Appendix 24
Minimum Data Set (MDS) Supplemental Assessment Forms

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1.	DATE OF ENTRY	*Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date* Month — Day — Year
2.	ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other
3.	LIVED ALONE (PRIOR TO ENTRY)	0. No 1. Yes 2. In other facility
4.	ZIP CODE OF PRIOR PRIMARY RESIDENCE	
5.	RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY	*(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above)* Prior stay at this nursing home — a. Stay in other nursing home — b. Other residential facility—board and care home, assisted living, group home — c. MH/psychiatric setting — d. MR/DD setting — e. *NONE OF ABOVE* — f.
6.	LIFETIME OCCUPATION(S) (Put "/" between two occupations)	
7.	EDUCATION (*Highest Level Completed*)	1. No schooling 2. 8th grade/less 3. 9-11 grades 4. High school 5. Technical or trade school 6. Some college 7. Bachelor's degree 8. Graduate degree
8.	LANGUAGE	*(Code for correct response)* a. Primary Language 0. English 1. Spanish 2. French 3. Other b. If other, specify
9.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem? 0. No 1. Yes
10.	CONDITIONS RELATED TO MR/DD STATUS	*(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely)* Not applicable—no MR/DD (Skip to AB11) — a. MR/DD with organic condition Down's syndrome — b. Autism — c. Epilepsy — d. Other organic condition related to MR/DD — e. MR/DD with no organic condition — f.
11.	DATE BACKGROUND INFORMATION COMPLETED	Month — Day — Year

SECTION AC. CUSTOMARY ROUTINE

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

END

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:			
a. Signature of RN Assessment Coordinator			Date
b. Signatures	Title	Sections	Date
c.			Date
d.			Date
e.			Date
f.			Date
g.			Date

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME[Θ]	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER[3]	1. Male 2. Female
3.	BIRTHDATE[Θ]	Month — Day — Year
4.	RACE/[Θ] ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY[Θ] AND MEDICARE NUMBERS[Θ] [C in 1st box if non med. no.]	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO.[Θ]	a. State No. b. Federal No.
7.	MEDICAID NO. [*+* if pending, "N" if not a Medicaid recipient] [Θ]	
8.	REASONS FOR ASSESSMENT	[Note—Other codes do not apply to this form] a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior assessment 5. Quarterly review assessment 0. *NONE OF ABOVE* b. *Special codes for use with supplemental assessment types in Case Mix demonstration states or other states where required* *1. 5 day assessment* *2. 30 day assessment* *3. 60 day assessment* *4. Quarterly assessment using full MDS form* *5. Readmission/return assessment* *6. Other state required assessment*
9.	SIGNATURES OF PERSONS COMPLETING THESE ITEMS:	
	a. Signature	Title Date
	b.	Date

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

Θ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter a. = When letter in box, check if condition applies

Numeric Identifier _____

MDS QUARTERLY ASSESSMENT FORM

A1. RESIDENT NAME
a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)

A2. ROOM NUMBER

A3. ASSESSMENT REFERENCE DATE
a. Last day of MDS observation period
Month — Day — Year
b. Original (0) or corrected copy of form (enter number of correction)

A4a DATE OF REENTRY
Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)
Month — Day — Year

A6. MEDICAL RECORD NO.

B1. COMATOSE
(*Persistent vegetative state/no discernible consciousness*)
0. No 1. Yes (*Skip to Section G*)

B2. MEMORY
(*Recall of what was learned or known*)
a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 1. Memory problem
b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 1. Memory problem

B4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING
(*Made decisions regarding tasks of daily life*)
0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

B5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/AWARENESS
(*Code for behavior in the last 7 days.*) [*Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time*].
0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)
b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)
e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)
f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

C4. MAKING SELF UNDERSTOOD
(*Expressing information content—however able*)
0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

C6. ABILITY TO UNDERSTAND OTHERS
(*Understanding verbal information content—however able*)
0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD
(*Code for indicators observed in last 30 days, irrespective of the assumed cause*)
0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

VERBAL EXPRESSIONS OF DISTRESS
a. Resident made negative statements—(e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*")
b. Repetitive questions—(e.g., "*Where do I go; What do I do?*")
c. Repetitive verbalizations—(e.g., calling out for help, ("*God help me*")
d. Persistent anger with self or others—(e.g., easily annoyed, anger at placement in nursing home; anger at care received)
e. Self deprecation—(e.g., "*I am nothing; I am of no use to anyone*")

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (cont.)

VERBAL EXPRESSIONS OF DISTRESS
f. Expressions of what appear to be unrealistic fears—(e.g., fear of being abandoned, left alone, being with others)
g. Recurrent statements that something terrible is about to happen—(e.g., believes he or she is about to die, have a heart attack)
h. Repetitive health complaints—(e.g., persistently seeks medical attention, obsessive concern with body functions)
i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues

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

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

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

E2. MOOD PERSISTENCE
One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days
0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered

E4. BEHAVIORAL SYMPTOMS
(A) *Behavioral symptom frequency in last 7 days*
0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) *Behavioral symptom alterability in last 7 days*
0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

(A) (B)

a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)
e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)

G1. (A) ADL SELF-PERFORMANCE—(*Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup*)
0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
— Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days (A)

a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)
c.	WALK IN ROOM	How resident walks between locations in his/her room.
d.	WALK IN CORRIDOR	How resident walks in corridor on unit.
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).

Appendix B
Resident _____

HCFA's RAI Version 2.0 Manual
Numeric Identifier _____

I.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	
J.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)	
G2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) *Code for most dependent in self-performance.* (A) BATHING SELF PERFORMANCE codes appear below	(A)
		0. Independent—No help provided	
		1. Supervision—Oversight help only	
		2. Physical help limited to transfer only	
		3. Physical help in part of bathing activity	
		4. Total dependence	
		8. Activity itself did not occur during entire 7 days	
G4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION	*(Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury)* (A) *RANGE OF MOTION* 0. No limitation 1. Limitation on one side 2. Limitation on both sides; (B) *VOLUNTARY MOVEMENT* 0. No loss 1. Partial loss 2. Full loss	(A) (B)
		a. Neck	
		b. Arm—including shoulder or elbow	
		c. Hand—including wrist or fingers	
		d. Leg—including hip or knee	
		e. Foot—including ankle or toes	
		f. Other limitation or loss	
G6.	MODES OF TRANSFER	*(Check all that apply during last 7 days)* Bedfast all or most of time (a.); Bed rails used for bed mobility or transfer (b.); *NONE OF ABOVE* (f.)	

H1. CONTINENCE SELF-CONTROL CATEGORIES
(Code for resident's PERFORMANCE OVER ALL SHIFTS)

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

a.	BOWEL CONTINENCE	Control of bowel movement; with appliance or bowel continence programs, if employed	
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	
H2.	BOWEL ELIMINATION PATTERN	Fecal impaction (d.); *NONE OF ABOVE* (e.)	
H3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan (a.); Bladder retraining program (b.); External (condom) catheter (c.); Indwelling catheter (d.); Ostomy present (f.); *NONE OF ABOVE* (j.)	
I2.	INFECTIONS	Urinary tract infection in last 30 days (l.); *NONE OF ABOVE* (m.)	
I3.	OTHER CURRENT DIAGNOSES AND ICD-9 CODES	*(Include only those diseases diagnosed in the last 90 days that have a relationship to current ADL status, cognitive status, mood/behavior status, medical treatments, nursing monitoring, or risk of death)* a. b.	
J1.	PROBLEM CONDITIONS	*(Check all problems present in last 7 days)* Dehydrated; output exceeds input (c.); Hallucinations (f.); *NONE OF ABOVE* (p.)	
J2.	PAIN SYMPTOMS	*(Code the highest level of pain present in the last 7 days)* a. FREQUENCY with which resident complains or shows evidence of pain: 0. No pain (*skip to J4*) 1. Pain less than daily 2. Pain daily; b. INTENSITY of pain: 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating	
J4.	ACCIDENTS	*(Check all that apply)* Fell in past 30 days (a.); Fell in past 31-180 days (b.); Hip fracture in last 180 days (c.); Other fracture in last 180 days (d.); *NONE OF ABOVE* (e.)	

J5.	STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating)	a.
		Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem	b.
		End-stage disease, 6 or fewer months to live	c.
		NONE OF ABOVE	d.
K3.	WEIGHT CHANGE	a. Weight loss—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes	
		b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days 0. No 1. Yes	
K5.	NUTRITIONAL APPROACHES	Feeding tube	b.
		On a planned weight change program	h.
		NONE OF ABOVE	i.
M1.	ULCERS (Due to any cause)	*(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) (Requires full body exam.)*	Number at Stage
		a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	
M2.	TYPE OF ULCER	*(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., Decubitus stages 1, 2, 3, 4)* a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue; b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
N1.	TIME AWAKE	*(Check appropriate time periods over last 7 days)* Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning (a.); Afternoon (b.); Evening (c.); *NONE OF ABOVE* (d.)	

(If resident is comatose, skip to Section O)

N2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 3. None	
O1.	NUMBER OF MEDICATIONS	*(Record the number of different medications used in the last 7 days; enter "0" if none used)*	
O4.	DAYS RECEIVED THE FOLLOWING MEDICATION	*(Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly)* a. Antipsychotic; b. Antianxiety; c. Antidepressant; d. Hypnotic; e. Diuretic	
P4.	DEVICES AND RESTRAINTS	*Use the following codes for last 7 days:* 0. Not used 1. Used less than daily 2. Used daily	
		Bed rails: a. — Full bed rails on all open sides of bed; b. — Other types of side rails used (e.g., half rail, one side); c. Trunk restraint; d. Limb restraint; e. Chair prevents rising	
Q2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support	

R2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete ___ — ___ — ____ (Month Day Year)

c. Other Signatures	Title	Sections	Date
d.			Date
e.			Date
f.			Date
g.			Date

Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

REENTRY TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ⊕	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER ⊕	1. Male 2. Female
3.	BIRTHDATE ⊕	Month — Day — Year
4.	RACE/ ETHNICITY ⊕	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY ⊕ AND MEDICARE NUMBERS ⊕ [C in 1st box if non med. no.]	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ⊕	a. State No. b. Federal No.
7.	MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] ⊕	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] a. Primary reason for assessment 9. Reentry
9.	SIGNATURES OF PERSONS COMPLETING FORM	
a. Signatures	Title	Sections Date
b.		Date
c.		Date

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

4a.	DATE OF REENTRY	Date of reentry Month — Day — Year
4b.	ADMITTED FROM (AT REENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other
6.	MEDICAL RECORD NO.	

⊕ = Key items for computerized resident tracking

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY Numeric Identifier _____

Resident's Name:	Medical Record No.:

1. Check if RAP is triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
   - Describe:
     - — Nature of the condition (may include presence or lack of objective data and subjective complaints).
     - — Complications and risk factors that affect your decision to proceed to care planning.
     - — Factors that must be considered in developing individualized care plan interventions.
     - — Need for referrals/further evaluation by appropriate health professionals.
   - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
   - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

A. RAP PROBLEM AREA	(a) Check if triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision—check if addressed in care plan
1. DELIRIUM	☐		☐
2. COGNITIVE LOSS	☐		☐
3. VISUAL FUNCTION	☐		☐
4. COMMUNICATION	☐		☐
5. ADL FUNCTIONAL/ REHABILITATION POTENTIAL	☐		☐
6. URINARY INCONTINENCE AND INDWELLING CATHETER	☐		☐
7. PSYCHOSOCIAL WELL-BEING	☐		☐
8. MOOD STATE	☐		☐
9. BEHAVIORAL SYMPTOMS	☐		☐
10. ACTIVITIES	☐		☐
11. FALLS	☐		☐
12. NUTRITIONAL STATUS	☐		☐
13. FEEDING TUBES	☐		☐
14. DEHYDRATION/FLUID MAINTENANCE	☐		☐
15. DENTAL CARE	☐		☐
16. PRESSURE ULCERS	☐		☐
17. PSYCHOTROPIC DRUG USE	☐		☐
18. PHYSICAL RESTRAINTS	☐		☐

B. _____
1. Signature of RN Coordinator for RAP Assessment Process

2. ☐☐ — ☐☐ — ☐☐☐☐ (Month Day Year)

_____
3. Signature of Person Completing Care Planning Decision

4. ☐☐ — ☐☐ — ☐☐☐☐ (Month Day Year)

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

Key:
- ● = One item required to trigger
- ❷ = Two items required to trigger
- ✱ = One of these three items, plus at least one other item required to trigger
- ⓐ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

MDS ITEM		CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL Rehabilitation Trigger A ⓐ	ADL Maintenance Trigger B ⓐ	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	
B2a	Short term memory	1		●																			B2a
B2b	Long term memory	1		●																			B2b
B4	Decision making	1,2,3		●																			B4
B4	Decision making	3					●																B4
B5a to B5f	Indicators of delirium	2	●																	●			B5a to B5f
B6	Change in cognitive status	2	●																	●			B6
C1	Hearing	1,2,3				●																	C1
C4	Understood by others	1,2,3				●																	C4
C6	Understand others	1,2,3		●		●																	C6
C7	Change in communication	2																		●			C7
O1	Vision	1,2,3			●																		O1
O2a	Side vision problems	✓			●																		O2a
E1a to E1p	Indicators of depression, anxiety, sad mood	1,2									●												E1a to E1p
E1n	Repetitive movements	1,2																		●			E1n
E1o	Withdrawal from activities	1,2								●													E1o
E2	Mood persistence	1,2									●												E2
E3	Change in Mood	2	●																	●			E3
E4aA	Wandering	1,2,3													●								E4aA
E4aA - E4eA	Behavioral symptoms	1,2,3										●											E4aA - E4eA
E5	Change in behavioral symptoms	1										●											E5
E5	Change in behavioral symptoms	2	●																	●			E5
F1d	Establishes own goals	✓								●													F1d
F2a to F2d	Unsettled relationships	✓								●													F2a to F2d
F3a	Strong id. past roles	✓								●													F3a
F3b	Lost roles	✓								●													F3b
F3c	Daily routine different	✓								●													F3c
G1aA - G1jA	ADL self-performance	1,2,3,4					●																G1aA - G1jA
G1aA	Bed mobility	2,3,4,8																	●				G1aA
G2A	Bathing	1,2,3,4					●																G2A
G3b	Balance while sitting	1,2,3																		●			G3b
G6a	Bedfast	✓																	●				G6a
G5a,b	Resident: staff believe capable	✓					●																G5a,b
H1a	Bowel incontinence	1,2,3,4																	●				H1a
H1b	Bladder incontinence	2,3,4							●														H1b
H2b	Constipation	✓																		●			H2b
H2d	Fecal impaction	✓																		●			H2d
H3c,d,e	Catheter use	✓							●														H3c,d,e
H3g	Use of pads/briefs	✓							●														H3g
I1i	Hypotension	✓																		●			I1i
I1j	Peripheral vascular disease	✓																	●				I1j
I1ee	Depression	✓																		●			I1ee
I1jj	Cataracts	✓			●																		I1jj
I1ll	Glaucoma	✓			●																		I1ll
I2	UTI	✓															●						I2
I3	Dehydration diagnosis	276.5															●						I3
J1a	Weight fluctuation	✓															●						J1a
J1c	Dehydrated	✓															●						J1c
J1d	Insufficient fluid	✓															●						J1d
J1f	Dizziness	✓													●					●			J1f
J1h	Fever	✓															●						J1h
J1i	Hallucinations	✓																		●			J1i
J1j	Internal bleeding	✓															●						J1j
J1k	Lung aspirations	✓																		●			J1k
J1m	Syncope	✓																		●			J1m

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

Key:
● = One item required to trigger
❷ = Two items required to trigger
✱ = One of these three items, plus at least one other item required to trigger
ⓐ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

MDS ITEM		CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL Rehabilitation Trigger A ⓐ	ADL Maintenance Trigger B ⓐ	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	
J1a	Unsteady gait	✓																			●		J1a
J4a,b	Fall	✓													●						●		J4a,b
J4c	Hip fracture	✓																			●		J4c
K1b	Swallowing problem	✓																			●		K1b
K1c	Mouth pain	✓																	●				K1c
K3a	Weight loss	1														●							K3a
K4a	Taste alteration	✓														●							K4a
K4c	Leave 25% food	✓														●							K4c
K5a	Parenteral/IV feeding	✓														●		●					K5a
K5b	Feeding tube	✓															●	●					K5b
K5c	Mechanically altered	✓														●							K5c
K5d	Syringe feeding	✓														●							K5d
K5e	Therapeutic diet	✓														●							K5e
L1a,c,d,e	Dental	✓																	●				L1a,c,d,e
L1f	Daily cleaning teeth	Not ✓														●			●				L1f
M2a	Pressure ulcer	2,3,4														●							M2a
M2a	Pressure ulcer	1,2,3,4																		●			M2a
M3	Previous pressure ulcer	1																		●			M3
M4e	Impaired tactile sense	✓																		●			M4e
N1a	Awake morning	✓											❷										N1a
N2	Involved in activities	0											❷										N2
N2	Involved in activities	2,3										●											N2
N5a,b	Prefers change in daily routine	1,2										●											N5a,b
O4a	Antipsychotics	1-7																		✱			O4a
O4b	Antianxiety	1-7													●					✱			O4b
O4c	Antidepressants	1-7													●					✱			O4c
O4e	Diuretic	1-7																●					O4e
P4c	Trunk restraint	1,2													●							●	P4c
P4c	Trunk restraint	2																		●			P4c
P4d	Limb restraint	1,2																				●	P4d
P4e	Chair prevents rising	1,2																				●	P4e