 of each year to the Governor, the State Commissioner of Health, the State Board of Health, the Speaker of the House of Representatives, the President Pro Tempore of the Senate, and the chief administrative officer of each agency affected by the report.

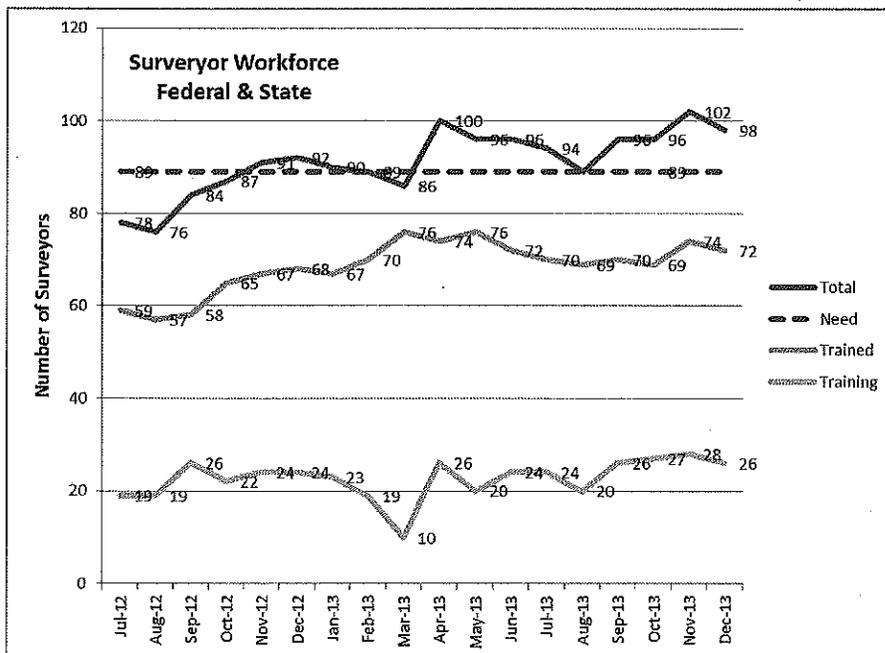
#### ***Historical Data***

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Added by Laws 1980, c. 241, § 23, eff. October 1, 1980; Amended by Laws 1984, c. 128, § 5, eff. November 1, 1984; Amended by Laws 1986, c. 16, § 1, eff. July 1, 1986; Amended by Laws 1987, c. 98, § 27, emerg. eff. May 20, 1987; Amended by Laws 1989, c. 192, § 10, eff. November 1, 1989; Amended by Laws 1989, c. 345, § 3, eff. October 1, 1989; Amended by Laws 1990, c. 51, § 127, emerg. eff. April 9, 1990; Amended by Laws 1992, c. 109, § 1, emerg. eff. April 20, 1992; Amended by Laws 1995, c. 230, § 17, eff. July 1, 1995; Amended by Laws 1998, c. 42, § 1, eff. April 2, 1998 ( superseded document available); Amended by Laws 2001, SB 385, c. 17, § 1, emerg. eff. July 1, 2001 ( superseded document available ); Amended by Laws 2004, HB 2093, c. 25, § 1, eff. August 27, 2004 (superseded document available).

# Long Term Care SFY 2013 Mandates

Facility Type	State Mandate	Description	SFY 11	SFY 12	SFY 13	SFY 14 (TD*) <small>*To date as of 3/7/2014</small>	Trend
NH & ICF/IID	2.1.1	The statewide average time interval between consecutive standard surveys must be 12.9 months or less.	12.3	12.2	12.4	11.7	
NH & ICF/IID	2.1.2	For 100% of facilities, the SA must conduct a standard survey not later than 15.9 months after the last day of the previous standard survey.	100%	100%	100%	100%	
NH	2.2.2	Non-immediate jeopardy high within ten working days: the SA initiates an investigation within 10 working days of the received end date for 100% of all complaints and incidents where the SA prioritizes the intake as "Non-IJ High."	35%	32%	61%	98%	
NH	2.2.3	Non-immediate jeopardy medium or low within 25 working days: the SA initiates an investigation within 25 working days of the received end date for 100% of all complaints and incidents where the SA prioritizes the intake as "Non-IJ Medium or Non-IJ Low."	45%	39%	60%	90%	
ALC	2.4.1	The statewide average time interval between consecutive standard surveys for Assisted Living Facilities must be 12.9 months or less.	17.3	12.4	12.9	11.8	
ALC	2.4.2	For 100% of facilities, the SA must conduct a standard survey FOR Assisted Living Facilities not later than 15.9 months after the last day of the previous standard survey.	66%	97%	89%	100%	
ADC	2.4.4	The SA must conduct 1 standard survey for Adult Day Care Facilities per year.	100%	100%	100%	80%	





**Recommended Assisted Living  
Resident Assessment Form**

All Areas Must Be Addressed, "N/A" if not applicable.

**\* Denotes items required for Admission Assessment.**

Admission Date \_\_\_\_\_

Facility Name \_\_\_\_\_ Assessment Date \_\_\_\_\_

\*Resident Name \_\_\_\_\_ Room #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Assessment Type (circle one): Preadmission      14 day      Annual      Significant Change

\*Disease Diagnoses and Medically Defined Conditions:

\_\_\_\_\_

\*History of Infections and Prior Medical History:

\_\_\_\_\_

\*List All Current Medications and dosages (list additional medications on separate page if needed):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

\*Mental / Cognitive Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe) (circle one):

Alert / Non-Alert / Oriented x \_\_\_\_      Confused / Confused at Times / Forgetful      Judgment: G / F / P

\*Mental Health History / Mental Retardation or Developmental Disabilities:

\_\_\_\_\_

\*Physical Functional Status (G=Good, F=Fair, P=Poor, if fair or poor, describe):

Mobility: G / F / P      Strength: G / F / P      Gait: G / F / P

Range of Motion: Full / Limited / Contractures (describe) \_\_\_\_\_

Weight Bearing: Yes / No (describe) \_\_\_\_\_

Ambulatory Without Assistance / With Staff Assistance (describe)

\_\_\_\_\_

Bedfast / Chair fast / Geri-chair / Walker / Wheelchair per Self / With Staff Assistance

\*List Number of Persons Required to Assist Resident with Activities of Daily Living to Include:

Bathing \_\_\_\_\_ Eating \_\_\_\_\_ Dressing \_\_\_\_\_ Transferring \_\_\_\_\_ Toileting \_\_\_\_\_ Ambulation \_\_\_\_\_

**Devices/Restraints (Describe):**

Side rails used? Yes / No

Restraint Devices (Describe) \_\_\_\_\_ Utilized When and Why (describe) \_\_\_\_\_

**Assisted Living Resident Assessment Form**

**Oral / Nutritional Status:**

Diet Order: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Weight Changes (loss or gain) \_\_\_\_\_

Abnormalities: Swallowing Problems Yes / No      Nausea / Vomiting (describe) \_\_\_\_\_

Ability to Eat: Independent / Meal Set Up & Cueing / Assistance to Use Utensils/ Supervision / Must be Fed

Oral Status: Own Teeth / Partial Teeth / Dentures / No Teeth / Condition of Teeth (describe) \_\_\_\_\_

Tube Feeding: Gastrostomy / Nasogastric (describe) \_\_\_\_\_

**\*Toileting Ability/Elimination:**

Bladder: Continent / Incontinent / Incontinent at times (describe) / Urinary Catheter – Indwelling / Other

Bowel: Continent / Incontinent / Incontinent at times (describe) \_\_\_\_\_

Toileting Ability: Independent / Assist / Total Assist / Adult Briefs / B&B Restoration / Toileting Schedule

**Customary Routine (G=Good, F=Fair, P=Poor, if fair or poor, describe):**

Sleep habits: G / F / P    How Many Hours in 24? \_\_\_\_\_    Sleep Problems (describe) \_\_\_\_\_

Meals: In Dining Room / In Room / Other Location / Eats Out (describe frequency) \_\_\_\_\_

Bathing: Prefers bath / Prefers shower / Preferred schedule (describe) \_\_\_\_\_

Usual time to rise \_\_\_\_\_ Usual bedtime \_\_\_\_\_ Naps during day? \_\_\_\_\_

**Psychosocial Status: (G=Good, F=Fair, P=Poor, if fair or poor, describe):**

Ability to communicate: G / F / P      Interviewable: Yes / No. If No describe: \_\_\_\_\_

Usual Mood: Calm / Fearful / Agitated / Anxious \_\_\_\_\_

History of Mood Disorder / Depression: \_\_\_\_\_

History of Abnormal Behaviors: Agitation / Anger Outburst /Crying / Aggressive / Combative / Elopement Risk

Family / Friends Involvement: Yes / No (describe) \_\_\_\_\_

**Skin Condition (G=Good, F=Fair, P=Poor, if fair or poor, describe):**

General Condition: G / F / P \_\_\_\_\_ Turgor: G / F / P \_\_\_\_\_

Describe Color, Texture and Appearance: \_\_\_\_\_

Describe Abnormalities: \_\_\_\_\_

Wounds (Describe All: location, size, color, drainage, treatment): \_\_\_\_\_

**Special Treatments and Procedures (i.e. wound care, respiratory therapy, physical therapy, restorative, etc.):**

**Sensory and Physical Impairments (i.e. vision, hearing, etc.):**

\_\_\_\_\_  
*Signature of Resident or Representative Interviewed*

\_\_\_\_\_  
*Participating Health Professional      Date*

\_\_\_\_\_  
*\*Signature (R.N. or Physician), Title      Date*

\_\_\_\_\_  
*Participating Health Professional      Date*

**DRAFT**  
**MINIMUM DATA SET, Version 3.0 (MDS 3.0)**

**FOR NURSING HOME RESIDENT  
ASSESSMENT AND CARE SCREENING**

*(Note: This MDS 3.0 Draft contains only the new/revised items that are being tested in the field trial. Some retained administrative items are not included in the study form in order to protect resident privacy.)*

**DRAFT VERSION - 7/31/2006**

Section

**A**

**Select Demographic Items**

**A1. Assessment Reference Date** (last day of MDS observation period)

/  /   
 M M / D D / Y Y Y Y

**A2. Gender**

- Enter  1. Male  
Code  2. Female

**A3. Language**

- Enter  Does the resident need or want an interpreter to communicate with a doctor or health care staff?  
Code  0. No  
1. Yes → If yes, specify primary language: \_\_\_\_\_  
9. Unable to determine

**A4. Ethnicity**

↓ Complete only on admission assessment ↓

- Enter  Is the resident of Hispanic or Latino origin or descent?  
Code  0. No  
1. Yes  
9. Unable to determine

**A5. Race**

↓ Complete only on admission assessment ↓

- Check all that apply.
- a. American Indian or Alaska Native
  - b. Asian
  - c. Black or African American
  - d. Native Hawaiian or Other Pacific Islander
  - e. White
  - f. Other
  - g. Unable to determine

**A6. Mental Health History**

↓ Complete only on admission assessment ↓

- Enter  The resident has been evaluated by Level II PASRR, and determined to have a serious mental illness and/or mental  
Code  retardation.  
0. No  
1. Yes  
9. Not applicable (Unit not Medicaid certified)

## Section

## B

## Hearing, Speech, and Vision

## B1. Comatose

Enter

  
Code

**Persistent vegetative state/no discernible consciousness last 5 days.**

0. No
1. Yes → If yes, skip to section G, Functional Status.

## B2. Hearing

Enter

  
Code

**Ability to hear (with hearing aid or hearing appliance if normally used) last 5 days.**

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

## B3. Hearing Aid

Enter

  
Code

**Hearing aid or other hearing appliance used in above 5-day assessment.**

0. No
1. Yes

## B4. Speech Clarity

Enter

  
Code

**Select best description of speech pattern in last 5 days.**

0. **Clear speech**—distinct intelligible words
1. **Unclear speech**—slurred, mumbled words
2. **No speech**—absence of spoken word

## B5. Makes Self Understood

Enter

  
Code

**Ability to express ideas and wants, consider both verbal and non-verbal expression in last 5 days.**

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

## B6. Ability to Understand Others

Enter

  
Code

**Understanding verbal content, however able (with hearing aid or device if used) in last 5 days.**

0. **Understands**—clear comprehension
1. **Usually understands**—misses some part/intent of message **BUT** comprehends most conversation
2. **Sometime understands**—responds adequately to simple, direct communication only
3. **Rarely/never understands**

## B7. Vision

Enter

  
Code

**Ability to see in adequate light (with glasses or other visual appliances) in last 5 days.**

0. **Adequate**—sees fine detail, including regular print in newspapers/books
1. **Impaired**—sees large print, but not regular print in newspapers/books
2. **Moderately impaired**—limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired**—object identification in question, but eyes appear to follow objects
4. **Severely impaired**—no vision or sees only light, colors or shapes; eyes do not appear to follow object

## B8. Corrective Lenses

Enter

  
Code

**Corrective lenses (contacts, glasses, or magnifying glass) used in above 5-day assessment.**

0. No
1. Yes

## Brief Interview for Mental Status (BIMS)

## C1. Interview Attempted

Enter

Code

0. **No** (resident is rarely/never understood or needed interpreter not present) → Skip to C8, Staff Assessment for Mental Status

1. **Yes**

## C2. Repetition of Three Words

Enter

Code

Ask resident: "I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are: **sock, blue, and bed**. Now tell me the three words."

**Number of words repeated after first attempt**

- 0. **None**
- 1. **One**
- 2. **Two**
- 3. **Three**

After the resident's first attempt, repeat the words using cues ("sock, something to wear; blue, a color; bed, a piece of furniture"). You may repeat the words up to two more times.

## C3. Temporal Orientation (orientation to year, month, and day)

Enter

Code

Ask resident: "Please tell me what year it is right now."

- a. **Able to report correct year**
- 3. **Correct**
- 2. **Missed by 1 year**
- 1. **Missed by 2–5 years**
- 0. **Missed by > 5 years or no answer**

Enter

Code

Ask resident: "What month are we in right now?"

- b. **Able to report correct month**
- 2. **Accurate within 5 days**
- 1. **Missed by 6 days to 1 month**
- 0. **Missed by > 1 month or no answer**

Enter

Code

Ask resident: "What day of the week is today?"

- c. **Able to report correct day of the week**
- 1. **Correct**
- 0. **Incorrect or no answer**

## C4. Recall

Enter

Code

Ask resident: "Let's go back to the first question. What were those three words that I asked you to repeat?"

If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

- a. **Able to recall "sock"**
  - 2. **Yes, no cue required**
  - 1. **Yes, after cueing** ("something to wear")
  - 0. **No**—could not recall
- b. **Able to recall "blue"**
  - 2. **Yes, no cue required**
  - 1. **Yes, after cueing** ("a color")
  - 0. **No**—could not recall
- c. **Able to recall "bed"**
  - 2. **Yes, no cue required**
  - 1. **Yes, after cueing** ("a piece of furniture")
  - 0. **No**—could not recall

## C5. Summary Score

Enter

Code

Enter Numbers

Add scores for questions C2–C4 and fill in total score (00–15).

Enter 99 if unable to complete interview

## C6. Organized Thinking

Enter

Code

- a. **Ask resident: "Are there fish in the ocean?"**
- 1. **Correct** ("yes")
- 0. **Incorrect or no answer**

Enter

Code

- b. **Ask resident: "Does one pound weigh more than two pounds?"**
- 1. **Correct** ("no")
- 0. **Incorrect or no answer**

Enter

Code

- c. **Ask resident: "Can a hammer be used to pound a nail?"**
- 1. **Correct** ("yes")
- 0. **Incorrect or no answer**

## C7. Skip Item: Interview Completed

Enter

Code

0. **No** (resident was unable to complete interview) → Continue to C8, Staff Assessment for Mental Status

1. **Yes** → Skip to C12, Signs and Symptoms of Delirium



Section

C

# Cognitive Patterns

**Staff Assessment for Mental Status**—Complete only if resident interview (C2–C6) not completed

**C8 Short Term Memory OK**

Enter  Seems or appears to recall after 5 minutes.  
Code  
0. **Memory OK**  
1. **Memory problem**

**C9 Long Term Memory OK**

Enter  Seems or appears to recall long past.  
Code  
0. **Memory OK**  
1. **Memory problem**

**C10: Memory/Recall/Ability**

Check all that the resident was normally able to recall during the last 5 days:

- Check all that apply.
- a. **Current season**
  - b. **Location of own room**
  - c. **Staff names and faces**
  - d. **That he or she is in a nursing home**
  - e. **None of the above is recalled**

**C11: Cognitive Skills for Daily Decision Making**

Enter  **Makes decisions regarding tasks of daily life.**  
Code  
0. **Independent**—decisions consistent/reasonable  
1. **Modified independent**—some difficulty in new situations only  
2. **Moderately impaired**—decisions poor; cues/supervision required  
3. **Severely impaired**—never/rarely made decisions

**Delirium**

**C12: Signs and Symptoms of Delirium** (from CAM)

After interviewing the resident, code the following behaviors (a–d) in last 5 days.

<p><b>Coding:</b></p> <p>0. <b>Behavior not present</b></p> <p>1. <b>Behavior continuously present, does not fluctuate</b></p> <p>2. <b>Behavior present, fluctuates</b> (comes and goes, changes in severity)</p>	<p>Enter Codes in Boxes →</p>	<p>Enter <input type="checkbox"/> <b>a. Inattention</b>—Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty keeping track of what was said)?</p> <p>Code</p>
		<p>Enter <input type="checkbox"/> <b>b. Disorganized thinking</b>—Was the resident’s thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?</p> <p>Code</p>
		<p>Enter <input type="checkbox"/> <b>c. Altered level of consciousness</b>—Did the resident have altered level of consciousness? (e.g., <b>vigilant</b>—startles easily to any sound or touch; <b>lethargic</b>—repeatedly dozes off when being asked questions, but responds to voice or touch; <b>stuporous</b>—very difficult to arouse and keep aroused for the interview; <b>comatose</b>—cannot be aroused)</p> <p>Code</p>
		<p>Enter <input type="checkbox"/> <b>d. Psychomotor retardation</b>—Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly?</p> <p>Code</p>

**C13: Acute Onset Mental Status Change**

Enter  **Is there evidence of an acute change in mental status** from the resident’s baseline in last 5 days?  
Code  
1. **Yes**  
0. **No**

Section

**D**

**Mood**

**Self-Rated Mood Interview**—Complete D1–D4 for all residents who are capable of any communication (B5 = 0, 1, or 2), and for whom an interpreter is present or not required.

**D1. Interview Attempted**

Enter  **0. No** (resident is rarely/never understood or needed interpreter not present) → Skip to D6, Staff Assessment  
 Code  **1. Yes**

**D2. Interview (From PHQ-9)**

	I: Symptom Presence If yes, obtain frequency.	II: Symptom Frequency Circle one response				
		0: 0–1 day (Not at all)	1: 2–6 days (Several days)	2: 7–11 days (More than half the days)	3: 12–14 days (Nearly every day)	
Say to resident: <i>“Over the last 2 weeks, have you been bothered by any of the following problems?”</i>						
a. <b>Little interest or pleasure in doing things</b>	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
b. <b>Feeling down, depressed, or hopeless</b>	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
c. <b>Trouble falling or staying asleep, or sleeping too much</b>	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
d. <b>Feeling tired or having little energy</b>	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
e. <b>Poor appetite or overeating</b>	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
f. <b>Feeling bad about yourself—or that you are a failure or have let yourself or your family down</b>	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
g. <b>Trouble concentrating on things, such as reading the newspaper or watching television</b>	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
h. <b>Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</b>	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response	0	1	2	3
i. <b>Thoughts that you would be better off dead, or of hurting yourself in some way</b> 1) If i = “Yes”, check here to indicate that the charge nurse has been informed: <input type="checkbox"/>	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response	0	1	2	3

**D3. Total Severity Score**

Enter Numbers

**Sum of all circled frequency responses (D2–II; items a–i).** Score may be between 00 and 27. Enter 99 if unable to complete interview (3 or more items in column I marked “No response”)

**Check here** if some or all frequency responses (D2–II; items a–i) are missing from total score.



**Section D Mood**

**D4. Evidence of Depression** 33/

Enter  Are 2 or more frequency items in shaded columns circled (D2–II, a–i), and at least one of these is question a or b?  
 Code  
 0. No  
 1. Yes

**D5. Skip Item: Resident Interview Completed** 34/

Enter  0. No (3 or more items in D2–I, items a–i marked "No response") → Continue to D6, Staff Assessment of Depression  
 Code  
 1. Yes → Skip to Section E, Behavior

**Staff Assessment of Mood** — Complete D6–D8 only if resident interview (D1–D5) not completed. (From PHQ-9)

D6. Staff Assessment		I. Symptom Presence		II. Symptom Frequency			
		If yes, obtain frequency:		Circle one response:			
Say to staff: "Over the last 2 weeks, did the resident have any of the following problems?"				0. 0–1 day (Not at all)	1. 2–6 days (Several days)	2. 7–11 days (More than half the days)	3. 12–14 days (Nearly every day)
a. Little interest or pleasure in doing things	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response		0	1	2	3
b. Feeling down, depressed, or hopeless	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response		0	1	2	3
c. Trouble falling or staying asleep, or sleeping too much	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response		0	1	2	3
d. Feeling tired or having little energy	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response		0	1	2	3
e. Poor appetite or overeating	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response		0	1	2	3
f. Feeling bad about themselves—or that he or she is a failure or has let themselves or their family down	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response		0	1	2	3
g. Trouble concentrating on things, such as reading the newspaper or watching television	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response		0	1	2	3
h. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response		0	1	2	3
i. Thoughts that they would be better off dead, or of hurting themselves in some way 1) If i = "Yes", check here to indicate that the charge nurse has been informed: <input type="checkbox"/>	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response		0	1	2	3
j. Feeling short-tempered, easily annoyed	Enter <input type="checkbox"/> Code	0. No 1. Yes → 9. No response		0	1	2	3

Section

**D**

# Mood

## D7. Total Severity Score

  
  
Enter Numbers

Sum of all circled frequency responses (D6-II, a-i; do not include D6j). Score may be between 00 and 27.

Check here if staff responses are based on observation for less than 14 days.

## D8. Evidence of Depression

  
Enter  
  
Code

Are 2 or more frequency items in shaded columns circled (D6-II, a-i), and at least one of these is question a or b?

0. No

1. Yes

## E1. Psychosis

Check all that apply.


Check if problem condition was present at any time in last 5 days:

- a. **Hallucinations** (perceptual experiences in the *absence* of real external sensory stimuli) **or illusions** (misperceptions in the *presence* of real external sensory stimuli)
- b. **Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
- c. **None of the above**

## Behavioral Symptoms

## E2. Behavioral Symptom—Presence &amp; Frequency

Note presence of symptoms and their frequency in the last 5 days:

## Coding:

0. Not present in last 5 days
1. Present 1–2 days
2. Present 3 or more days

Enter Codes in Boxes

  
Code  
  
Code  
  
Code

- a. **Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
- b. **Verbal behavioral symptoms directed toward others** (e.g., threatening, screaming at others; cursing at others)
- c. **Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as the resident hitting or scratching Self, pacing, rummaging, public sexual acts, disrobing in public, and throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

## E3. Overall Presence of Behavioral Symptoms in the last 5 days

  
Code

Were any behavioral symptoms in questions E2 coded 1 or 2?

0. No → Skip to E6, Rejection of Care
1. Yes → Considering all of the symptoms together, answer E4 and E5 below

## E4. Impact on Resident

Did any of the identified symptom(s):

  
Code

a. Put the resident at significant risk for physical illness or injury?

0. No
1. Yes

  
Code

b. Significantly interfere with the resident's care?

0. No
1. Yes

  
Code

c. Significantly interfere with the resident's participation in activities or social interactions?

0. No
1. Yes

## Section

## E

## Behavior

## E5. Impact on Others

Did any of the identified symptom(s):

- Enter  
  
Code
- a. Put others at clinically significant risk for physical injury?  
0. No  
1. Yes
- Enter  
  
Code
- b. Significantly intrude on the privacy or activity of others?  
0. No  
1. Yes
- Enter  
  
Code
- c. Significantly disrupt care or living environment?  
0. No  
1. Yes

## E6. Rejection of Care—Presence

- Enter  
  
Code
- In the last 5 days, did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being? Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and/or determined to be consistent with resident values, preferences, or goals.  
0. No → Skip to E8, Wandering  
1. Yes

## E7. Rejection of Care—Frequency

- Enter  
  
Code
- Number of days on which care was rejected  
1. 1–2 days  
2. 3 or more days

## Wandering

## E8. Wandering—Presence

- Enter  
  
Code
- In the last 5 days, has the resident wandered on at least one occasion?  
0. No → Skip to E11, Change in Behavioral Symptoms  
1. Yes

## E9. Wandering—Impact

- Enter  
  
Code
- a. Does the wandering place the resident at significant risk of getting to a place having greater risk of danger (e.g., stairs, outside of the facility)?  
0. No  
1. Yes
- Enter  
  
Code
- b. Does the wandering significantly intrude on the privacy or activities of others?  
0. No  
1. Yes

## E10. Wandering—Frequency

- Enter  
  
Code
- Of the last 5 days, on how many days has wandering occurred?  
1. 1–2 days  
2. 3 or more days

## E11. Change in Behavioral or Other Symptoms—Consider all of the symptoms assessed in items E1 through E10.

↓ Complete only on follow-up assessment ↓

- Enter  
  
Code
- How does resident's current behavior status, care rejection, or wandering compare to last assessment?  
0. Same  
1. Improved  
2. Worse

Section  
**F**

# Preferences for Customary Routine, Activities, Community Setting

## F1. Preferred Routine

All residents should be asked about preferences. Complete F1 for all residents who are capable of any communication (B5 is coded 0, 1, or 2), and for whom an interpreter is present or not required. For residents who are not able to communicate, interview family member, or significant other who knows the resident and can provide information on past customs and preferences.

Preface a-h by saying to resident: "While you are in the nursing home..."

### Coding:

1. *Very important*
2. *Somewhat important*
3. *Not very important*
4. *Not important at all*
5. *Important, but can't do or no choice*
9. *No response or non-responsive*

Enter Codes in Boxes

Enter  
  
Code

a. How important is it to you to **choose what clothes to wear?**

Enter  
  
Code

b. How important is it to you to **take care of your personal belongings or things?**

Enter  
  
Code

c. How important is it to you to **choose between a tub bath, shower, bed bath, or sponge bath?**

Enter  
  
Code

d. How important is it to you to have **snacks available between meals?**

Enter  
  
Code

e. If you could go to bed whenever you wanted, how important would it be to you to **stay up past 8:00 p.m.?**

Enter  
  
Code

f. How important is it to you to have your **family or a close friend involved in discussions about your care?**

Enter  
  
Code

g. How important is it to you to be able to **use the phone in private?**

Enter  
  
Code

h. How important is it to you to have a **place to lock your things to keep them safe?**

## F2. Primary Respondent

Indicate primary respondent for F1, Preferred Routine:

Enter  
  
Code

1. **Resident**
2. **Significant Other** (family, close friend, or other representative)
9. **Could not be completed by resident or significant other**



Section  
**F**

# Preferences for Customary Routine, Activities, Community Setting

## F3. Activity Pursuit Patterns

All residents who are able to communicate should be asked about activity pursuit patterns—even if they have not been able to complete F1. Complete F3 for all residents who are capable of any communication (B5 is coded 0, 1, or 2), and for whom an interpreter is present or not required. For residents who are not able to communicate, interview family, or significant other who knows the resident and can provide information on past customs and preferences.

Preface a–j by saying to resident: "While you are in the nursing home..."

**Coding:**

1. *Very important*
2. *Somewhat important*
3. *Not very important*
4. *Not important at all*
5. *Important, but can't do or no choice*
9. *No response or non-responsive*

Enter Codes in Boxes →

Enter  
  
Code

a. How important is it to you to have **books, newspapers, and magazines** to read?

Enter  
  
Code

b. How important is it to you to listen to **music** you like?

Enter  
  
Code

c. How important is it to you to be around **animals** such as pets?

Enter  
  
Code

d. How important is it to you to keep up with the **news**?

Enter  
  
Code

e. How important is it to you to do things with **groups of people**?

Enter  
  
Code

f. How important is it to you to do your **favorite activities**?

Enter  
  
Code

g. How important is it to you to do things **away from the nursing home**?

Enter  
  
Code

h. How important is it to you to **go outside** to get fresh air when the weather is good?

Enter  
  
Code

i. How important is it to you to participate in **religious services or practices**?

Enter  
  
Code

- j. If your doctor approves, would you like to be offered **alcohol on occasion** at meals or social events?
0. *No*
  1. *Yes*
  5. *Yes, but can't do or no choice*
  9. *No response or non-responsive answer*

## F4. Primary Respondent

Enter  
  
Code

Indicate primary respondent for F3, Activity Pursuit Patterns:

1. **Resident**
2. **Significant Other** (family, close friend, or other representative)
9. **Could not be completed by resident or significant other**



**Section  
F**

# Preferences for Customary Routine, Activities, Community Setting

**F5. Return to Community**

↓ **Complete only on admission assessment** ↓

Ask resident (or family or significant other if resident unable to respond):

Enter  
  
Code

*"Do you want to talk to someone about the possibility of returning to the community?"*

- 0. No
- 1. Yes

**F6. Skip Item: Staff Assessment Required**

Enter  
  
Code

Was either F2, Preferred Routine Respondent, or F4, Activity Respondent coded 9?

- 0. No → Skip to Section G, Functional Status
- 1. Yes → Complete F7, Staff Assessment of Activity and Daily Preferences

**F7. Staff Assessment of Activity and Daily Preferences**—Complete only if unable to interview resident or other representative for either F1, Preferred Routine, or F3, Activity/Pursuit Patterns.

**Resident Prefers:**

Check all that apply.	<input type="checkbox"/>	a. Choosing clothes to wear	Check all that apply.	<input type="checkbox"/>	k. Place to lock personal belongings
	<input type="checkbox"/>	b. Caring for personal belongings		<input type="checkbox"/>	l. Reading books, newspapers, or magazines
	<input type="checkbox"/>	c. Receiving tub bath		<input type="checkbox"/>	m. Listening to music
	<input type="checkbox"/>	d. Receiving shower		<input type="checkbox"/>	n. Being around animals such as pets
	<input type="checkbox"/>	e. Receiving bed bath		<input type="checkbox"/>	o. Keeping up with the news
	<input type="checkbox"/>	f. Receiving sponge bath		<input type="checkbox"/>	p. Doing things with groups of people
	<input type="checkbox"/>	g. Snacks between meals		<input type="checkbox"/>	q. Participating in favorite activities
	<input type="checkbox"/>	h. Staying up past 8:00 p.m.		<input type="checkbox"/>	r. Spending time away from the nursing home
	<input type="checkbox"/>	i. Family or close friend involvement in care discussions		<input type="checkbox"/>	s. Spending time outdoors
	<input type="checkbox"/>	j. Use of phone in private		<input type="checkbox"/>	t. Participating in religious activities or practices
			<input type="checkbox"/>	u. None of the above	



## G1. Activities of Daily Living (ADL) Assistance

Code for most dependent episode in last 5 days:

## Coding:

0. **Independent**—resident completes activity with no help or oversight
1. **Set up assistance**
2. **Supervision**—oversight, encouragement or cueing provided throughout the activity
3. **Limited assistance**—guided maneuvering of limbs or other non-weight bearing assistance provided at least once
4. **Extensive assistance, 1 person assist**—resident performed part of the activity while one staff member provided weight-bearing support or completed part of the activity at least once
5. **Extensive assistance, 2 + person assist**—resident performed part of the activity while two or more staff members provided weight-bearing support or completed part of the activity at least once
6. **Total dependence, 1 person assist**—full staff performance of activity (requiring only 1 person assistance) at least once. The resident must be unable or unwilling to perform any part of the activity.
7. **Total dependence, 2 + person assist**—full staff performance of activity (requiring 2 or more person assistance) at least once. The resident must be unable or unwilling to perform any part of the activity.
8. **Activity did not occur** during entire period

Enter Codes in Boxes

Enter

Code

- a. **Bed mobility** moving to and from lying position, turning side to side and positioning body while in bed.
- b. **Transfer** moving between surfaces—to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet).
- c. **Toilet transfer** how resident gets to and moves on and off toilet or commode.
- d. **Toileting** using the toilet room (or commode, bedpan, urinal); cleaning self after toileting or incontinent episode(s), changing pad, managing ostomy or catheter, adjusting clothes (**excludes** toilet transfer).
- e. **Walk in room** walking between locations in his/her room.
- f. **Walk in facility** walking in corridor or other places in facility.
- g. **Locomotion** moving about facility, with wheelchair if used.
- h. **Dressing upper body** dressing and undressing above the waist, includes prostheses, orthotics, fasteners, pullovers.
- i. **Dressing lower body** dressing and undressing from the waist down, includes prostheses, orthotics, fasteners, pullovers.
- j. **Eating** includes eating, drinking (regardless of skill) or intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids for hydration).
- k. **Grooming/personal hygiene** includes combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** bath and shower).
- l. **Bathing** how resident takes full-body bath/shower, sponge bath and transfers in/out of tub/shower (**excludes** washing of back and hair).

Section

**G**

**Functional Status**

**G2: Mobility Prior to Admission**

Complete only on admission assessment

Enter Code <input type="checkbox"/>	a. Did resident have a <b>hip fracture, hip replacement, or knee replacement</b> in the 30 days prior to this admission? 0. <b>No</b> → Skip to G3, Balance During Transitions and Walking 1. <b>Yes</b> → Complete G2b 9. <b>Unable to determine</b> → Skip to G3, Balance During Transitions and Walking
Check all that apply <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	b. <b>If yes, check all that apply for tasks in which the resident was independent prior to fracture/replacement.</b> 1. <b>Transfer</b> 2. <b>Walk across room</b> 3. <b>Walk 1 block on a level surface</b> 4. <b>Resident was not independent in any of these activities</b> 9. <b>Unable to determine</b>

**G3: Balance During Transitions and Walking**

After observing the resident, code the following walking and transition items for most dependent over the last 5 days:

<b>Coding:</b>  0. <b>Steady at all times</b> 1. <b>Not steady, but able to stabilize without human assistance</b> 2. <b>Not steady, only able to stabilize with human assistance</b> 3. <b>Activity did not occur</b>	Enter Codes in Boxes ↓ → ↓	<table border="1"> <tr> <td style="width: 50px; text-align: center;">                             Enter Code  <input type="checkbox"/> </td> <td>a. <b>Moving from seated to standing position</b></td> </tr> <tr> <td style="text-align: center;">                             Enter Code  <input type="checkbox"/> </td> <td>b. <b>Walking</b> (with assistive device if used)</td> </tr> <tr> <td style="text-align: center;">                             Enter Code  <input type="checkbox"/> </td> <td>c. <b>Turning around</b> and facing the opposite direction while walking</td> </tr> <tr> <td style="text-align: center;">                             Enter Code  <input type="checkbox"/> </td> <td>d. <b>Moving on and off toilet</b></td> </tr> <tr> <td style="text-align: center;">                             Enter Code  <input type="checkbox"/> </td> <td>e. <b>Surface-to-surface transfer</b> (transfer from wheelchair to bed or bed to wheelchair)</td> </tr> </table>	Enter Code <input type="checkbox"/>	a. <b>Moving from seated to standing position</b>	Enter Code <input type="checkbox"/>	b. <b>Walking</b> (with assistive device if used)	Enter Code <input type="checkbox"/>	c. <b>Turning around</b> and facing the opposite direction while walking	Enter Code <input type="checkbox"/>	d. <b>Moving on and off toilet</b>	Enter Code <input type="checkbox"/>	e. <b>Surface-to-surface transfer</b> (transfer from wheelchair to bed or bed to wheelchair)
Enter Code <input type="checkbox"/>	a. <b>Moving from seated to standing position</b>											
Enter Code <input type="checkbox"/>	b. <b>Walking</b> (with assistive device if used)											
Enter Code <input type="checkbox"/>	c. <b>Turning around</b> and facing the opposite direction while walking											
Enter Code <input type="checkbox"/>	d. <b>Moving on and off toilet</b>											
Enter Code <input type="checkbox"/>	e. <b>Surface-to-surface transfer</b> (transfer from wheelchair to bed or bed to wheelchair)											

**G4: Functional limitation in range of motion**

Code for limitation during last 5 days that interfered with daily functions or placed resident at risk of injury.

<b>Coding:</b>  0. <b>No impairment</b> 1. <b>Impairment on one side</b> 2. <b>Impairment on both sides</b>	Enter Codes in Boxes ↓ → ↓	<table border="1"> <tr> <td style="width: 50px; text-align: center;">                             Enter Code  <input type="checkbox"/> </td> <td>a. <b>Lower extremity</b> (hip, knee, ankle, foot)</td> </tr> <tr> <td style="text-align: center;">                             Enter Code  <input type="checkbox"/> </td> <td>b. <b>Upper extremity</b> (shoulder, elbow, wrist, hand)</td> </tr> </table>	Enter Code <input type="checkbox"/>	a. <b>Lower extremity</b> (hip, knee, ankle, foot)	Enter Code <input type="checkbox"/>	b. <b>Upper extremity</b> (shoulder, elbow, wrist, hand)
Enter Code <input type="checkbox"/>	a. <b>Lower extremity</b> (hip, knee, ankle, foot)					
Enter Code <input type="checkbox"/>	b. <b>Upper extremity</b> (shoulder, elbow, wrist, hand)					

## Functional Status

## G5. Gait and Locomotion

Check all that were normally used in the past 5 days:

Check all that apply.


- a. Cane/Crutch
- b. Walker
- c. Wheelchair (manual or electric)
- d. Limb prosthesis
- e. None of the above were used

## G6. Bedfast

Enter  
  
 Code

In bed or in recliner in room for more than 22 hours on at least three of the past 5 days.

0. No
1. Yes

## G7. Functional Rehabilitation Potential

↓ Complete only on admission assessment ↓

Enter  
  
 Code

a. Resident believes s/he is capable of increased independence in at least some ADL's.

0. No
1. Yes
9. Unable to determine

Enter  
  
 Code

b. Direct care staff believe resident is capable of increased independence in at least some ADL's.

0. No
1. Yes

## H1. Urinary Appliances

Check all that applied in last 5 days:

- Check all that apply.
- a. Indwelling bladder catheter
- b. External (condom) catheter
- c. Ostomy (suprapubic catheter, ileostomy)
- d. Intermittent catheterization
- e. None of the above

## H2. Urinary Continence

Enter  Urinary continence in last 5 days. Select the one category that best describes the resident over the last 5 days:

- Code
0. Always continent
1. Occasionally incontinent (less than 5 episodes of incontinence)
2. Frequently incontinent (5 or more episodes of incontinence but at least one episode of continent voiding)
3. Always incontinent (no episodes of continent voiding)
9. Not rated, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for entire 5 days

## H3. Urinary Incontinence Management

Enter  a. Has a trial of a toileting program (e.g. scheduled toileting, prompted voiding, or bladder training) been attempted on admission or since urinary incontinence was noted in this facility?

- Code
0. No → Skip to Item H4, Bowel Continence
1. Yes
9. Unable to determine

Enter  b. Response—What was the resident's response to the trial program?

- Code
0. No improvement
1. Decreased wetness
2. Completely dry (continent)
9. Unable to determine

Enter  c. Current toileting program—Is a toileting program currently being used to manage the resident's urinary incontinence?

- Code
0. No
1. Yes

## H4. Bowel Continence

Enter  Bowel continence in last 5 days. Select the one category that best describes the resident over the last 5 days:

- Code
0. Always continent
1. Occasionally incontinent (one episode of bowel incontinence)
2. Frequently incontinent (2 or more episodes of bowel incontinence but at least one continent bowel movement)
3. Always incontinent (no episodes of continent bowel movements)
9. Not rated, resident had an ostomy or did not have a bowel movement for the entire 5 days

## H5. Bowel Patterns

Enter  Constipation present in the past 5 days?

- Code
0. No
1. Yes

## Active Disease Diagnosis

## Active Diseases in the last 30 days

## Cancer

1. **Cancer** (with or without metastasis)

## Heart/Circulation

2. **Anemia** (includes aplastic, iron deficiency, pernicious, and sickle cell)
3. **Atrial Fibrillation and Other Dysrhythmias** (includes bradycardias, tachycardias)
4. **Coronary Artery Disease** (includes angina, myocardial infarction)
5. **Deep Venous Thrombosis/ Pulmonary Embolus**
6. **Heart Failure** (includes pulmonary edema)
7. **Hypertension**
8. **Peripheral Vascular Disease/Peripheral Arterial Disease**
9. **Other Heart/ Circulation:** enter diagnosis and ICD-9: \_\_\_\_\_

## Gastrointestinal

10. **Cirrhosis**
11. **GERD/Ulcer** (includes esophageal, gastric, and peptic ulcers)
12. **Ulcerative Colitis/ Crohn's Disease/Inflammatory Bowel Disease**
13. **Other Gastrointestinal:** enter diagnosis and ICD-9: \_\_\_\_\_

## Genitourinary

14. **Benign Prostatic Hyperplasia**
15. **Renal Insufficiency**
16. **Other Genitourinary:** enter diagnosis and ICD-9: \_\_\_\_\_

## Infections

17. **Human Immunodeficiency Virus (HIV) Infection** (includes AIDS)
18. **MRSA, VRE, Clostridium diff. Infection / Colonization**
19. **Pneumonia**
20. **Tuberculosis**
21. **Urinary Tract Infection**
22. **Viral Hepatitis** (includes Hepatitis A, B, C, D, and E)
23. **Wound Infection**
24. **Other Infections:** enter diagnosis and ICD-9: \_\_\_\_\_

## Metabolic

25. **Diabetes Mellitus** (includes diabetic retinopathy, nephropathy, and neuropathy)
26. **Hyponatremia**
27. **Hyperkalemia**
28. **Hyperlipidemia**
29. **Thyroid Disorder** (includes hypothyroidism, hyperthyroidism, and Hashimoto's thyroiditis)
30. **Other Metabolic:** enter diagnosis and ICD-9: \_\_\_\_\_

## Musculoskeletal

31. **Arthritis** (Degenerative Joint Disease, Osteoarthritis, and Rheumatoid Arthritis)
32. **Osteoporosis**
33. **Hip Fracture** (includes any hip fracture that continues to have a relationship to current status, treatments, monitoring. Includes sub-capital fractures, fractures of the trochanter and femoral neck) (last 90 days)
34. **Other Fracture**
35. **Other Musculoskeletal:** enter diagnosis and ICD-9: \_\_\_\_\_

## Neurological

36. **Alzheimer's Disease**
37. **Aphasia**
38. **Cerebral Palsy**
39. **CVA/TIA/ Stroke**
40. **Dementia** (Non-Alzheimer's dementia, including vascular or multi-infarct dementia, mixed dementia, frontotemporal dementia (e.g., Pick's disease), and dementia related to stroke, Parkinson's, Huntington's, Pick's, or Creutzfeldt-Jakob diseases)
41. **Hemiplegia/Hemiparesis/Paraplegia/Quadriplegia**
42. **Multiple Sclerosis**
43. **Parkinson's Disease**
44. **Seizure Disorder**
45. **Traumatic Brain Injury**
46. **Other Neurological:** enter diagnosis and ICD-9: \_\_\_\_\_

## Nutritional

47. **Protein Calorie Malnutrition** or at risk for malnutrition
48. **Other Nutritional:** enter diagnosis and ICD-9: \_\_\_\_\_

## Psychiatric/Mood Disorder

49. **Anxiety Disorder**
50. **Depression** (other than Bipolar)
51. **Manic Depression** (Bipolar Disease)
52. **Schizophrenia**
53. **Other Psychiatric/Mood Disorder:** enter diagnosis and ICD-9: \_\_\_\_\_

## Pulmonary

54. **Asthma/ COPD Chronic Lung Disease** (includes restrictive lung diseases such as asbestosis and chronic bronchitis)
55. **Other Pulmonary:** enter diagnosis and ICD-9: \_\_\_\_\_

## Other

56. **Note Additional Diagnoses:** enter diagnosis and ICD-9: \_\_\_\_\_  
ICD-9: \_\_\_\_\_  
ICD-9: \_\_\_\_\_  
ICD-9: \_\_\_\_\_  
ICD-9: \_\_\_\_\_

Check all that apply.

## Section

## J

## Health Conditions

**J1: Pain Management** (answer for all residents, regardless of current pain level)

At any time in the last 5 days, has the resident:

- |                                   |   |
|-----------------------------------|---|
| Enter<br><input type="checkbox"/> | <b>a. Been on a scheduled pain medication regimen?</b><br>0. No<br>1. Yes   |
| Code<br><input type="checkbox"/>  |   |
| Enter<br><input type="checkbox"/> | <b>b. Received PRN pain medications?</b><br>0. No<br>1. Yes                 |
| Code<br><input type="checkbox"/>  |   |
| Enter<br><input type="checkbox"/> | <b>c. Received non-medication intervention for pain?</b><br>0. No<br>1. Yes |
| Code<br><input type="checkbox"/>  |   |

**Pain Assessment Interview**—All residents should be asked about pain. Complete J2–J7 for all residents who are capable of any communication (B5 is coded 0, 1, or 2), and for whom an interpreter is present or not required.

**J2: Interview Attempted**

- |                                   |  |
|-----------------------------------|--|
| Enter<br><input type="checkbox"/> | 0. <b>No</b> (resident is rarely/never understood or needed interpreter is not present) → Skip to J9, Staff Assessment of Pain |
| Code<br><input type="checkbox"/>  | 1. <b>Yes</b>  |

**J3: Pain Presence**

- |                                   |   |
|-----------------------------------|---|
| Enter<br><input type="checkbox"/> | Ask resident: <b>"Have you had pain or hurting at any time in the last 5 days?"</b> |
| Code<br><input type="checkbox"/>  | 0. <b>No</b> → Skip to J8, Interview Completed                                      |
|                                   | 1. <b>Yes</b> → Proceed to items J4–J8 below  |
|                                   | 9. <b>Unable to answer</b> → Skip to J8, Interview Completed                        |

**J4: Pain Frequency**

- |                                   |  |
|-----------------------------------|--|
| Enter<br><input type="checkbox"/> | Ask resident: <b>"How much of the time have you experienced pain or hurting over the last 5 days?"</b> |
| Code<br><input type="checkbox"/>  | 1. <b>Almost constantly</b>  |
|                                   | 2. <b>Frequently</b>   |
|                                   | 3. <b>Occasionally</b>   |
|                                   | 4. <b>Rarely</b>   |
|                                   | 9. <b>Unable to answer</b>   |

**J5: Pain Effect on Function**

- |                                   |   |
|-----------------------------------|---|
| Enter<br><input type="checkbox"/> | <b>a.</b> Ask resident: <b>"Over the past 5 days, has pain made it hard for you to sleep at night?"</b>             |
| Code<br><input type="checkbox"/>  | 0. <b>No</b>  |
|                                   | 1. <b>Yes</b>   |
|                                   | 9. <b>Unable to answer</b>  |
| Enter<br><input type="checkbox"/> | <b>b.</b> Ask resident: <b>"Over the past 5 days, have you limited your day-to-day activities because of pain?"</b> |
| Code<br><input type="checkbox"/>  | 0. <b>No</b>  |
|                                   | 1. <b>Yes</b>   |
|                                   | 9. <b>Unable to answer</b>  |



## Section

## J

## Health Conditions

J6. Pain Intensity—Administer **one** of the following pain intensity questions (a or b)

Administer one scale

  
Code

## a. Verbal Descriptor Scale

Ask resident: "Please rate the intensity of your worst pain over the last 5 days" (Show resident verbal scale.)

1. *Mild*
2. *Moderate*
3. *Severe*
4. *Very severe, horrible*
9. *Unable to answer or not attempted*

  
Enter Number

## b. Numeric Rating Scale (00–10)

Ask resident:

"Please rate your worst pain over the last 5 days on a zero to ten scale with zero being no pain and ten as the worst pain you can imagine."

(Show resident 0–10 pain scale.)

**Enter two-digit response. Enter 99 if unable to answer or not attempted.**

## c. Indicate which Pain Intensity question was administered.

  
Code

1. **Verbal Descriptor Scale only**
2. **Numeric Rating Scale (00–10) only**
3. **Both were tried and one scale completed**
9. **Both were tried, and neither scale completed**

## J7. Pain Treatment Goals

  
Code

Ask resident: "In your opinion, how important is it for your pain treatment to **completely eliminate** your pain?"

1. *Extremely important*
2. *Very important*
3. *Somewhat important*
4. *Not at all important*
9. *Unable to answer*

## J8. Skip Item: Interview Completed

  
Code

0. **No** (Resident was unable to answer whether pain was present in J3, or unable to answer 3 or more pain descriptors in Items J4–J7) → Proceed to J9, Staff Assessment for Pain
1. **Yes** → Skip to J10, Shortness of Breath

## Staff Assessment for Pain

## J9. Staff Assessment for Pain—Complete only if pain interview (J2–J8) not completed

Indicators of pain or possible pain in the last 5 days. Check all that apply:

- |                      |                          |  |
|----------------------|--------------------------|--|
| Check all that apply | <input type="checkbox"/> | a. <b>Non-verbal sounds</b> (crying, whining, gasping, moaning, or groaning)   |
|                      | <input type="checkbox"/> | b. <b>Vocal complaints of pain</b> (that hurts, ouch, stop)  |
|                      | <input type="checkbox"/> | c. <b>Facial expressions</b> (grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)   |
|                      | <input type="checkbox"/> | d. <b>Protective body movements or postures</b> (bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement) |
|                      | <input type="checkbox"/> | e. <b>None of these signs observed or documented</b>   |



## Section

J

## Health Conditions

## Other Health Conditions

## J10. Shortness of Breath (dyspnea)

Select all that apply in last 5 days:

- Check all that apply
- a. Shortness of breath or trouble breathing with exertion (e.g. walking, bathing, transferring)
- b. Shortness of breath or trouble breathing when sitting at rest
- c. Shortness of breath or trouble breathing when lying flat
- d. None of the above

## J11. Cough Present

Enter: Cough present in last 5 days.

- Code: 0. No
1. Yes

## J12. Chest Pain or Angina

Select all that apply in last 5 days:

- Check all that apply
- a. Chest pain or angina with exertion (e.g. walking, bathing, transferring)
- b. Chest pain or angina when sitting or at rest
- c. None of the above

## J13. Current Tobacco Use

Enter: Tobacco use in last 5 days.

- Code: 0. No
1. Yes

## J14. Prognosis

Enter: Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?**

Requires physician documentation. If not documented, discuss with physician and request supporting documentation)

- Code: 0. No
1. Yes

## Health Conditions

## Falls Assessment

## J15. Skip/Item for Falls: Admission or Follow-up

Enter  
Code

What assessment type are you completing?

1. **Admission assessment** → Complete J16, Fall History (Admission)
2. **Follow-up assessment (quarterly or annual)** → Skip to J17, Any Falls Since Last Assessment

## J16. Fall History (Admission)

↓ Complete J16a-d only on Admission Assessment ↓

Enter  
Code

a. Did the resident fall one or more times in the **30 days** (i.e., month) before admission?

0. No
1. Yes
9. Unable to determine

Enter  
Code

b. Did the resident fall one or more times in the **31–180 days** (i.e., 1–6 months) before admission?

0. No
1. Yes
9. Unable to determine

Enter  
Code

c. Did the resident have any **fracture related to a fall** in the **6 months** prior to admission?

0. No
1. Yes
9. Unable to determine

Enter  
Code

d. Has the resident **fallen since admission** to the nursing home?

0. No → Skip to Section K, Swallowing
1. Yes → Skip to Section K, Swallowing

## J17. Any Falls Since Last Assessment (Quarterly or Annual Assessment)

↓ Complete J17 only on Quarterly or Annual Assessment ↓

Enter  
Code

Has the resident **had any falls since the last assessment**?

0. No → Skip to Section K, Swallowing
1. Yes

## J18. Number of Falls Since Last Assessment (Quarterly or Annual Assessment)

↓ Complete only on Quarterly or Annual Assessment ↓

Code the number of falls in each category since the last assessment.

## Coding:

0. None
1. One
2. Two or more

Enter Codes in Boxes ↓

Enter  
Code

a. **No injury**—no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall

Enter  
Code

b. **Injury (except major)**—skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain

Enter  
Code

c. **Major injury**—bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

## Swallowing/Nutritional Status

## K1: Swallowing Disorder

Signs and symptoms of possible swallowing disorder. Check all that applied in last 5 days:

- |                       |                          |   |
|-----------------------|--------------------------|---|
| Check all that apply. | <input type="checkbox"/> | a. Loss of liquids/solids from mouth when eating or drinking          |
|                       | <input type="checkbox"/> | b. Holding food in mouth/cheeks or residual food in mouth after meals |
|                       | <input type="checkbox"/> | c. Coughing or choking during meals or when swallowing medications    |
|                       | <input type="checkbox"/> | d. Complaints of difficulty or pain with swallowing                   |
|                       | <input type="checkbox"/> | e. None of the above  |

## K2: Height and Weight

- |  |  |
|--|--|
| <input type="text"/><br><input type="text"/><br>inches                         | a. <b>Height</b> (in inches) most recent height measure since admission. (If height includes a fraction, round up to nearest inch.)  |
| <input type="text"/><br><input type="text"/><br><input type="text"/><br>pounds | b. <b>Weight</b> (in pounds) base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc). (If weight includes a fraction, round up to nearest pound.) |

## K3: Weight Loss

- |                                       |  |
|---------------------------------------|--|
| Enter<br><input type="text"/><br>Code | <b>Loss of 5% or more in last 30 days</b> (or since last assessment if sooner) <b>or loss of 10% or more in last 180 days.</b><br>0. No or unknown<br>1. Yes, planned loss<br>2. Yes, unplanned loss |
|---------------------------------------|--|

## K4: Nutritional Approaches

Check all that applied in last 5 days:

- |                       |                          |  |
|-----------------------|--------------------------|--|
| Check all that apply. | <input type="checkbox"/> | a. Parenteral/IV feeding   |
|                       | <input type="checkbox"/> | b. Feeding-tube—nasogastric or abdominal (PEG)   |
|                       | <input type="checkbox"/> | c. Mechanically altered diet—require change in texture of food or liquids (e.g., pureed food, thickened liquids) |
|                       | <input type="checkbox"/> | d. Therapeutic diet (low salt, diabetic, low cholesterol)  |
|                       | <input type="checkbox"/> | e. None of the above   |

## K5: Percent Intake by Artificial Route → Skip to Section L, Oral/Dental Status, if neither K4a or K4b is checked

- |                                       |   |
|---------------------------------------|---|
| Enter<br><input type="text"/><br>Code | a. <b>Proportion of total calories the resident received through parenteral or tube feedings</b> in the last 5 days.<br>1. 25% or less<br>2. 26–50%<br>3. 51% or more |
| Enter<br><input type="text"/><br>Code | b. <b>Average fluid intake per day by IV or tube</b> in last 5 days.<br>1. 500 cc/day or less<br>2. 501 cc/day or more  |

# Oral/Dental Status

## L1: Dental

Check all that applied in last 5 days:

Check all that apply.


- a. **Broken or loosely fitting denture or partial** (chipped, cracked, uncleanable, or loose)
- b. **No natural teeth or tooth fragment(s)** (edentulous)
- c. **Abnormal mouth tissue** (ulcers, masses, oral lesions, including under denture or partial if one is worn)
- d. **Obvious cavity or broken natural teeth**
- e. **Inflamed or bleeding gums or loose natural teeth**
- f. **Mouth or facial pain, discomfort or difficulty with chewing**
- g. **None of the above** were present
- h. **Unable to examine**

**M1. Current Pressure Ulcer**

Enter

**Did the resident have a pressure ulcer in the last 5 days?**

0. No → Skip to M11, Healed Pressure Ulcers, Page 26

1. Yes

Code

**M2. Stage 1 Ulcers**

Report based on highest stage of existing ulcer(s) at its worst; do not reverse stage.

Enter

**Number of existing pressure ulcers at Stage 1**—Observable pressure-related alteration of an area of intact skin whose indicators may include change in: skin temperature (warm or cool), tissue consistency (firm or boggy feel), or sensation (pain, itching). In lightly pigmented skin, appears as an area of persistent redness. In darker skin tones, may appear with persistent red, blue, or purple hues.

Number

**M3. Stage 2 Ulcers**

Report based on highest stage of existing ulcer(s) at its worst; do not reverse stage.

Enter

Number

**a. Number of existing pressure ulcers at Stage 2**—Partial thickness skin loss involving epidermis, dermis, or both. The ulcer presents clinically as an abrasion, blister, or shallow crater. **If number entered = 0 → Skip to M4, Stage 3 ulcers.**

Enter

Number

**b. Number of these Stage 2 pressure ulcers that were present on admission.** Of the pressure ulcers listed in M3a, how many were first noted at Stage 2 within 48 hours of admission and not acquired in the facility?

Length (cm)

**c. Current dimensions of largest Stage 2 pressure ulcer.**  
Enter 99.9 if unable to determine (for study purposes only).

Width (cm)

**M4. Stage 3 Ulcers**

Report based on highest stage of existing ulcer(s) at its worst; do not reverse stage.

Enter

Number

**a. Number of existing pressure ulcers at Stage 3**—Full thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. **If number entered = 0 → Skip to M5, Stage 4 ulcers.**

Enter

Number

**b. Number of these Stage 3 pressure ulcers that were present on admission.** Of the pressure ulcers listed in M4a, how many were first noted at Stage 3 within 48 hours of admission and not acquired in the facility?

Length (cm)

**c. Current dimensions of largest Stage 3 pressure ulcer.**  
Enter 99.9 if unable to determine (for study purposes only).

Width (cm)

Depth (cm)

**M5. Stage 4 Ulcers**

Report based on highest stage of existing ulcer(s) at its worst; do not reverse stage.

Enter

Number

**a. Number of existing pressure ulcers at Stage 4**—Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint, capsule). Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers. **If number entered = 0 → Skip to M6, Nonstageable ulcers.**

Enter

Number

**b. Number of these Stage 4 pressure ulcers that were present on admission.** Of the pressure ulcers listed in M5a, how many were first noted at Stage 4 within 48 hours of admission and not acquired in the facility?

Length (cm)

**c. Current dimensions of largest Stage 4 pressure ulcer.**  
Enter 99.9 if unable to determine (for study purposes only).

Width (cm)

Depth (cm)

## M6. Nonstageable Ulcers

Enter

Number  
Enter

Number  
Enter

- a. **Not Stageable**—Cannot be observed due to presence of eschar that is intact and fully adherent to edges of wound or wound covered with non-removable dressing/cast and no prior staging known.
- b. **Number of these nonstageable pressure ulcers that were present on admission.** Of the pressure ulcers listed in M6a, how many were first noted as nonstageable within 48 hours of admission and not acquired in the facility?

## M7. Exudate Amount for Most Advanced Stage

Enter

Code  
Enter

- Select the item that best describes the **amount of exudate in the largest pressure ulcer at the most advanced stage.**
0. **None**
  1. **Light**
  2. **Moderate**
  3. **Heavy**
  9. **Not observable/not documented**

## M8. Tissue Type for Most Advanced Stage

Enter

Code  
Enter

- Select the item that best describes the **type of tissue present in the ulcer bed of the largest pressure ulcer at the most advanced stage.**
0. **Closed/resurfaced**—completely covered with epithelium
  1. **Epithelial Tissue** —new skin growing in superficial ulcer
  2. **Granulation Tissue** —pink or red tissue with shiny, moist, granular appearance
  3. **Slough**—yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous
  4. **Necrotic Tissue (Eschar)** —black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin.
  9. **Not observable/not documented**

## M9. Data Source for Current Pressure Ulcer items (M2–M8)

This item is for study/analysis purposes; not for consideration for MDS 3.0.

Enter

Code  
Enter

- Select the **data source** used for information on pressure ulcers.
1. **Research nurse direct observation with facility nurse**
  2. **Facility nurse completing MDS 3.0 assessment**
  3. **Chart review**

## M10. Worsening in Pressure Ulcer Status Since Last Assessment

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on last MDS (if no current pressure ulcer at a given stage, enter 0).

Enter

Number  
Enter

Number  
Enter

Number  
Enter

- a. **Check here if N/A** (no prior assessment)
- b. **Stage 2**
- c. **Stage 3**
- d. **Stage 4**

Section

**M**

**Skin Conditions**

**M11: Healed Pressure Ulcers**

Indicate the number of pressure ulcers that were noted on last MDS that have **completely healed**. (If no current pressure ulcer at a given stage, enter 0).

<input type="checkbox"/>	<b>a. Check here if N/A</b> (no prior assessment or no pressure ulcers on prior assessment)
Enter <input type="text"/>	<b>b. Stage 2</b>
Number Enter <input type="text"/>	<b>c. Stage 3</b>
Number Enter <input type="text"/>	<b>d. Stage 4</b>

**M12: Other Ulcers, Wounds, and Skin Problems**

Check all that apply in the past 5 days:

Check all that apply.	<input type="checkbox"/>	<b>a. Venous or arterial ulcer(s)</b>
	<input type="checkbox"/>	<b>b. Diabetic foot ulcer(s)</b>
	<input type="checkbox"/>	<b>c. Other foot or lower extremity infection</b> (cellulitis)
	<input type="checkbox"/>	<b>d. Surgical wound(s)</b>
	<input type="checkbox"/>	<b>e. Open lesion(s) other than ulcers, rashes, cuts</b> (e.g., cancer lesion)
	<input type="checkbox"/>	<b>f. Burn(s)</b>
	<input type="checkbox"/>	<b>g. None of the above</b> were present

**M13: Skin Treatments**

Check all that apply in the past 5 days:

Check all that apply.	<input type="checkbox"/>	<b>a. Pressure reducing device for chair</b>
	<input type="checkbox"/>	<b>b. Pressure reducing device for bed</b>
	<input type="checkbox"/>	<b>c. Turning/repositioning program</b>
	<input type="checkbox"/>	<b>d. Nutrition or hydration intervention</b> to manage skin problems
	<input type="checkbox"/>	<b>e. Ulcer care</b>
	<input type="checkbox"/>	<b>f. Surgical wound care</b>
	<input type="checkbox"/>	<b>g. Application of dressings</b> (with or without topical medications) other than to feet
	<input type="checkbox"/>	<b>h. Applications of ointments/medications</b> other than to feet
	<input type="checkbox"/>	<b>i. None of the above</b> were provided

## Medications

## N1. Injections

Days

Record the **number of days that injectable medications were received** during the last 5 days or since admission if less than 5 days.

## N2. Medications Received

**Check all medications the resident received** at any time during the last 5 days or since admission if less than 5 days:

- |                      |                          |   |
|----------------------|--------------------------|---|
| Check all that apply | <input type="checkbox"/> | a. Antipsychotic  |
|                      | <input type="checkbox"/> | b. Antianxiety  |
|                      | <input type="checkbox"/> | c. Antidepressant   |
|                      | <input type="checkbox"/> | d. Hypnotic   |
|                      | <input type="checkbox"/> | e. Anticoagulant (warfarin, heparin, or low-molecular weight heparin) |
|                      | <input type="checkbox"/> | f. None of the above  |

# Special Treatments and Procedures

01. Special Treatments and Programs		
	↓ Complete for all Assessments ↓ I. Past 5 days, or since admission if less than 5 days	↓ Complete only for ↓ 5-day Assessment II. In 5 days prior to admission
		Check here if not a 5-day assessment: <input type="checkbox"/> → Skip this column
<b>Cancer Treatment</b>		
a. Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
b. Radiation	<input type="checkbox"/>	<input type="checkbox"/>
<b>Respiratory Treatments</b>		
c. Oxygen therapy	<input type="checkbox"/>	<input type="checkbox"/>
d. Suctioning	<input type="checkbox"/>	<input type="checkbox"/>
e. Tracheostomy care	<input type="checkbox"/>	<input type="checkbox"/>
f. Ventilator or respirator	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other</b>		
g. IV medications	<input type="checkbox"/>	<input type="checkbox"/>
h. Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
i. Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
j. Hospice care	<input type="checkbox"/>	<input type="checkbox"/>
k. Respite care	<input type="checkbox"/>	<input type="checkbox"/>
l. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)	<input type="checkbox"/>	<input type="checkbox"/>
m. None of the above	<input type="checkbox"/>	<input type="checkbox"/>

Check all that apply

**02. Influenza Vaccine**

Enter  Code

a. Did the resident receive the Influenza Vaccine in this facility for this year's influenza season (October 1 through March 31)?

0. No

1. Yes → Skip to O3, Pneumococcal Vaccine

9. Does not apply because assessment outside influenza season → Skip to O3, Pneumococcal Vaccine

Enter  Code

b. If Influenza Vaccine not received, state reason:

1. Not in facility during this year's flu season

2. Received outside of this facility

3. Not eligible

4. Offered and declined

5. Not offered

6. Inability to obtain vaccine due to declared shortage

7. None of the above

**03. Pneumococcal Vaccine**

Enter  Code

a. Is the resident's Pneumococcal Vaccine status up to date?

0. No

1. Yes → Skip to O4, Therapies

Enter  Code

b. If Pneumococcal Vaccine not received, state reason:

1. Not eligible

2. Offered and declined

3. Not offered

4. Vaccine status not up to date by admission ARD

# Special Treatments and Procedures

## 04. Therapies

Record the **number of days** each of the following therapies was administered for at least 15 minutes a day in the last 5 calendar days (column I). Enter 0 if none or less than 15 minutes daily. For Therapies a–c also record the total number of minutes (column II). Note: Count only post admission therapies.

I: Days	II: Minutes	
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	a. Speech-language pathology and audiology services
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	b. Occupational Therapy
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	c. Physical Therapy
<input type="text"/>		d. Respiratory Therapy
<input type="text"/>		e. Psychological Therapy (by any licensed mental health professional)
<input type="text"/>		f. Recreational Therapy (includes recreational and music therapy)

## 05. Nursing Rehabilitation/Restorative Care

Record the **number of days** each of the following rehabilitative or restorative techniques was administered (for at least 15 minutes a day) in the last 5 calendar days (enter 0 if none or less than 15 minutes daily).

Number of Days	
<input type="text"/>	a. Range of motion (passive)
<input type="text"/>	b. Range of motion (active)
<input type="text"/>	c. Splint or brace assistance
	Training and skill practice in:
<input type="text"/>	d. Bed mobility
<input type="text"/>	e. Transfer
<input type="text"/>	f. Walking
<input type="text"/>	g. Dressing or grooming
<input type="text"/>	h. Eating or swallowing
<input type="text"/>	i. Amputation/prostheses care
<input type="text"/>	j. Communication

## 06. Physician Examinations

Days

Over the last 5 days, on how many days did the physician (or authorized assistant or practitioner) examine the resident?

## 07. Physician Orders

Days

Over the last 5 days, on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?

# Restraints

## P1 Physical Restraints

Physical restraints are any manual method, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. Code for last 5 days:

<p><b>Coding:</b></p> <p>0. Not used</p> <p>1. Used less than daily</p> <p>2. Used daily</p>	↓ Enter Codes in Boxes ↓	Enter <input type="checkbox"/> Code	<b>Used in Bed</b>	
		a. Full bed rails on all open sides of the bed		
		b. Other type of side rail used (e.g., half rail, one side)		
		c. Trunk restraint		
		d. Limb restraint		
		e. Other		
		<b>Used in Chair or Out of Bed</b>		
		f. Trunk restraint		
		g. Limb restraint		
		h. Chair prevents rising		
i. Other				

# Participation in Assessment and Goal Setting

## Q1. Participation in Assessment

Enter

Code

a. Resident

0. No

1. Yes

Enter

Code

b. Family

0. No

1. Yes

9. No family

Enter

Code

c. Significant other

0. No

1. Yes

9. None

## Q2. Resident's Overall Goals

↓ Complete only on Admission Assessment ↓

Enter

Code

a. Select one for resident's goals established during assessment process.

1. Post acute care—expects to return to community

2. Post acute care—expects to have continued NH needs

3. Respite stay—expects to return home

4. Other reason for admit—expects to return to community.

5. Long term care for medical, functional, and/or cognitive impairments

6. End-of-life care

9. Unknown or uncertain

Enter

Code

b. Indicate information source for this item

1. Resident

2. Close family member or significant other

3. Neither

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Room 352-G  
200 Independence Avenue, SW  
Washington, DC 20201



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## CMS NEWS

FOR IMMEDIATE RELEASE  
August 27, 2013

Contact: CMS Media Relations  
(202) 690-6145

### **New data show antipsychotic drug use is down in nursing homes nationwide**

Nursing homes are using antipsychotics less and instead pursuing more patient-centered treatment for dementia and other behavioral health care, according to new data released on Nursing Home Compare in July by the Centers for Medicare & Medicaid Services (CMS).

Unnecessary antipsychotic drug use is a significant challenge in dementia care. CMS data show that in 2010 more than 17 percent of nursing home patients had daily doses exceeding recommended levels. In response to these trends, CMS launched the National Partnership to Improve Dementia Care in 2012.

“This important partnership to improve dementia care in nursing homes is yielding results,” said Dr. Patrick Conway, CMS chief medical officer and director of the Center for Clinical Standards and Quality. “We will continue to work with clinicians, caregivers, and communities to improve care and eliminate harm for people living with dementia.”

The Partnership’s goal is to reduce antipsychotic drug usage by 15 percent by the end of 2013. These new data show that the Partnership’s work is making a difference:

- The national prevalence of antipsychotic use in long stay nursing home residents has been reduced by 9.1 percent by the first quarter of 2013, compared to the last quarter of 2011.
- There are approximately 30,000 fewer nursing home residents on these medications now than if the prevalence had remained at the pre-National Partnership level.
- At least 11 states have hit or exceeded a 15 percent target and others are quickly approaching that goal. The states that have met or exceeded the target are: Alabama, Delaware, Georgia, Kentucky, Maine, North Carolina, Oklahoma, Rhode Island, South Carolina, Tennessee and Vermont.

The Partnership aims to reduce inappropriate use of antipsychotics in several ways – including enhanced training for nursing home providers and state surveyors; increased transparency by

making antipsychotic use data available online at [Nursing Home Compare](#); and highlighting alternate strategies to improve dementia care.

Since its launch in early 2012, the goal of the Partnership has been to improve quality of care and quality of life for the country's 1.5 million nursing home residents. This broad-based coalition includes long-term care providers, caregivers and advocates, medical and quality improvement experts, government agencies, and consumers.

For more information on the Partnership's efforts to reduce use of antipsychotic drugs in nursing homes, please visit the Advancing Excellence in America's Nursing Homes website: [http://www.nhqualitycampaign.org/star\\_index.aspx?controls=MedicationsExploreGoal](http://www.nhqualitycampaign.org/star_index.aspx?controls=MedicationsExploreGoal).

###



**Oklahoma State Department of Health**  
Creating a State of Health

**Health Resource Development Service**  
Oklahoma National Background Check Program



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Walter@health.ok.gov - Susand@health.ok.gov  
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<http://onbc.health.ok.gov>

**Effective Dates: all may start as of Feb. 1, 2014**

Must Comply by **March 1, 2014:**

- Adult Day Care Centers
- Residential Care Homes

Must Comply by **April 1, 2014:**

- Specialized Nursing Facilities (ICF/IID and ICF/AD)

Must Comply by **May 1, 2014:**

- Applicants for employment with DHS and OSDH working inside LTCFs
- Nursing Facilities

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**Effective Dates: all may start as of Feb. 1, 2014**

Must Comply by **June 1, 2014:**

- Continuum of Care and Assisted Living facilities
- Hospice programs

Must Comply by **July 1, 2014:**

- Medicare Certified Home Care Agencies

Must Comply by **August 1, 2014:**

- All other employers defined in Title 63 O.S. § 1-1945(4)

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**Other Effective Dates**

- For Nurse Aide Scholarship Programs operated under contract with the OHCA: may begin July 1, required by August 1, 2014.
- Staffing agencies and independent contractors must match the compliance of the contracted employer.
- Medicaid HCBS waived providers as defined in Section 1915(c) or 1915(i) of the SSA may voluntarily participate in the submission of fingerprints for applicants. Instead:
  - a name-based check from the OSBI
  - fee established in Section 150.9 of Title 74 (currently \$15)
  - determination of employment eligibility made by providers based on new barrier criteria

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## Oklahoma National Background Check Program 2014 Schedule of Trainings, Presentations and Attendance as of 1/6/2014

### Training Events - Scheduled & Tentative

Date	Time	Duration	Organization	Venue	Town/City	Capacity
Wednesday, January 15, 2014	10:00am	1 Hour		Wes Watkins Career Tech	Wetumka	10
Tuesday, January 21, 2014	8:00am	4 Hours		Francis Tuttle Rockwell Campus	Oklahoma City	100
Thursday, January 23, 2014	9:00am	4 Hours		South Oklahoma Technical Center	Ardmore	60
Monday, February 03, 2014	TBD	TBD		Northeast Technology Center	Afton	100

### Conference Participations Planned

Date	Time	Duration	Organization	Venue	Town/City	Capacity
March 11-12, 2014	TBD	TBD	Leading Age Oklahoma	Reed Conference Center	Midwest City	
Tuesday, March 25, 2014	10:00am	1 Hour	Tulsa RC Conference	TBD	Tulsa	Unk.
May 5-7, 2014	9:00am		OAHCP/OKALA	Embassy Suites Norman	Norman	Unk.
May 20-22, 2014			Inspired Living Conference	Embassy Suites Norman		



Nurse Aide Registry

Oklahoma State  
Department of Health

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## **Nurse Aide Registry Statistics**

**Prepared for**

**Long Term Advisory Board**

**Wednesday, January 10, 2014**

**Vicki Kirtley, Director  
Nurse Aide Registry**

**For questions regarding:  
Nurse Aide Registry, call (405) 271- 5124**

**Long Term Care Advisory Board Meeting  
Nurse Aide Registry Activity Report  
Second Quarter FY 2014  
October 1, 2013 to December 31, 2013**



**New Advanced CMA Training Endorsements**

<b>Added Per Quarter</b>	<b>CMA Respiratory</b>	<b>CMA Gastrostomy</b>	<b>CMA Glucose Monitor</b>	<b>CMA Insulin Administration</b>	<b>Total Certifications &amp; Registrations</b>
<b>1<sup>st</sup></b>	<b>133</b>	<b>127</b>	<b>54</b>	<b>43</b>	<b>357</b>
<b>2<sup>nd</sup></b>	<b>80</b>	<b>76</b>	<b>37</b>	<b>33</b>	<b>226</b>
<b>3<sup>rd</sup></b>					
<b>4<sup>th</sup></b>					
<b>Totals</b>	<b>213</b>	<b>203</b>	<b>91</b>	<b>76</b>	<b>583</b>

CMA's with Advance CMA training do not receive an additional Certification. The State regulation do not require that a notation of the advanced training be entered on the Nurse Aide Registry

**New Feeding Assistants**

<b>Added Per Quarter</b>	<b>Feeders Assistants</b>
<b>1<sup>st</sup></b>	<b>47</b>
<b>2<sup>nd</sup></b>	<b>55</b>
<b>3<sup>rd</sup></b>	
<b>4<sup>th</sup></b>	
<b>Totals</b>	<b>102</b>

Feeding Assistants are registered versus certified.

Long Term Care Advisory Board Meeting  
 Nurse Aide Registry Activity Report  
 Second Quarter FY 2014  
 October 1, 2013 to December 31, 2013



Nurse Aide Registry  
 Oklahoma State  
 Department of Health

**Count of Certificates by Type**

Types of Certifications	Unexpired Certifications	Certifications Eligible for Renewal	Total Certifications
ADC	26	171	197
LTC	40,026	77,721	117,752
CMA	5,560	14,473	20,039
CMA Gastro	2,259	1,578	3,837
CMA GM	797	370	1,169
CMA IA	572	290	864
CMA R	2,362	1,641	4,004
Feeding Assistant	558	1,160	1,718
HHA	15,445	35,187	50,633
DDCA	2,093	8,430	10,525
RCA	128	954	1,082
<b>TOTAL</b>	<b>69,826</b>	<b>141,975</b>	<b>211,825</b>

**Substantiated Abuse - Long Term Care Aides**

Added Per Quarter	Physical	Sexual	Verbal	Mistreatment	Neglect	Misappropriation of Property	Total
1 <sup>st</sup>	0	0	0	0	2	7	9
2 <sup>nd</sup>	1				3	3	7
3 <sup>rd</sup>							
4 <sup>th</sup>							
<b>TOTAL</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>5</b>	<b>10</b>	<b>9</b>

**Long Term Care Advisory Board Meeting  
Nurse Aide Registry Activity Report  
Second Quarter FY 2014  
October 1, 2013 to December 31, 2013**



**Number of Approved Training Programs by Type**

Long Term Care Aides	Home Health Aides	Developmentally Disabled Direct Care Aides	Residential Care Aides	Adult Day Care Aides	Certified Medication Aides	Total
188	0	14	7	2	48	259

Home Health Aides are going through HHA Deeming Programs to become Certified.

**Advanced CMA and CMA/CEU Training Programs**

CMA Respiratory	CMA Respiratory/ Gastrostomy	CMA Glucose Monitor	CMA Insulin Administration	CMA/CEU	Total
1	26	2	18	35	82

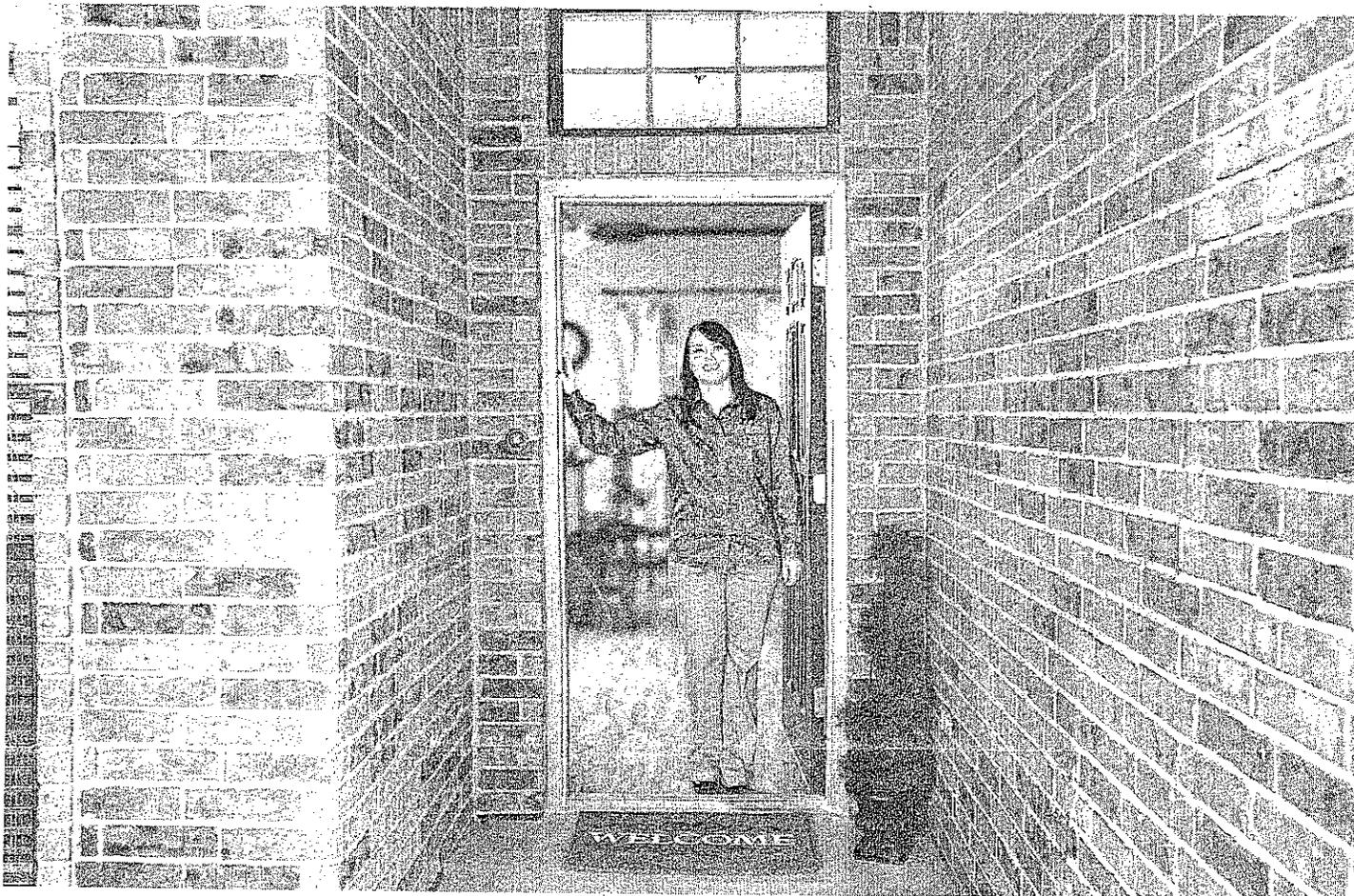
**Grand Total Number of Approved Nurse Aide Registry Programs - 341**

**Number of LTC Training Program Onsite Reviews Performed FY2014**

1 <sup>st</sup> Quarter	2 <sup>nd</sup> Quarter	3 <sup>rd</sup> Quarter	4 <sup>th</sup> Quarter	Total
19	41			60

Inspections are ongoing for 2014 Biennial LTC Nurse Aide Training Programs including all approved Nurse Aide Registry training programs (CMA, CMA Advanced, CMA/CEU, DDCA, RCA, ADC).

# Program provides seniors care in single-family setting



Kendra Davis, a registered nurse, is an intake specialist for Comfort Keepers.

PHOTOS PROVIDED BY COMFORT KEEPERS

## BY TIM FALL

For The Oklahoman  
trfall@gmail.com

Not long ago, Mary Thompson faced the agonizing decision that so many families face: how to care for an aging loved one who is no longer able to remain in her own home.

Thompson's mother, Dixie, became dependent on full-time care, and for 18 months, Thompson relied on Comfort Keepers, an in-home care provider, to help her meet the constant needs of her mother.

When it became clear that Dixie wouldn't be able to remain in her own home, "We started shopping for a nursing home," Thompson said, assuming "there wouldn't be an affordable alternative."

She chose what she considered the "least bad" option, a nearby nursing home with a relatively small number of residents, 30.

Within a week, Thompson said, she grew uncomfortable with what was quickly becoming "a bad experience." Dixie appeared unkempt when Thompson visited, and staff members weren't maintaining her medication regime.

On the 10th day, Dixie fell while in the nursing home and had to be hospitalized.

"It was actually a blessing," her daughter said, "because hospital tests showed how badly de-



A Comfort Keepers residence in Oklahoma City.

hydrated she was."

Facing the grim reality of Dixie's circumstances from her hospital room, Thompson called Comfort Keepers to move Dixie into the its LifeSelect program.

Joe Forrest, Comfort Keeper's general manager for the Oklahoma City area, said that in 2013 the company began offering LifeSelect, a service he described as "interactive caregiving," an opportunity for seniors to have full-time supervision while living in a single-family home setting.

Comfort Keepers, in partnership with a real estate investor, converts suitable four-bedroom,

two-bathroom houses into shared-living, supervised-care facilities for their clients.

That's right: Senior citizens with up to three roomies and round-the-clock personal care.

"It can be very much like 'The Golden Girls,'" Forrest said.

He said the upsides can be many, including cost-effectiveness.

While individual circumstances vary, clients pay "about \$2,000" per month in rent and in the neighborhood of \$4,800 per month for full-time Comfort Care supervision services.

Thompson said that once she had placed Dixie in a nursing

home, "we learned pretty quick" that the base monthly cost was subject to upgrade fees for most additional services.

"We had to pay \$500 a month to make sure her CPAP (continuous positive airway pressure) machine was fitted and turned on at night, and someone to sit with Dixie at meals to make sure she didn't choke cost an additional \$800 a month," she said.

But Thompson said choosing LifeSelect for her mother means that "I don't have to worry any more" about her moment-to-moment well-being.

SEE PROGRAM, PAGE 2F



This view shows the living room of a Comfort Keepers residence.

PHOTOS PROVIDED BY COMFORT KEEPERS

## Program: Can be like 'Golden Girls'

FROM PAGE 1F

"They call me all the time" with updates, Thompson said. "It's such a relief."

Now that her mother's transition to a LifeSelect house is complete, Thompson said, they'll sell her former house, confident that Dixie has moved on happily.

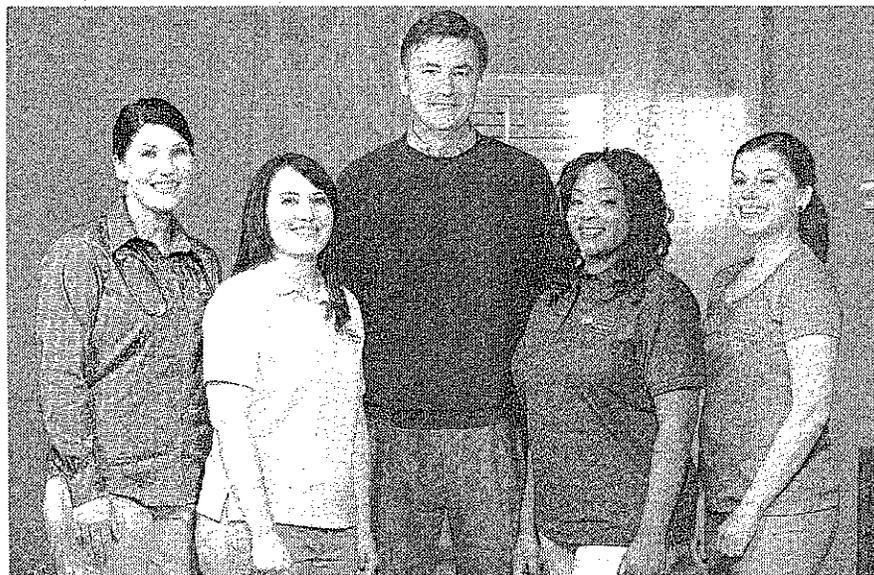
Forrest, a Smithville native with a long history in health care administration, worked in real estate for a few years after his 2001 sale of Americare Home Health Care — the skilled nursing agency he founded — but it didn't take a deep background in real estate for Forrest to recognize the appeal of providing a familiar home life environment to assisted-care clients.

His experience in health care taught him that families are seeking high caregiver-to-patient ratios, along with companionship and social connectedness.

Now that LifeSelect is off the launchpad, Forrest said his goal is to establish 15 to 20 shared-housing environments for seniors in 2014 with Comfort Keepers, which operates a network of independent offices with headquarters in Dayton, Ohio.

The ideal LifeSelect house is "a four-bedroom ranch-style, all one level," in an established neighborhood, Forrest said.

Once a home has been identified, "we go in and retrofit" as required, wid-



Joe Forrest, middle, general manager of the Edmond office of Comfort Keepers, is shown with, left to right, Sara Kennedy, registered nurse and client care manager; Kendra Davis, registered nurse and intake specialist; Eleasha Cobb, caregiver; and Jordan Spotted Elk, scheduling coordinator and caregiver.

ening doors, adding ramps and making adaptations in the bathrooms.

For Forrest, Comfort Keepers is "a calling" rooted in his small-town upbringing. His dad, a pastor, "always had to deal with" the fact that there was no formalized in-home health care in those days.

"People needed care, and you just did what needed to be done," Forrest said.

For Thompson, her choice of LifeSelect meant that two days before Christmas she was able to do some shopping, secure in the knowledge that her mother was well cared for.

"We tell her it's her new house," Thompson said. "And she's just fine with that."

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