Quality in North Carolina Assisted Living Facilities: 
Legislative and Research Recommendations

By

Carla M. Julian

A Masters Paper submitted to the faculty of 
The University of North Carolina at Chapel Hill 
In Partial fulfillment of the requirements for 
The degree of Master of Public Health in 
The Public Health Leadership Program

Chapel Hill 
2003

Christina A. Harlan, Advisor

Dr. William A. Sollecito, Second Reader

April 16, 2003

Date
Abstract

The number of persons age 65 and older is increasing rapidly in many areas of the world. By the year 2030, one in five Americans will be age 65 or older. As the population ages, more people require long term care services in nursing homes and assisted living facilities. This paper reviews key issues in nursing home and assisted living care, but the main focus is the assisted living industry. A brief overview of nursing home characteristics is followed by a more in-depth analysis of the assisted living industry, including a review of North Carolina assisted living legislation. The main topics discussed include:

- long-term care terminology;
- caregiving workforce;
- resident characteristics;
- licensure and certification;
- quality measurement;
- staffing requirements;
- resident assessment standards;
- staffing affect on quality;
- resident values and preferences;
- availability of meaningful activities.

Assisted living is a promising option for older adults who can no longer live independently at home, but there are concerns surrounding staff training, qualifications, and supervision; medication administration; resident assessment protocols; and the availability of meaningful activities. Minimal research is available documenting the structure and process of care relative to medication administration errors. Professional nursing oversight has been recommended as a possible intervention to reduce medication error rates, but without supporting evidence documenting the processes contributing to these errors, recommending such legislation is premature. There are also no available studies documenting the proportion of assisted living residents whose conditions deteriorate after admission, how personal care staff react to changes, assessment tools and interventions used by professional nurses in response to changes, or whether interventions affect outcomes. Observational studies are needed in this area so advocates and care providers can lobby for appropriate legislation. Another critical component to quality of life for assisted living residents is the availability of meaningful activities that are individualized and sufficient to relieve loneliness, boredom, and depression. It is possible that current state legislation requiring resident assessment documentation could be amended to include documented evidence of adequate assessment and planning to meet resident activity needs.

One thing is certain, as the older adult population continues to rise over the next 30 years; the assisted living industry will see a corresponding rise in the number of frail, functionally impaired residents. Policies and regulation particular to assisted living will need to change along with these changing demographics.
Introduction

The population of many areas of the world is aging rapidly. Some countries have already reached negative growth rates due to lower birth rates and higher life expectancies. According to the 2000 United States Census (U.S. Census Bureau), 12.4% of the U.S. population or approximately 35 million persons were age 65 years or older, and 4.2 million or 1.5% were 85 years or older. This is a 3.7 million or 12% increase in the national 65 years and older population since the 1990 U.S. census. In North Carolina, the 2000 Census revealed there were approximately 970,000 (12.0%) persons age 65 and older and 105,000 (1.3%) persons age 85 and older. This is a 20.5% increase in the age 65 and older North Carolina population since 1990. By 2030 it is estimated that one in five Americans will be age 65 and older, which is a 100% increase in the 65+ population from the year 2000. Tables 1 and 2 compare North Carolina aging demographics to the National figures for 1990, 2000, 2010, 2020, and 2030.

Table 1. Percentage of Persons 65 Years and Older

<table>
<thead>
<tr>
<th>Year</th>
<th>United States</th>
<th>North Carolina</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>31,241,831 (12.6%)</td>
<td>804,341 (12.1%)</td>
</tr>
<tr>
<td>2000</td>
<td>34,991,753 (12.4%)</td>
<td>969,048 (12.0%)</td>
</tr>
<tr>
<td>2010</td>
<td>39,715,000 (13.2%)</td>
<td>1,190,003 (12.5%)</td>
</tr>
<tr>
<td>2020</td>
<td>53,733,000 (16.5%)</td>
<td>1,664,980 (15.1%)</td>
</tr>
<tr>
<td>2030</td>
<td>70,300,000 (20.0%)</td>
<td>2,221,470 (17.8%)</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, North Carolina State Demographics Center
Table 2. Percentage of Persons 85 years and Older

<table>
<thead>
<tr>
<th>Year</th>
<th>United States</th>
<th>North Carolina</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>3.1 million (1.2%)</td>
<td>69,969 (1.1%)</td>
</tr>
<tr>
<td>2000</td>
<td>4.2 million (1.5%)</td>
<td>105,461 (1.3%)</td>
</tr>
<tr>
<td>2010</td>
<td>5,786,000 (1.9%)</td>
<td>151,681 (1.6%)</td>
</tr>
<tr>
<td>2020</td>
<td>6,763,000 (2.1%)</td>
<td>192,207 (1.8%)</td>
</tr>
<tr>
<td>2030</td>
<td>8,931,000 (2.5%)</td>
<td>267,679 (2.2%)</td>
</tr>
</tbody>
</table>

Source: U.S. Census Bureau, North Carolina State Demographics Center

It is estimated that 60% of older adults age 65 and over will require long-term care services at some point in their lives (NCIOM, 2001). This care is typically provided through home and community-based services or in long-term care facilities such as nursing homes and assisted living facilities. It is believed that long-term care services provided in the home are preferred, but there are times when it is not feasible for an older adult to remain at home. There is often no other alternative than to have a loved one placed in a nursing home or assisted living facility. Without sufficient financial resources, such as long-term care insurance or public assistance, the older adult and their loved ones are faced with few alternatives for care. They can attempt to organize care in the home by unpaid caregivers or family members, they can pay a caregiver out-of-pocket, or as is often the case, they can “spend down” their earnings in order to qualify for public assistance in a residential care setting (NCIOM, 2001).
Long-term care Terminology

Before examining the issues surrounding quality in long-term care, it is important to define the relative terminology. There is tremendous variation in the definition of “long-term care.” Historically, long-term care referred to residential care in state or federally regulated facilities with twenty-four hour oversight (NCIOM, 2001). Long-term care, however, no longer refers solely to residential care facilities, but also encompasses home and community-based services. Since most older adults prefer to remain in their homes as long as possible, long-term care now represents a continuum of care from independence at home to dependence in a residential care setting such as a nursing home or assisted living facility.

Quality in Long-Term Care

The quality of long-term care services has been a long-standing concern for consumers, policymakers, administrators, and service providers. As the “baby boom” generation (individuals born between 1946 and 1964) begins reaching the age of 65, these concerns will only multiply. The “baby boomers” will begin reaching age 65 in the year 2011, and the tail end of the generation will finally reach age 65 in the year 2030. Additionally, individuals age 85 and older are the fastest growing segment of the U.S. population, and this fact will soon be realized as our society struggles to meet their long-term care needs (Wunderlich and Kohler, 2001).
Concerns over the quality of long-term care include home and community-based services as well as care received in nursing homes and residential care facilities, but nowhere are these concerns greater than in facilities such as nursing homes and assisted living (Wunderlich and Kohler, 2001). Attempts have been made to improve quality through regulatory oversight, enforcement, reimbursement, and quality improvement systems, but it is doubtful a major impact will occur without addressing the caregiver workforce problems in long-term care.

Methods

Quality concerns in long-term care are overwhelming and encompass organizational processes and structure, as well as how process and structure relate to resident outcomes. Each of these areas deserves thorough examination; however, the main focus of this paper will be the affect of staff qualifications, training and supervision on the quality of care and quality of life for residents of assisted living. To understand this focus, the general issues surrounding the caregiving workforce in long-term care will presented. Next, nursing home definitions, demographics, quality measures, licensure, and staffing will be reviewed for general comparisons with assisted living. Finally, a more in-depth analysis of the assisted living industry will be presented, including a review of North Carolina legislation. A discussion with conclusions and recommendations for further study will follow. Funding and reimbursement in long-term care are
also extremely important issues in terms of quality, but a discussion of those complicated topics is beyond the scope of this paper.

Caregiving Workforce

Residents of long-term care facilities receive care from a diverse workforce. It is difficult to discuss improving quality in long-term care without discussing the enormous impact these caregivers have on the quality of care and quality of life for older and disabled adults living in long-term care facilities. The majority of care is delivered by registered nurses, licensed practical nurses, and nurse aides. However, there are a number of other professionals, paraprofessionals, and nonprofessionals who have a major impact on the quality of care and well-being of residents. This caregiving workforce includes physical, occupational, speech, and recreational therapists, physicians, social workers, mental health professionals, pharmacists, nutritionists, dentists, food service workers, housekeeping, and administration (Wunderlich and Kohler, 2001).

According to 1998 data, 57% of the paraprofessional caregiving workforce is employed at nursing homes, adult care homes, or other residential care facilities (Wunderlich and Kohler, 2001). It is important to point out that nonprofessional caregivers (nurse aides) that assist older adults with bathing, eating, dressing, and other personal care have probably the most profound impact on resident quality of life in long-term care facilities (Wunderlich and Kohler, 2001).

According to a report from the North Carolina Institute of Medicine (NCIOM, 2001), the annual turnover rate for nurse aides (NAs) in 1999 was
100% in nursing homes and 140% in adult care homes. The Agency for Healthcare Research and Quality (AHRQ, 2001) found most studies on staffing show turnover rates are highest during the first three to six months of employment due to insufficient training and support. In addition, most nurse aide training programs do not adequately train future NAs on caring for challenging residents and families; effective interpersonal communication; conflict resolution; problem solving; or critical thinking skills (AHRQ, 2001).

Most long-term care paraprofessionals earn a salary below the federal poverty level ($6.50 to $8.00 per hour) and many have more than one job (Bowers, Esmond, Jacobson, 2000). Increased wages and benefits are the most frequently quoted strategies for improving frontline caregiver recruitment and retention. While at the same time, others believe staffing is the major component in the tradeoff between cost and quality (Bowers, et al., 2000).

Multiple reasons have been given for the shortage of frontline caregivers in long-term care. The most frequently given reasons include: insufficient salaries and benefits, lack of a career path, risk of injury from physically demanding work, lack of recognition, lack of respect by professional caregivers and supervisors, and lack of training on real job demands (AHRQ, 2001; NCIOM, 2001; Zimmerman, Sloane, & Eckert, 2001). Nurse aides claim they have received inadequate training on how to deal with residents exhibiting aggression, dementia, depression, or other mental disorders. They also verbalize frustration over the lack of appropriate equipment to adequately perform their job responsibilities. Many nurse aides and other paraprofessionals have reported poor relationships
with their supervisor as a main reason for leaving or remaining employed in long-term care facilities. Providers believe reasons for the caregiving workforce shortage include: insufficient reimbursement, excessive governmental regulation and oversight, unmotivated workers, untrained workers, and high turnover rates (AHRQ, 2001).

The long-term care industry is in the midst of a staffing crisis, which will steadily increase as the older adult population grows. Providers, regulators, consumers, and all long-term care stakeholders are scrambling to find viable solutions to the staffing problems so the vision of quality care provision can be realized. The Agency for Healthcare Research and Quality (AHRQ, 2001) lists the following interventions that have had a positive impact on reducing turnover rates: nurse aide involvement in care planning, improved wages and benefits, guaranteed hours, increased training and support, career advancement, financial incentives, culture change initiatives, and employee recognition awards.

Wisconsin’s Wellspring model of long-term care stresses frontline caregiver training and development (Bonifazi, 2000). One multilevel long-term care facility in Wisconsin sent nurse aides and other paraprofessionals for intensive training in behavior management, incontinence care and prevention, assessment skills, skin care, fall prevention, and restraint guidelines. As a result of these ongoing training programs, they saw a drop in their nurse aide turnover rate from 105% to 25% in one year. Bonifazi also reported that most nurse aides flourish when given respect and empowered with authority, self-scheduling, and the ability to organize care teams.
Nursing Homes

Simply defined, nursing homes are “facilities with three or more beds that routinely provide nursing care services” (US Department of Health and Human Services [USDHHS], 2002). A physician’s order is required for admission, and in North Carolina there are three subcategories of nursing homes: skilled nursing, intermediate care, and Alzheimer care. Skilled nursing facilities provide continuous nursing supervision by registered nurses or licensed practical nurses, and residents require assistance with multiple activities of daily living (ADLs). Intermediate care units provide at least eight hours of professional nursing supervision, and residents do not require as many skilled services. Finally, Alzheimer’s units within a nursing home setting are considered “protected” and must be locked to ensure the safety of residents (Triangle J Area Agency on Aging [TJAAA], n.d.).

Resident Characteristics

In 2000, the number of individuals age 65 and older living in nursing homes at any given point in time was relatively low at 4.5% (1.6 million people) (Older Americans, 2002). However, when this age bracket is divided into 10 year increments, there is a startling difference in the number of older adults residing in nursing homes based on age. For example, according to the 2000 U.S. Census, 1.1% of persons age 65-74 years, 4.7% of persons age 75-84, and 18.2% of persons age 85 and older were living in nursing homes at any given point in time (Older American, 2002). According to a report by the National Center for Health
Statistics (Sahyoun, Pratt, Lentzner, Dey and Robinson, 2001), the 1997 National Nursing Home Survey revealed the average age of residents was 82.6 years at the time of admission. Additionally, from 1985 to 1997, the proportion of nursing home residents age 65 to 84 years has decreased while the proportion of persons age 85 years and older has increased. As illustrated in Figure 1, at the time of the survey in 1997, fourteen percent of nursing home residents were age 65 to 74, thirty-six percent were age 75 to 84, and fifty-one percent were age 85 years or older, (Sahyoun, et al., 2001). This survey also reported 89% of residents were white and 10% were black, compared to 93% and 6% respectively in 1985 (Figure 2) (Sahyoun et al, 2001).

**Figure 1.** Average Age of Nursing Home Residents: 1985 & 1997

![Bar chart showing the age distribution of nursing home residents in 1985 and 1997.](chart.png)

Source: Adapted from Sahyoun, et al., 2001
The 1999 National Nursing Home Survey (USDHHS, 2002) revealed that 90% of nursing home residents were 65 years or older, 72% were female, and 57% were widowed. Forty-two percent of nursing home residents are admitted from a hospital, and most discharges were due to death (24%) or admission to the hospital (29%). The average length of stay prior to discharge was 272 days.

Nursing homes provide 24-hour nursing care to sick and disabled persons who are not eligible for inpatient hospital services but are not well enough to be cared for at home. A small number of nursing home residents are adults who have been injured or were recently critically ill and are admitted to nursing homes for short rehabilitation stays prior to going home. Some short stay residents are too ill to be cared for at home and are admitted to nursing homes for end of life care. Finally, a large number of nursing home residents are disabled or chronically ill and are not able to live independently or be cared for at home by family or home and community-based service providers (Sahyoun, et al., 2001).
Seventy-five percent of nursing home residents require assistance with three or more activities of daily living (ADLs) (NCDHHS, 2002). Ninety-four percent of nursing home residents require assistance with bathing, 87% with dressing, 56% with toileting, and 47% with eating (Figure 3) (NCDHHS, 2002).

**Figure 3.** Percent Distribution of Nursing Home Resident ADL Dependency

![Bar chart showing percent distribution of ADL dependency for bathing, dressing, toileting, eating, and transfers.]

**Licensure and Certification**

North Carolina nursing homes are licensed annually by the Licensure and Certification Section of the NC Division of Facility Services (North Carolina Department of Health and Human Services [NCDHHS], n.d.). Detailed licensing regulations are in place for administration, medical services, nursing, pharmacy, dental, dietary, and many other nursing home services. In addition to licensing, the NC Division of Facility Services also controls the number and location of nursing homes through the state Certificate of Need Program (NCDHHS, n.d.).
To receive Medicare and/or Medicaid funding, the nursing home must also meet Federal standards established in the 1987 Nursing Home Reform Act, which was embedded in the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). These standards include more detailed residents bill of rights, care planning standards, enhanced nursing assistant training and certification, and the utilization of surveys designed to measure quality of care. The Nursing Home Reform act was intended to promote resident quality of life by helping individuals reach their best level of physical, mental, and psychosocial functioning and well-being (NCDHHS, n.d.). Nursing homes that violate state licensure regulations or federal certification standards may be sanctioned in the form of monetary fines, requirements to provide correctional plans, interruption in admissions, temporary management by state or federally appointed individuals, provisional licensure, loss of licensure, or complete termination from the Medicare and Medicaid programs (NCDHHS, n.d.).

Measuring Quality in Nursing Homes

Accurate and reliable data on the indicators of quality in long-term care is important to a wide-range of stakeholders such as regulators, consumers, caregivers, payers, researchers, and administrators. There are two well-known data systems for monitoring quality in nursing homes that provide crucial information regarding compliance with federal regulations (Wunderlich and Kohler, 2001). The first is OSCAR or On-line Survey Certification and Reporting system for nursing homes and home health agencies. This database provides
certification and survey data on long term care providers that receive Medicare and Medicaid funding and thus must comply with federal regulations. The database provides information on how well nursing homes have complied with regulations and provides information on prior performance. OSCAR also provides information on resident and facility characteristics, staffing patterns, survey violations, and complaints filed. Due to the breadth of information available, OSCAR can be considered a quality assessment tool (Wunderlich and Kohler, 2001).

The second quality monitoring tool was mandated in the OBRA '87 reforms, which required nursing homes to establish Resident Assessment Instruments (RAIs) (Wunderlich and Kohler, 2001). The RAI is intended to provide a structured approach to assessing the needs of nursing home residents and for establishing a care plan based on that assessment. The RAI consists of a core assessment known as the Minimum Data Set (MDS) and more detailed assessment guidelines known as Resident Assessment Protocols (RAPs) (Wunderlich and Kohler, 2001). See Appendix A for the current MDS for resident assessments from the Centers for Medicare and Medicaid Services.

The Centers for Medicare and Medicaid Services (CMS, 1995c) also provide a “Quality of Life Assessment” instrument, which is a state survey tool based on resident interview responses (Appendix B). In addition to the resident interview, CMS Quality of Life Assessment instruments are available for families (Appendix C) (CMS, 1995a) and groups of residents (Appendix D) (CMS, 1995b).
Staffing in Nursing Homes

Staffing requirements for nursing homes are complex and detailed but will be only briefly reviewed in this paper. In order to participate in the Medicare and Medicaid programs, nursing homes must satisfy certification requirements established by the Centers for Medicare and Medicaid Services (Wunderlich and Kohler, 2001). The Nursing Home Reform Act (NHRA) enacted in 1987 as part of OBRA '87 established minimum staff training requirements for nursing assistants and required increased professional and nonprofessional services (Wunderlich and Kohler, 2001). To receive Medicare and/or Medicaid funding, each nursing home must provide the following (National Citizens Coalition for Nursing Home Reform, [NCCNHR], n.d.):

- 24 hour licensed nursing services sufficient to meet the needs of every resident;
- At least 8 consecutive hours of registered nurse services, 7 days per week;
- A Director of Nursing on duty at least 8 consecutive hours, 7 days a week (the RN and DON can be the same individual);
- A medical director must be responsible for the medical services;
- Facilities with more than 120 residents must have a full time staff member with a Bachelor of Social Work or related field.
Assisted Living Facilities

The definition, regulation, and monitoring of assisted living facilities varies among states. According to Zimmerman, et al. (2001, p. 2), the Assisted Living Quality Coalition defines assisted living as 'a congregate residential setting that provides or coordinates personal services, 24-hour supervision and assistance (scheduled and unscheduled), activities, and health related services; designed to minimize the need to move; designed to accommodate individual residents’ changing needs and preferences; designed to maximize resident’s dignity, autonomy, privacy, independence, and safety; and designed to encourage family and community involvement.’ The Coalition’s definition represents an ideal description of assisted living, but for a more specific description, this paper will examine North Carolina statutes with regard to assisted living definitions and regulation.

According to North Carolina law (Licensing of Adult Care Homes, 1995), "Assisted living residence means any group housing and services program for two or more unrelated adults, by whatever name it is called, that makes available, at a minimum, one meal a day and housekeeping services and provides personal care services (hands-on care provided by aides) directly or through a formal written agreement with one or more licensed home care or hospice agencies. Effective October 1, 1995, there are two types of assisted living residences: adult care homes and group homes for the developmentally disabled. Effective July 1, 1996, there is a third type, multiunit assisted housing with services.” Assisted living facilities traditionally provide less skilled or less comprehensive care than nursing
homes, but it is not uncommon for older adults who require more skilled care to reside in assisted living facilities without access to appropriate care by skilled personnel.

Adult care homes were formerly referred to as rest homes, domiciliary care homes, homes for the aged and personal care homes. Today, the terms “rest home” and “domiciliary care homes” are rarely used, but many states still refer to these facilities as board and care homes (Zimmerman et al., 2001). To qualify as an adult care home, the facility must have more than six beds and provide 24 hour supervision and personal care assistance such as bathing and grooming (Licensing of Adult Care Homes, 1995). Family care homes are adult care homes with two to six beds. Multiunit assisted living housing with services are assisted living facilities in which personal care or nursing services are arranged by the facility management and provided by a licensed home care or hospice agency (Licensing of Adult Care Homes, 1996). Alzheimer’s disease and dementia care units located in assisted living facilities must meet the following minimum staffing requirements: on 1st and 2nd shift, there must be one staff person to every eight residents, and the night shift must have one staff person to every ten residents (TJAAA, n.d.). The N.C. “Special Care Unit Disclosure Act” states that adult care homes or adult day cares that promote dementia care units must disclose the following information to consumers: mission statement, staff to resident ratio, staff training, cost of care, additional fees, criteria for admission and discharge, family involvement in care, care planning, physical environment, and activities (TJAAA, n.d.).
Resident Characteristics

Defining assisted living resident characteristics is critical to developing sound organizational processes to improve quality and for creating appropriate services to meet desired outcomes. Few studies have been done defining the characteristics of assisted living residents. According to the National Center for Assisted Living (NCAL) and the National Study of Assisted Living for the Frail Elderly (NSALFE), the average resident is female, in her early 80s, and widowed (Kovner, C.T. and Harrington, C., 2003). A study published in 2001 by the NCAL reported that 60% of residents need assistance with one to three activities of daily living (ADLs), 75% need assistance with medications, and 50% have Alzheimer disease or some other form of dementia (Kovner and Harrington, 2003). The NSALFE study (Hawes, C. and Phillips, C.D., 2000) was the first nationally representative sample of assisted living facilities, and based on this study, the authors concluded that 27% of residents suffered from moderate to severe cognitive impairment, 51% required assistance with bathing, 77% received help with their medications, and 32% experienced urinary incontinence.

The General Accounting Office (GAO, 1999) conducted a four-state study of assisted living facilities and concluded there was no characteristic type of resident or facility. The GAO discovered that both resident and facility characteristics varied among states surveyed. Despite resident demographic variability, it is generally believed that the overall acuity of assisted living residents has steadily increased over the past ten to fifteen years. Many residents
have become more functionally impaired and require higher levels of services (Hawes, et al., 1995; Zimmerman, et al., 2001).

Zimmerman et al. (2001) conducted a four-state study known as “The Collaborative Studies in Long-Term Care” (CS-LTC), which was the first study to examine outcome data with regard to care delivered in assisted living facilities, as well as the relationship between the structure and process of care to outcomes and resident quality of life. The study was conducted between October 1997 and November 1998 and outcome data was collected through November 1999. A total of 2,839 residents were enrolled in the study and data was collected from 233 facilities. With this data, researchers were able to describe the characteristics of residents in assisted living. Many assisted living facilities house younger, physically and mentally disabled adults, and the proportion of residents over the age of 85 in smaller facilities was 46.2%, compared to 57.4% in larger board and care settings. Other characteristics described in this study, such as gender, race, and marital status, can be found in Table 3. As noted in Table 3, larger traditional board and care facilities tend to house a smaller proportion of minorities than smaller assisted living facilities, and the racial disparities among residential care facilities is currently another area under investigation.
Table 3. Resident Characteristics in Assisted Living and Traditional Facilities

<table>
<thead>
<tr>
<th>Category</th>
<th>Assisted Living (less than 16 beds)</th>
<th>Traditional Facilities (more than 16 beds)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n=665)</td>
<td>(n=648)</td>
</tr>
<tr>
<td>Age: above 85 years</td>
<td>46.2%</td>
<td>57.4%</td>
</tr>
<tr>
<td>Gender: female</td>
<td>76.0%</td>
<td>76.8%</td>
</tr>
<tr>
<td>Race or ethnicity:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>85.1%</td>
<td>92.4%</td>
</tr>
<tr>
<td>Black</td>
<td>10.1%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Other</td>
<td>4.7%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Marital Status:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>67.4%</td>
<td>67.3%</td>
</tr>
<tr>
<td>Married</td>
<td>10.0%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Other</td>
<td>21.0%</td>
<td>22.4%</td>
</tr>
</tbody>
</table>

Source: Adapted from Zimmerman et al. (2001, p. 148)

One important issue in regard to assisted living care is the level of resident functional capacity. As stated previously, most residents of nursing homes require assistance with three or more activities of daily living. In Figure 4, the assisted living ADL dependency distribution found in the CS-LTC study is compared to the ADL dependency distribution from the USDHHS 1999 National Nursing Home Survey. This comparison illustrating how the ADL dependency distribution in assisted living facilities is less than that reported in nursing homes has tremendous implications in terms of the level and type of staff required to care for residents.
Despite the lower reported ADL dependency ratio in assisted living facilities, Zimmerman, et al. (2001) found four subgroups of residents that have particular needs, which must be taken into consideration when placing individuals in assisted living facilities. The first subgroup was defined as having significant cognitive impairments but who were in relatively good physical health. The second subgroup experienced significant physical impairment but were cognitively intact. The third subgroup was impaired both physically and cognitively, and the fourth subgroup had minimal physical and cognitive impairments. The overall level of physical and mental impairment found in assisted living was less than that found in nursing homes. However, the rising use of dementia care and special care units within assisted living facilities, coupled
with complex resident case mixes, further emphasizes the need to find effective ways to ensure quality for assisted living residents (Zimmerman, et al., 2001).

Licensure and Certification

Licensure and certification of assisted living facilities varies greatly among states (GAO, 1999; Hawes and Phillips, 2000; Zimmerman, et al., 2001). Zimmerman et al. (2001) report that only 29 states actually use the term “assisted living” as the licensing category but all 50 states license facilities that could be considered assisted living. Many states have separate licensing categories for older board and care homes and assisted living, while others, such as North Carolina and Maryland, have combined the facilities into one licensing category (Zimmerman, et al., 2001). Florida and Louisiana require additional licensure if nursing services or higher levels of care are offered. Multiple assisted living domains are covered by state regulations, such as philosophy of care, living unit options, resident agreements, tenant policy, admission-and-retention criteria, consumer-focused care, allowable services, requirements for assisted living facility administrators, staffing and training requirements, and resident assessment protocols (Zimmerman, et al., 2001).

In North Carolina, adult care homes are licensed and inspected by the North Carolina Division of Facility Services (NCDFS) of the Department of Health and Human Services. The state contracts with the Department of Social Services (DSS) in each county to monitor homes at least twice monthly. An
“adult care home specialist” from the county DSS conducts the facility surveys and reports to the NCDFS (TJAAA, n.d.).

In North Carolina, there are two basic types of adult care home violations. Type A violations occur when residents are at significant risk for death or serious injury (NCDFS, n.d.). Type B violations directly affect the health, safety, or welfare of residents but do not present a substantial risk of death or injury. Monetary penalties for Type A violations range from $250 to $5,000, and uncorrected violations are subject to a $500 daily fine. There are no monetary penalties for Type B violations unless they are not corrected within the specified time frame. If they are not corrected by the deadline, there is a $200 daily fine (NCDFS, n.d.).

The North Carolina Division of Facility Services (NCDFS) can impose non-monetary penalties as well. The other means of enforcement include: a reduction from full to provisional licensure, suspension of resident admissions, temporary management, revocation of licensure, and summary suspension of licensure without due process when imminent life-threatening conditions exist (NCDFS, n.d.).

Staffing in Assisted Living

Most states require assisted living facilities have sufficient staff to meet the needs of residents, but the staffing regulations vary among states. Kovner and Harrington (2003) report that according to the 2001 Assisted Living Sourcebook from the National Center for Assisted Living, 70% of facilities report having an
RN or LPN on duty or on call for a portion of the day or week. Some have minimum staffing ratios, some require a licensed nurse be available 24 hours a day but not necessarily on site, and approximately 80% of skilled nursing care is provided by contract nurses employed by the resident or through facility contracts with home health agencies (Kovner and Harrington, 2003). Considering the variable state staffing regulations in assisted living, this paper will examine North Carolina’s statutes and rules pertaining resident assessment protocols and staff qualifications, training, and supervision.

**NC Assisted Living Staffing Requirements**

According North Carolina statute, (Licensing of Adult Care Homes, 2001), “The Medical Care Commission shall adopt rules necessary to carry out this section. The Commission has the authority, in adopting rules, to specify the limitation of nursing services provided by assisted living residences. In developing rules, the Commission shall consider the need to ensure comparable quality of services provided to residents, whether these services are provided directly by a licensed assisted living provider, licensed home care or hospice agency. In adult care homes, living arrangements where residents require supervision due to cognitive impairments, rules shall be promulgated to ensure that supervision is appropriate and adequate to meet the special needs of these residents.” The NC Medical Care Commission is a regulatory body appointed by the governor that adopts rules and regulations pertaining to the care and safety of
individuals residing in adult care homes and other types of health care facilities and programs (State government, n.d.).

The primary adult care home rules to be adopted by the NC Medical Care Commission according to NC General Statute (NCGS) §131D (2001) are outlined in Table 4. The main components of this statute include the following: a minimum of 75 hours of training for staff with heavy care tasks that is comparable to state-approved Certified Nurse Aide I (CNA I) training; a minimum of 40 hours of training for personal care aides (PCAs) to include 20 hours of classroom training on basic nursing skills, personal care skills, cognitive, social and behavioral care, basic restorative services, and residents' rights; a minimum of 20 hours of training for PCAs in family care homes; conspicuous posting of daily staffing requirements; and minimum qualifications and competency evaluation for medication aides.

Table 4. NC Adult Care Home Rules for Adoption by Medical Care Commission

§ 131D-4.3 Adult Care Home Rules
(a) Pursuant to G.S. 143B-165, the North Carolina Medical Care Commission shall adopt rules to ensure a minimum, but shall not be limited to, the provision of the following by adult care homes:

(2) a minimum of 75 hours of training for personal care aides performing heavy care tasks and a minimum of 40 hours of training for all personal care aides. The training for aides providing heavy care tasks shall be comparable to state-approved Certified Nurse Aide I training. For those aides meeting the 40-hour requirement, at least 20 hours shall be classroom training to include at a minimum: basic nursing skills, personal care skills, cognitive, behavioral, and social care, basic restorative services, and resident’s rights.

“A minimum of 20 hours of training shall be provided for aides in family care homes that do not have heavy care residents. Persons who either pass a competency examination developed by the Department of Health and Human Services, have been employed as personal care aides for a period of time as established by the Department, or meet minimum requirements of a combination of training, testing, and experience as established by the Department shall be exempt from the training requirements.”
(3) Monitoring and supervision of residents

(5) Adult care homes shall comply with all of the following staffing requirements:

   a) First shift (morning): 0.4 hours of aide duty for each resident, or 8.0 hours of aide duty per each 20 residents plus 3.0 hours for all other residents, whichever is greater.
   b) Second shift (afternoon): 0.4 hours of aide duty for each resident, or 8.0 hours of aide duty per each 20 residents plus 3.0 hours for all other residents
   c) Third shift (evening): 8.0 hours of aide duty per 30 or fewer residents.

"In addition to these requirements, the facility shall provide staff to meet the needs of the facility’s heavy care residents equal to the amount of time reimbursed by Medicaid." ‘Heavy care resident means an individual residing in an adult care home who is defined ‘heavy care’ by Medicaid and for which the facility is receiving enhanced Medicaid payments for such needs.”

"Each facility shall post in a conspicuous place information about required staffing that enables residents and their families to ascertain each day the number of direct care staff and supervisors that are required by law to be on duty for each shift for that day.”

§ 131D-4.5 Rules adopted by Medical Care Commission

The Medical Care Commission shall adopt rules as follows:

1) Minimum medication administration standards for adult care homes including minimum staffing and training requirements for medication aides and standards for professional supervision of adult care homes’ medication controls. The requirements are designed to reduce the medication error rate to an acceptable level. The requirements shall include, but need not be limited to, all of the following:

   a. Training for medication aides, including periodic refresher training
   b. Standards for management of complex medication regimens
   c. Oversight by licensed professionals
   d. Measures to ensure proper storage of medication.

2) Establishing training requirements for adult care home staff in behavioral interventions.

3) Establishing minimum training and education qualifications for supervisors in adult care homes and specifying the safety responsibilities of supervisors.

4) Specifying the qualifications of staff who shall be on duty in adult care homes during various portions of the day in order to assure safe and quality care for residents.

The rules pursuant to the above statute adopted by the NC Medical Care Commission can be found in Title 10, Subchapter 42C and 42D of the N.C. Administrative Code. The qualifications and training for personal care aides is
specifically outlined in the rules, but the training for medication aides is not clearly stated. Instead, the rules set forth the qualifications and competency evaluations that medication aides should complete. These evaluations include a clinical skills evaluation and a written examination on which the medication aide must score at least ninety percent (10 NCAC 42C .2014, July 1, 2000). Table 5 outlines basic staff competency and training and basic qualifications of adult care home and family care home supervisors and medication staff. The rules pertaining to the basic qualifications of personal care staff were repealed on July 1, 1990 (10 NCAC 42C .2007; 10 NCAC 42D .1408). The training criteria outlined in NCGS § 131D is slightly different in the rules adopted by the Medical Care Commission. For example, staff that perform heavy care tasks and supervise other personal care staff are required to have 80 hours of training vs. 75 hours in the statute. Additionally, personal care staff are required to have 45 hours of training for adult care homes and 25 hours of training for family care homes, compared to the statute specifications of 40 hours and 20 hours respectively. It is interesting to note that personal care staff can be employed for as long as one year before their training and competency evaluation is complete. It is also concerning that the rules allow personal care staff to be exempt from training and competency evaluation if they have been performing the identified personal care tasks for at least 12 months during the three years prior to the date of hire.
<table>
<thead>
<tr>
<th>Table 5. NC Assisted Living Staff Qualifications, Training, and Competency</th>
</tr>
</thead>
</table>
| **Basic Qualifications of Supervisor-in-charge: Family Care Homes & Adult Care Homes**  
- Must be 18 years of age or older  
- Must meet health requirements in Rule .2004  
- Must be high school graduate or certified under the GED Program or alternate approved examination  
- Must verify that earns 12 hours per year of continuing education credits related to management of domiciliary homes and homes for the aged and disabled |
| **Basic Qualifications of Medication Staff: Family Care Homes and Adult Care Homes**  
10 NCAC 42C .2013 & 10 NCAC 42D .1414, Effective Feb. 15 2000  
- Staff who administer medication and staff who directly supervise them need documented proof of successful completion of the clinical skills validation portion of a competency evaluation  
- Effective October 1, 2000, medication aides and staff that supervise them need to successfully complete written examination of competency evaluation prior to administering medications or within 90 days after successful completion of clinical skills examination.  
- Medication aides and staff that supervise them must complete six hours of continuing education per year related to medication administration. |
| **Adult Care Home & Family Care Home Staff Competency and Training**  
10 NCAC 42C .2011 & 10 NCAC 42D .1410, Amended effective July 2000  
- Personal care staff and those who directly supervise them must successfully complete a 45-hr training program (25-hr for family care homes) and competency evaluation  
- Those who directly supervise staff who perform personal care tasks need to successfully complete an 80-hr training program and competency evaluation comparable to State-Approved Nurse Aide I training  
- Training described above must be completed within 6 months after hiring. DHHS may extend training for additional 6 months before paperwork is submitted  
- Exempt from 25 hr training if successfully complete competency evaluation or if have been employed performing the identified personal care tasks for at least 12 months during the 3 yrs prior to the date of hire.  
- Exempt from 80 hr training if successfully complete 15 hr refresher training and competency evaluation or if have been employed to perform direct supervision of personal care tasks for at least 12 months during the 3 yrs prior to date of hire.  
- Exempt from 25-hr and 80-hr training and competency evaluation if licensed health professionals or CNA |
In addition to the above staff training requirements, the facility is required to assure that staff who perform personal care tasks or who directly supervise them receive on-the-job training and supervision as necessary. Some, but not all, of the personal care tasks performed by personal care staff are as follows (10 NCAC 42D.1410, July 1, 2000):

**Personal care tasks that require 25-hr or 45-hr training programs**

1. Assist with toileting and maintaining bowel and bladder continence
2. Assist with mobility and transferring
3. Provide care to normal unbroken skin
4. Assist with personal hygiene
5. Provide basic first aid
6. Assist with dressing
7. Assist with feeding except if have swallowing difficulties
8. Take temperature, pulse and respirations
9. Take BP if a registered nurse has determined and documented that staff is competent to perform this task

**Personal care tasks that require 80-hr training programs**

1. Assist with feeding if have swallowing difficulty
2. Assist with gait training and assistive devices
3. Empty and record drainage of catheter bag;
4. Administer enemas
5. Bowel and bladder retraining
6. Non-sterile dressing procedures
7. Force and restrict fluids
8. Apply heat therapy
9. Care for non-infected pressure ulcers

The training programs and competency evaluation content for the 25-hour, 45-hour, and 80-hour training are specified in 10 NCAC 42C .2012 (family care homes) and 10 NCAC 42C .1411 (adult care homes), but these programs will not be reviewed in this paper.

Resident Assessment Standards

North Carolina General Statutes (Licensing of Adult Care Homes, 1997) require that the NCDHHS ensure that residents admitted to assisted living facilities are assessed within seventy-two hours of admission and annually thereafter using an assessment instrument approved by the Secretary of the NCDHHS upon advice from the Division on Aging. The NCDHHS is also required to provide assisted living facility staff with ongoing training on the use of the assessment instrument of choice. The facility must utilize the assessment data to develop a comprehensive care plan for each resident and to determine the level of facility staff needed to meet the resident’s needs. The inspection and licensing procedures by North Carolina’s Division of Facility Services (NCDFS) include a review of selected resident assessments, the assessment instrument utilized, the care plans developed in response to those assessments, whether the facility is capable of providing planned services, and whether these service and
care plans are actually being implemented. If the facility is not meeting these requirements, NCDFS may require implementation of a corrective action plan, may notify residents of the results of their review, and they may suspend admission of new residents for a period of time determined by the Secretary of the NCDHHS (Licensing of Adult Care Homes, 1997).

Resident assessment rules are the same for family care homes and adult care homes and can be found in 10 NCAC 42C .3701 (1997) in the family care home subchapter. Resident care plan rules are also the same and can be found in 10 NCAC 42C .3702 (1997) in the family care home subchapter. According to the rules, the “facility” should assure that each resident receives and admission assessment within 72 hours of admission, and the assessment instrument used must be approved by the NC Dept. of Health and Human Services (10 NCAC 42C .3701, (a), 1997). Also according to the rules of this subchapter, as of January 1, 2002, “an evaluation” must be completed within 30 calendar days of the resident’s admission and annually thereafter. This evaluation should consist of a functional assessment to determine each resident’s level of functioning in activities of daily living, needs, daily routines and personal preferences, mood and psychosocial well-being, and cognitive status. Activities of daily living to be considered include bathing, dressing, personal hygiene, ambulation, transferring, toileting, and eating. The results of this assessment shall be used to determine if the resident should be referred to their primary care physician, other licensed health care professional or community resource (Title 10, Subchapter 42C, 1997).
The rules also stipulate that after January 1, 2002, the "Resident Assessment Instrument" should be used within ten days of a significant change in the resident's condition (10 NCAC 42C .3701). If any of these significant changes occur, the resident should be referred to a physician, mental health professional, nurse practitioner, physician assistant, or registered nurse. According to the rules of this subchapter, a "significant change" can be one or more of the following conditions [10 NCAC 42C .3701 (b)]:

1. Deterioration in 2 or more ADLs;
2. Change in ability to ambulate or transfer;
3. Change in ability to use hands to grasp small objects;
4. Deterioration in behavior or mood to the point it creates daily problems;
5. No response to an identified treatment;
6. Initial onset of unplanned weight loss or gain of 5% of body weight within a 30-day period or 10% of body weight within a 6-month period;
7. Any threat to life such as a stroke, heart attack, or metastatic cancer;
8. Emergence of a Stage II or higher pressure ulcer;
9. New diagnosis which may affect physical, mental, or psychosocial well-being, such as Alzheimer's disease;
10. An improvement in behavior, mood, or functional health status which no longer matches the current plan of care;
11. New onset of impaired decision making;
12. Change from continence to incontinence or need for indwelling catheter;
13. New need for restraint when there is no current restraint order.
The rules above do not explicitly state who should perform resident assessments, but the assessment must be completed and signed by the administrator or a person designated by the administrator to perform resident assessments or reassessments [10 NCAC 42C .3701 (d)]. Additionally, the rule requires that the facility administrator or individual appointed by the administrator successfully complete training provided by the NCDHHS prior to conducting resident assessments or reassessments. However, registered nurses are exempt from the assessment training.

Rules pertaining to licensed health professional support (10 NCAC 42C .3703 (a), July 1, 2000) are very explicit regarding conditions in which the facility must assure that a registered nurse participates in the on-site review and evaluation of the residents’ health status, care plan and care provided. The registered nurse assessment should be done within 30 days of admission or within 30 days from the date the resident develops the need and quarterly thereafter.

Tasks requiring a registered nurse assessment include one or more of the following:

1. Applying and removing ace bandages, ted hose and binders;
2. Feeding techniques for residents with swallowing problems;
3. Bowel or bladder training programs to regain continence;
4. Enemas, suppositories, and vaginal douches;
5. Positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter;
6. Chest physiotherapy or postural drainage;
7. Clean dressing changes;

8. Collecting and testing of fingerstick blood samples;

9. Care of a well established colostomy or ileostomy;

10. Care of pressure ulcers;

11. Inhalation medication by a machine;

12. Maintaining accurate intake and output data;

13. Medication administration through gastrostomy feeding tube;

14. Oxygen administration and monitoring;

15. The care of residents who are physically restrained and the use of care practices as alternatives to restraints;

16. Oral suctioning;

17. Care of well established tracheostomy; or;

18. Administering and monitoring of gastrostomy tube feedings.

Other rules pertaining to licensed health professional support are outlined in Table 6. The rules presented in Table 6 pertain to personal care tasks, which can be provided by a registered nurse, occupational therapist, or physical therapist. The rules in 10 NCAC 42C .3703 also specify the conditions in which a licensed practical nurse or non-licensed personal care staff should be trained in order to perform the outlined tasks.
Table 6. Conditions Requiring Licensed Health Professional Support in NC
Assisted Living Facilities

10 NCAC 42C.3703

(b) The facility shall assure that a registered nurse, occupational therapist licensed under
G.S. 90, Article 18D or physical therapist licensed under G.S. 90-270.24, Article 18B,
participates in the on-site review and evaluation of the residents' health status, care plan
and care provided within the time frames specified in Paragraph (a) of this Rule for those
residents who require one or more of the following personal care tasks:

1. application of prescribed heat therapy;
2. application and removal of prosthetic devices except as used in early
   post-operative treatment for shaping of the extremity;
3. ambulation using assistive devices;
4. range of motion exercises;
5. any other prescribed physical or occupational therapy; or
6. transferring semi-ambulatory or non-ambulatory residents.

(c) The facility shall not provide care to residents with conditions or care needs as stated
in G.S. 131D-2(a1).

(d) The facility shall assure that participation by a registered nurse, occupational
therapist or physical therapist in the on-site review and evaluation of the residents' health
status, care plan and care provided includes:

1. assuring that licensed practical nurses and non-licensed personnel
   providing care and performing the tasks are competency validated
   according to Paragraph (e) of this Rule;
2. performing a physical assessment of the residents as related to their
diagnosis and current condition;
3. evaluating the resident's progress to care being provided;
4. recommending changes in the care of the resident as needed; and
5. documenting the activities in Subparagraphs (1) through (4) of this
   Paragraph.

(e) The facility shall assure that licensed practical nurses and non-licensed personnel are
trained and competency validated for personal care task specified in Paragraphs (a) and
(b) of this Rule. Competency validation shall be completed prior to staff performing the
personal care task and documentation shall be in the facility and readily available. Staff
shall be competency validated by the following health professionals:

1. A registered nurse shall validate the competency of staff who perform
   personal care task specified in Paragraph (a) of this Rule. In lieu of a
   registered nurse, a registered respiratory therapist may validate the
   competency of staff who perform personal care task (6), (11), (15), (17)
   and (18) specified in Paragraph (a) of this Rule. In lieu of a registered
   nurse, a registered pharmacist may validate the competency of staff who
   perform personal care task (8) specified in Paragraph (a) of this Rule.
2. A registered nurse, occupational therapist or physical therapist shall
   validate the competency of staff who performs personal care task
   specified in Paragraph (b) of this Rule.

(f) The facility shall assure that training on the care of residents with diabetes is provided
to unlicensed staff prior to the administration of insulin as follows and documented:

1. Training shall be provided by a registered nurse or registered pharmacist.

continued
(2) Training shall include at least the following:

(A) basic facts about diabetes and care involved in the management of diabetes;
(B) insulin action;
(C) insulin storage;
(D) mixing, measuring and injection techniques for insulin administration;
(E) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms;
(F) blood glucose monitoring; and
(G) universal precautions.

(g) The facility shall assure that staff who perform personal care tasks listed in Paragraphs (a) and (b) of this Rule are at least annually observed providing care to residents by a licensed registered nurse or other appropriate licensed health professional, as specified in Paragraph (d) of this Rule, who is employed by the facility or under contract or agreement, individually or through an agency, with the facility. Annual competency validation shall be documented and readily available for review.

Measuring Quality in Assisted Living

There are many concerns surrounding the monitoring of quality in residential care facilities that are not Medicare and Medicaid certified and receive no federal funding. Due to lack of federal oversight, many state and local governments have established statutes and ordinances requiring the use of residential assessment instruments such as the MDS or RAPs, which are applicable to assisted living residents (Wunderlich and Kohler, 2001).

Researchers in the CS-LTC study chose to examine process-of-care modalities in assisted living because understanding how process of care influences resident outcomes is important when evaluating quality and making recommendations for improvement (Zimmerman et al., 2001). Zimmerman et al. recognized that identifying process-related indicators of quality would be difficult in the assisted living industry due to the variation in state regulation and the heterogeneity of resident care requirements, level of functional capacity, and
preferences. The CS-LTC study collected process-related data utilizing a modified version of the Policy and Program Information Form (POLIF) of the Multiphasic Environmental Assessment Procedure (MEAP) by Moos and Lemke, 1996 (Zimmerman et al., 2001). The authors aggregated 10 quality measures across three process-of-care domains (Table 7). The information in Table 7 is presented as an example of a possible quality measurement tool for assisted living facilities, but the results of the study will not be specifically reviewed in this paper.

Table 7. CS-LTC Study Quality Measures & Process-of-Care Domains

<table>
<thead>
<tr>
<th>Individual Freedom and Institutional Order Domain</th>
<th>Requirements for Residents Domain</th>
<th>Provisions of Services Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Policy choice (extent to which residents can individualize routine)</td>
<td>1. Acceptance of Problem Behavior (how resident behavior is tolerated in facility)</td>
<td>1. Availability of social and recreational activities (facility activities available)</td>
</tr>
<tr>
<td>2. Policy clarity (extent expectations are communicated to residents)</td>
<td>2. Overall admission policies (admission expectations facility has for residents)</td>
<td>2. Overall provision of services (extent to which multiple services are available)</td>
</tr>
<tr>
<td>3. Resident control (degree residents involved in facility administration)</td>
<td>3. Admission policies specific to ADL functioning (functional level expectations facility has for residents)</td>
<td>3. Provision of health services (prevalence and accessibility of health services for residents)</td>
</tr>
<tr>
<td>4. Provision for privacy (amount of privacy given to residents)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In another study sponsored by the Office of the Assistant Secretary for Planning and Evaluation (Hawes, et al., 1995), researchers determined the effect of regulation and licensure on quality of care in board and care homes. Quality measures utilized in the Hawes et al. study included: operator education, training and experience; lower use of psychotropic drugs and contraindicated medications; presence of a "home-like" environment; availability of social and recreational aids; availability of supportive aids and devices; staff knowledge of Ombudsman program; availability of and resident involvement in activities; staff knowledge of basic care and monitoring; and the availability of licensed nurses.

Finally, the Washington State Boarding Home Consultation program developed, implemented, and evaluated a quality improvement service delivery model based on continuous quality improvement principles focused on customer satisfaction and outcomes (Dupler, Crogan, and Short, 2001). The Washington State Model created Quality Improvement (QI) pathways to assess resident issues related to quality of life, quality of care, and safety (Appendix E) (Dupler, et al, 2001). Researchers concluded that participating facilities were able to address resident needs based on the QI pathways, and as a result, 78% of residents demonstrated clinical improvement after six months (Dupler, et al., 2001).

Quality Concerns in Assisted Living

Assisted living facilities are a relatively new form of residential care with 60 percent of facilities having been in operation for ten or less years and one-third having been in operation for five or less years (Zimmerman, et al., 2001). Many
believe assisted living will develop into a viable, trustworthy alternative to nursing home care when a loved one is no longer capable of living independently or when home and community-based services do not meet individual long-term care needs (Zimmerman, et al., 2001). Despite the potential benefit the assisted living industry can provide, there is little information about this new type of residential care. Based on a recent report published by the General Accounting Office (GAO, 1999), there is growing concern surrounding the quality of care provided in assisted living coupled with questionable marketing practices that limit consumer capability to make informed decisions when selecting an assisted living facility.

The National Study of Assisted Living for the Frail Elderly (Hawes and Phillips, 2000) found most staff were knowledgeable about the appropriate response to a variety of care issues, but they were less knowledgeable about dementia care and antipsychotic drug use in frail elders. The authors reported the most concerning finding was that staff were poorly informed about the normal aging process. This is concerning because many of the issues felt to be a part of the normal aging process are actually treatable and often reversible conditions (Hawes and Phillips, 2000).

The Institute of Medicine's committee on improving quality in long term care seriously question the ability of state regulation and licensure to ensure quality of care and quality of life for individuals living in residential care facilities (Wunderlich and Kohler, 2001). Their findings raised a number of concerns and questions, and although they did not have definite suggestions on how state
regulation should be changed, they did recommend further research on the actual
effect of state surveys and penalty enforcement on quality of care and quality of
life. They also strongly recommended that state regulatory procedures should
more closely resemble the strict regulatory procedures by the Federal government
of nursing homes (Wunderlich and Kohler, 2001).

A study sponsored by The Office of the Assistant Secretary for Planning
and Evaluation looked at the effect of regulation on the quality of care in board
and care homes (Hawes et al., 1995). This ten-state study revealed a number of
key findings related to resident status, staff ratios, and staff training. For
example, in many of the facilities studied, when a resident became acutely ill and
needed professional nursing care for more than fourteen consecutive days, most of
the homes discharged the resident to a nursing home or hospital rather than
continuing to provide needed nursing care at the facility. Another important
finding was the existence of minimal staff training and knowledge adequate to
manage medications and monitor for side effects (Hawes et al., 1995).

Variation also exists among local surveyors and care providers with regard
to quality concerns in Orange County, North Carolina assisted living facilities.
Florence Soltys, Chair of the Orange County Advisory Board on Aging and
member of the Orange County Adult Care Home Community Advisory
Committee, stated, "I think one of the main problems in assisted living facilities is
that no one closely monitors the residents after they have been admitted. Some
residents deteriorate after admission and need closer monitoring and additional
assistance with ADLs or medications, and the staff is frequently unaware of their
increased needs" (personal communication, March 6, 2003). According to Jill Passmore, long-term care Ombudsman for Orange, Durham, and Chatham County, NC, no professional nurses are required to be on site in assisted living facilities, but some facilities provide professional nursing care and supervision by choice. Ms. Passmore receives fewer complaints from residents and families with loved ones in facilities that provide professional nursing care and supervision. In her opinion, the quality of care and quality of life is better for residents in assisted living facilities with professional nurses because residents are assessed more frequently, problems are discovered sooner, and staff receive consistent supervision, training and leadership. She explained that many facilities only employ resident assistants or medication aides who are not trained to adequately assess residents, which she believes often leads to two possible outcomes. First, a resident’s physical or mental health or psychosocial well-being can deteriorate to the point where the resident reaches an acute crisis requiring medical intervention or admission to a local hospital. The opposite problem can also occur. The paraprofessional caregiving staff can overreact to a resident’s change in condition, and because they do not have adequate assessment and critical thinking skills, they summon emergency medical services to escort the resident to an emergency room. The resident’s condition frequently does not warrant an emergency room visit, and this practice leads to increased costs and stress for the resident and caregivers alike (personal communication March 17, 2003).

Ms. Passmore believes state legislation is needed requiring professional nursing oversight at least eight hours per day and more frequent resident
assessments by RNs or LPNs. She explained that either the NC Medical Care Commission or one of our representatives in the state legislature could institute this policy change (personal communication, March 17, 2003). This regulatory recommendation may be a viable option, but researchers in the Hawes et al. study (1995) found that additional regulation frequently had no effect on requirements for staff training, availability of licensed nurses, staff knowledge of basic care, resident monitoring, or medication supervision.

As a long-term care Ombudsman, Ms. Passmore is also concerned about the medication administration errors by “Med Techs,” which she reports have been as high as 20 to 25 percent. She explained that many long-term care advocates in Orange County pressed for legislative changes to improve quality in assisted living. As a result of these advocacy efforts, in 1999 the NCDHHS introduced proposed changes in adult care home regulation which resulted in new legislation requiring changes in adult care home practices. Some of the new regulatory requirements are listed below (NCDFS, n.d.). However, follow-up studies on the medication error rate since the new regulations went into affect were not accessible.

- Competency evaluation for staff administering medications;
- Behavioral intervention training;
- Supervisory staff (not professional nurses);
- Special care unit rules and disclosure requirements;
- Stricter medication administration and resident assessment rule; and
- Certification of adult care home administrators.
While many long-term care advocates and service professionals are concerned about the healthcare aspects of assisted living, allied health professionals believe one of the main problems in assisted living is the failure of staff and administrators to address resident activity preferences. Cheryl Rosemond, physical therapist and member of the Orange County Adult Care Home Community Advisory Committee, believes this failure to assess and meet each resident’s activity needs directly leads to decreased quality of life and depression (personal communication, March 20, 2003). Sue Coppola, occupational therapist and member of the Orange County Adult Care Home Community Advisory Committee, believes assisted living staff do not adequately assess resident activity preferences or specific needs relative to their daily lives, such as needs for visual or auditory assistive devices (personal communication, March 25, 2003). In talking with these local advocates and from personal experience, it appears each discipline tends to identify problems in assisted living relative to their perspective profession. For this reason, it is important to review the available literature on the above-mentioned problems.

**Staffing Affect on Quality in Assisted Living**

Each long-term care setting has different personnel standards, and most research on the impact of the number and type of staff (RN, LPN, and/or nurse aides) on quality of care and quality of life has been conducted in nursing home settings (Kayser-Jones, J, 2001; “CMS study,” 2002; “The relationship,” 2000).
Little documented evidence exists with regard to the impact of staffing patterns on quality in other long-term care settings, such as assisted living facilities.

The Agency for Healthcare Research and Quality (AHRQ, 2001) found that adequate staff supervision provides leadership, motivation, and improved care of residents. Also, based on reviews by the IOM’s committee on improving quality in long-term care, a number of studies have shown that staffing, in terms of number of nursing staff to residents and number of professional nurses to other nursing personnel, is positively correlated with quality care (Wunderlich and Kohler, 2001). Other studies demonstrated that professional nursing management and management by professionals trained in gerontology had a positive impact on the quality of care and quality of life for nursing home residents (Wunderlich and Kohler, 2001).

Bowers et al. (2000) found studies showing that the quality of care in long-term care facilities is influenced by both the level of staffing (staff-to-patient ratios) and the mix of staff (numbers of RNs, LPNs, and NAs). Many studies demonstrated higher RN-to-resident ratios and higher RN-to-LPN or RN-to-NA mixes were positively correlated with improved resident outcomes and fewer deficiencies on state surveys (Bowers et al., 2000). Most of these studies on the relationship between staffing and quality used different definitions and measurements of quality. Some used quality indicators from the CMS Minimum Data Set, some used indicators of the clinical aspects of care such as decubitus ulcers and incontinence without a bladder management plan, and still others used
multiple item quality measures including resident rights, resident behaviors, resident assessment procedures, and overuse of antibiotics (Bowers et al., 2000).

Bowers et al. (2000) found few studies examining the process of care on resident outcomes and therefore chose to examine nurse aide viewpoints on the staffing processes that affect quality. The researchers interviewed 38 nurse aides in 6 nursing homes to determine how these frontline caregivers believed staffing was related to resident outcomes. The nurse aides in this study understood the importance of staffing on resident outcomes, and they understood the processes by which staffing levels affect quality. The nurse aides reported that their ability to establish meaningful relationships with residents is the key to providing quality care, and that these relationships can only be built with adequate, consistent staffing and minimal turnover. Furthermore, the nurse aides believe that inadequate staffing is detrimental to resident-staff relationships, which ultimately affects both quality of care and quality of life. The nurse aides explained that when close relationships develop between staff and residents, the staff view residents as family, and thus provide more consistent, individualized care. The nurse aides also stated that when understaffed, they find it necessary to rush care and accomplish multiple tasks at the same time. In these instances the residents feel rushed and are unable to practice their normal daily routines on a timetable important to them, thus eroding their quality of life (Bowers et al., 2000).
Resident Values And Preferences In Assisted Living

In order to improve care in assisted living, it is important to determine resident expectations and definitions of quality (Ball, Whittington, Perkins, Patterson, Hollingsworth, King, and Combs, 2000). Few studies have looked at resident values, but the research that has been done shows residents most value independence, autonomy, privacy, and control of their living space (Ball, et al., 2000). Other factors valued include personal health; a feeling of comfort in one’s environment; social activities; interpersonal relationships with family, other residents and staff; dietary choices; and cost of services (Ball et al., 2000).

Ball et al. (2000) found no comprehensive literature documenting the typical daily life of assisted living residents, their functional abilities or their care needs. The authors believe policy makers need this information in order to make decisions regarding assisted living regulation. Therefore, they conducted a study of 17 Atlanta assisted living facilities and interviewed 55 residents to determine what their daily lives encompassed and what they valued in terms of quality of life. From their study they discovered the following primary care needs: managing money (69%), bathing (34%), medications (31%), dressing (25%), walking (15%), and writing letters (13%). These findings have important implications for determining the care residents typically require and the type and number of caregivers needed to meet these needs.

Based on the study results, Ball et al. (2000) identified 14 broad quality of life domains valued by assisted living residents. Some of these domains overlap and individual residents value each domain differently. These domains were as
follows: psychological well-being, independence and autonomy, social relationships and interactions, meaningful activities, care from facility, comfort, cognitive functioning/memory, sleep, food, connectedness to community, physical functioning, religion/spirituality, physical environment, and safety and security. The researchers concluded that most of these domains pertain to the physical and social environment of the facility and many are influenced by the structure and process of care. They also felt the study results demonstrated that quality of life is not dramatically improved by merely meeting basic needs such as nutrition and assistance with activities of daily living. The residents did not report significant satisfaction with their quality of life until the higher-level social interaction needs were met (Ball, et al., 2000).

The most common mental health problems for residents of assisted living are anxiety and depression (Ball, et al., 2000). Loneliness and boredom are also frequently verbalized complaints. Ball et al. found that 44% of residents reported loneliness, and most missed their families, interaction with friends, and involvement in the community. Seventy percent of respondents in the Ball et al. study reported that boredom was a moderate to severe problem, and boredom was most frequently due to lack of meaningful activities.

**Meaningful Activities**

One of the most concerning findings from the National Study of Assisted Living for the Frail Elderly (Hawes and Phillips, 2000) was that nearly 60% of residents reported that staff never or infrequently inquired about their activity
preferences. Researchers also found that few residents were involved in activities outside the facility mainly due to unavailability of transportation with 55% of residents reporting that transportation to activities they enjoyed outside the facility was never or only sometimes available. Additionally, nearly 50% of residents reported that the facility never or only sometimes offered activities they enjoyed (Hawes and Phillips, 2000).

Ball et al. (2000) found that the availability of meaningful activities was crucial to resident quality of life, but the definition of “meaningful activities” varied. Activities reported as meaningful included: sitting with others at meal times; reading; watching television; religious activities; and activities outside the facility, such as church, singing groups, trips, and music events. No matter what the activity, the key is providing choice and focusing on ways to relieve loneliness, boredom, and depression (Ball et al., 2000).

Discussion

The quality of care in long-term care facilities remains concerning, especially in terms of building a high-quality long-term care workforce. Most efforts to improve quality are difficult, if not impossible, to implement without an adequate supply of frontline caregivers who are well-trained and motivated to provide the best care possible. These caregivers have tremendous influence on the quality of care, quality of life, and safety of residents in all long-term care settings. Given these facts, North Carolina legislation relative to personal care staff training and qualifications deserves further examination. For example, the
number of training hours required for personal care staff in adult care homes is 45 hours compared to 25 hours for personal care staff in family care homes. The main difference between family care homes and adult care homes are the number of resident beds, one to six and seven or more respectively. Since the admission criteria and resident characteristics can be the same, it seems the training of personal care staff should be the same as well. Unfortunately, there is insufficient evidence to determine the reason for this discrepancy, but it needs further investigation.

Another troublesome area in the NC assisted living legislation pertains to the administrative rules allowing personal care staff to be employed for 12 months before all training and competency evaluation paperwork must be submitted to the NCDHHS. This rule coupled with the rule that personal care staff are exempt from training if they have been performing the personal care tasks for at least 12 months prior to the date of hire allows employment of personal care staff who have not successfully completed training or competency evaluation. Given the critical nature of the caregiver workforce shortage, it is understandable that assisted living employers want personal care staff to begin working immediately. Unfortunately, this leaves residents vulnerable without a full compliment of trained staff. In my opinion, personal care staff should not be employed or allowed to care for residents until required training and/or competency evaluations are complete.
The frequency of resident assessments in assisted living, as well as the qualifications of staff performing these assessments are other areas of concern. Nursing homes are available to older adults who are frail, functionally and/or cognitively impaired, and incapable of living independently. Assisted living facilities are intended to house individuals who can live independently with assistance from personal care staff and medication aides. Persons that cannot live independently are not candidates for assisted living. Here in lies the problem. As the population of older adults continues to rise over the next thirty years, the assisted living industry will see a corresponding rise in the number of frail, functionally impaired residents. The policies and regulations particular to assisted living facilities will need to be amended along with these changing demographics.

Many states, such as North Carolina, use the Minimum Data Set (MDS) for resident assessments (Appendix A) that are mandated for use by nursing homes by the Centers for Medicare and Medicaid Services. Many aspects of the MDS are appropriate as an admission assessment for assisted living residents and as a reassessment tool every 90 days as required by the state of North Carolina. However, questions remain regarding whether residents of assisted living should be assessed more frequently, and if so, which assessment tool would be most appropriate. North Carolina provides a number of situations in which residents should be assessed by a licensed nurse (see pp. 33-34 and Table 6, p. 35), but are the nurse aides and medication aides that provide the daily personal care capable of assessing residents for conditions that require more thorough assessment and evaluation by registered nurses? There are no available studies documenting the
proportion of residents whose conditions deteriorate after admission, how personal care staff react to those changes, the assessment tools used by registered nurses when conditions change, and most importantly, whether these interventions change outcomes. Observational studies are desperately needed in this area, so advocates and care providers can lobby for the most appropriate legislative action. It seems premature to recommend legislation without adequate data to support new laws.

Medication errors in assisted living are another disturbing issue. In North Carolina in particular, regulations requiring additional training for medication aides have been enacted, but anecdotally, long-term care advocates still believe the medication error rate is too high. Studies are needed documenting the error rate in assisted living facilities, but merely having raw data on medication error rates is not helpful. Without research on the process and structure of care relative to medication administration, it will be difficult to determine why medication error rates remain unacceptable. The error rate could be due to a number of reasons, such as insufficient training hours for medication aides, inadequate training content, lack of continuing education, lack of assessment skills necessary to recognize adverse drug reactions or situations where medications are contraindicated, etc. Greater nursing oversight, supervision, and leadership could result in lower medication error rates, but it is difficult to recommend this type of state regulation without supporting evidence.

One other issue relative to the assisted living industry is the availability of meaningful activities for residents. Sufficient evidence exists demonstrating that
the availability of meaningful activities is directly related to resident quality of life. Additional research in this area would be helpful but should not preclude local community planning initiatives advocating for meaningful activities in assisted living. Residents, family members, staff, and involved community members can collaborate to advocate for meaningful activities. As documented in Ball et al. (2000), nearly 60% of respondents reported staff never or infrequently asked about their activity preferences. With additional evidence, perhaps advocates could lobby for state legislation requiring documentation that residents were asked about their activity preferences and that attempts were made to meet those needs. In North Carolina, the admission assessment is reviewed and violations are reported if deficiencies are found. It is possible that the statute regarding this component of assisted living care could be amended to include documented evidence of sufficient assessment and planning to meet resident activity needs.

It is important to keep in mind that much of the regulation imposed on the assisted living industry has been passed with little or no supporting data. There is also insufficient data demonstrating regulation actually improves or assures quality (Zimmerman et al., 2001). Zimmerman et al. (p.327) suggested, “The optimal approach would be to regulate select aspects of the structure and process of care that relate most strongly to resident outcomes.” Ball et al. (2000) concluded from their study on resident viewpoints about quality that an individualized plan of care for each resident was critical to assuring quality of life. However, in order to do this, staff must take the time to get to know each
resident's unique personalities, desires, needs, and preferences. Instituting a process of individualized care planning in assisted living will require a change in philosophy by facility staff and administration (Ball et al., 2000). Unfortunately, barriers such as inadequate pay, high turnover, and insufficient training have predominately hampered individualized care planning in most assisted living facilities (Ball et al., 2000). In order to achieve a goal of quality long-term care provision, the problems surrounding the caregiving workforce must be addressed.

Washington State's "Pathways to Quality Improvement" tools (Appendix F) may be the best example of how to institute quality improvement management principles into the assisted living industry. Whatever tools are ultimately used to assess quality and improve care, one thing is certain, the staff that provide the most intimate care to our loved ones deserve adequate compensation, along with appropriate leadership to learn, grow, and feel empowered to provide the best care possible.
References

Adult Care Home Rules. NCGS §131D-4.3 (2001).


Licensing of adult care homes for the aged and disabled, NCGS §131D-2 (a) (1d) (1995).

Licensing of adult care homes for the aged and disabled, NCGS §131D-2 (e) (1997).

Licensing of adult care homes for the aged and disabled, NCGS §131D-2 (c2) (2000).


Page 56

APPENDIX A
### SECTION AA. IDENTIFICATION INFORMATION

**1. RESIDENT NAME**
- a. (First) [ ]
- b. (Middle Initial) [ ]
- c. (Last) [ ]
- d. (HIS) [ ]

**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**
- 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.**
- 1. "*" if pending, "N" if not a Medicaid recipient [ ]

**8. REASONS FOR ASSESSMENT**
- 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 full assessment [ ]
  - 5. Significant correction of prior quarterly assessment [ ]
  - 6. NONE OF ABOVE [ ]

- b. Codes for assessments required for Medicare PPS or the State
  - 1. Medicare 5 day assessment [ ]
  - 2. Medicare 90 day assessment [ ]
  - 3. Medicare 90 day assessment [ ]
  - 4. Medicare readmission/mortification assessment [ ]
  - 5. Other state required assessment [ ]
  - 6. Other Medicare required assessment [ ]

### 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.)

© = Key items for computerized resident tracking

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

MDS 2.0 September, 2000
### Minimum Data Set (MDS) — Version 2.0

**Background (Face Sheet) Information at Admission**

#### Section A. Demographic Information

<table>
<thead>
<tr>
<th>1. Date of Entry</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>Day</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Admitted From (at Entry)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Private home/flat, with no home health services</td>
<td></td>
</tr>
<tr>
<td>2. Private home/flat, with home health services</td>
<td></td>
</tr>
<tr>
<td>3. Board and care/assisted living group home</td>
<td></td>
</tr>
<tr>
<td>4. Nursing home</td>
<td></td>
</tr>
<tr>
<td>5. Acute care hospital</td>
<td></td>
</tr>
<tr>
<td>6. Psychiatric hospital, MR/DD facility</td>
<td></td>
</tr>
<tr>
<td>7. Rehabilitation hospital</td>
<td></td>
</tr>
<tr>
<td>8. Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Lived Alone (Prior to Entry)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
<tr>
<td>2. In other facility</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Zip Code of Prior Primary Residence</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Residential History 5 Years Prior to Entry</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above)</strong></td>
<td></td>
</tr>
<tr>
<td>Prior stay at this nursing home</td>
<td></td>
</tr>
<tr>
<td>Stay in other nursing home</td>
<td></td>
</tr>
<tr>
<td>Other residential facility—board and care home, assisted living group home</td>
<td></td>
</tr>
<tr>
<td>Mental health setting</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Lifetime Occupation(s) [Put &quot;*&quot; between two occupations]</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Education (Highest Level Completed)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No schooling</td>
<td></td>
</tr>
<tr>
<td>2. 8th grade or below</td>
<td></td>
</tr>
<tr>
<td>3. 9-11th grades</td>
<td></td>
</tr>
<tr>
<td>4. High school</td>
<td></td>
</tr>
<tr>
<td>5. Technical or trade school</td>
<td></td>
</tr>
<tr>
<td>6. Some college</td>
<td></td>
</tr>
<tr>
<td>7. Bachelor's degree</td>
<td></td>
</tr>
<tr>
<td>8. Graduate degree</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Language</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Primary Language</td>
<td></td>
</tr>
<tr>
<td>0. English</td>
<td></td>
</tr>
<tr>
<td>1. Spanish</td>
<td></td>
</tr>
<tr>
<td>2. French</td>
<td></td>
</tr>
<tr>
<td>3. Other</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. Mental Health History</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No</td>
<td></td>
</tr>
<tr>
<td>1. Yes</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. Conditions Related to MR/DD Status</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(Check all conditions that are related to MR/DD status that were manifested before age 21, and are likely to continue indefinitely)</strong></td>
<td></td>
</tr>
<tr>
<td>Not applicable—no MR/DD (Skip to AB11)</td>
<td></td>
</tr>
<tr>
<td>MR/DD with organic condition</td>
<td></td>
</tr>
<tr>
<td>Down's syndrome</td>
<td></td>
</tr>
<tr>
<td>Autism</td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
</tr>
<tr>
<td>Other organic condition related to MR/DD</td>
<td></td>
</tr>
<tr>
<td>MR/DD with no organic condition</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11. Date Background Information Completed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
<td>Day</td>
</tr>
</tbody>
</table>

### Section B. Customary Routine

#### 1. Customary Routine

<table>
<thead>
<tr>
<th>Cycle of Daily Events</th>
<th>(Check all that apply. If all information UNKNOWN, check last box only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stays up late at night (e.g., after 9 pm)</td>
<td>a.</td>
</tr>
<tr>
<td>Naps regularly during day (at least 1 hour)</td>
<td>b.</td>
</tr>
<tr>
<td>Goes out 1+ days a week</td>
<td>c.</td>
</tr>
<tr>
<td>Stays busy with hobbies, reading, or fixed daily routine</td>
<td>d.</td>
</tr>
<tr>
<td>Spends most of time alone or watching TV</td>
<td>e.</td>
</tr>
<tr>
<td>Uses tobacco products at least daily</td>
<td>f.</td>
</tr>
<tr>
<td>NONE OF ABOVE</td>
<td></td>
</tr>
</tbody>
</table>

#### Eating Patterns

<table>
<thead>
<tr>
<th>Distinct food preferences</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Eats between meals all or most days</td>
<td></td>
</tr>
<tr>
<td>Uses alcoholic beverage(s) at least weekly</td>
<td></td>
</tr>
<tr>
<td>NONE OF ABOVE</td>
<td></td>
</tr>
</tbody>
</table>

#### ADL Patterns

| In bedclothes much of day |  |
| Wakens to toilet all or most nights |  |
| Has irregular bowel movement pattern |  |
| Showers for bathing |  |
| Bathing in PM |  |
| NONE OF ABOVE |  |

#### Involution Patterns

| Daily contact with relatives/close friends |  |
| Usually attends church, temple, synagogue (etc.) |  |
| Finds strength in faith |  |
| Daily animal companion/presence |  |
| Involved in group activities |  |
| NONE OF ABOVE |  |
| UNKNOWN—Resident/family unable to provide information |  |

### Section C. Face Sheet Signatures

**Signatures of Persons Completing Face Sheet:**

<table>
<thead>
<tr>
<th>Signature of RN Assessment Coordinator</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature and Title</td>
<td>Sections</td>
</tr>
<tr>
<td>a.</td>
<td>b.</td>
</tr>
<tr>
<td>d.</td>
<td>e.</td>
</tr>
<tr>
<td>g.</td>
<td>h.</td>
</tr>
<tr>
<td>j.</td>
<td>k.</td>
</tr>
<tr>
<td>m.</td>
<td>n.</td>
</tr>
<tr>
<td>p.</td>
<td>q.</td>
</tr>
<tr>
<td>s.</td>
<td>t.</td>
</tr>
<tr>
<td>v.</td>
<td>w.</td>
</tr>
<tr>
<td>y.</td>
<td>z.</td>
</tr>
</tbody>
</table>
### SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

<table>
<thead>
<tr>
<th>1. RESIDENT NAME</th>
<th>a. (First)</th>
<th>b. (Middle initial)</th>
<th>c. (Last)</th>
<th>d. (Suffix)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. ROOM NUMBER</td>
<td>[ ] [ ] [ ]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. ASSESSMENT REFERENCE DATE</td>
<td>a. Last day of MDS observation period</td>
<td>Month</td>
<td>Day</td>
<td>Year</td>
</tr>
<tr>
<td>b. Original (0) or corrected copy of form (enter number of correction)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. DATE OF REENTRY</td>
<td>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)</td>
<td>Month</td>
<td>Day</td>
<td>Year</td>
</tr>
<tr>
<td>6. MEDICAL RECORD NO.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. CURRENT PAYMENT SOURCES FOR N.H. STAY</td>
<td>a. Medicare per diem</td>
<td>b. Va. per diem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Medicaid per diem</td>
<td>d. Self or family pays for full per diem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Medicare ancillary part A</td>
<td>f. Medicaid resident liability or Medicare co-payment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Medicare ancillary part B</td>
<td>h. Private insurance per diem (including co-payment)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. CHAMPUS per diem</td>
<td>j. Other per diem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. REASONS FOR ASSESSMENT</td>
<td>a. Primary reason for assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Note—if this is a discharge or reentry assessment, only a limited subset of MDS items need be completed)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Codes for assessments required for Medicare PPS or the State</td>
<td>1. Medicare 5-day assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Medicare 30-day assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Medicare 60-day assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Medicare readmission return assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Other state required assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Medicare 14-day assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Medicare 14-day required assessment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. RESPONSIBILITY LEGAL GUARDIAN</td>
<td>a. Legal guardian</td>
<td>b. Patient responsible for self</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Family member responsible</td>
<td>d. None of above</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. ADVANCED DIRECTIVES</td>
<td>a. Living will</td>
<td>b. Advance directive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(For those items with supporting documentation in the medical record, check all that apply)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Do not resuscitate</td>
<td>d. Do not hospitalize</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Feeding restrictions</td>
<td>f. Other treatment restrictions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Medication restrictions</td>
<td>h. Autopsy requested</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. None of above</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SECTION B. COGNITIVE PATTERNS

| 1. CONFUSION (Persistent vegetative state/no discernible conscious state) | a. No | b. Yes (If yes, skip to Section C) |
| 2. MEMORY (Recall of what was learned or known) | a. Short-term memory OK—seems to recall after 5 minutes |
| b. Long-term memory OK—seems to recall prior to last assessment or admission if less than 90 days |
| c. Memory problem |
| d. Memory OK |

### SECTION C. COMMUNICATION/HEARING PATTERNS

| 1. HEARING (With hearing appliance, if used) | a. HEARS ADEQUATELY — normal talk, TV, telephone |
| b. MINIMAL DIFFICULTY when not in quiet setting |
| c. HEARS IN SPECIAL SITUATIONS ONLY — speaker has to adjust tone and loudness |
| d. HIGHLY IMPAIRED — complete hearing aid |
| 2. COMMUNICATION DEVICE/TÉCHNIQUES | a. Speech |
| b. Writing messages to express or clarify needs |
| c. American sign language or Braille |
| 3. MODALITIES OF EXPRESSION | a. Speech |
| b. Writing |
| c. Communication board |
| 4. MAKING SELF UNDERSTOOD | a. UNDERSTOOD |
| b. USUALLY UNDERSTOOD — difficulty finding words or finishing thoughts |
| c. SOMETIMES UNDERSTOOD — ability is limited to making concrete requests |
| d. RARELY/NEVER UNDERSTOOD |
| 5. SPEECH CLARITY (Code for speech in the last 7 days) | a. CLEAR SPEECH — distinct, intelligible words |
| b. UNCLEAR SPEECH — mumbled words |
| c. NO SPEECH — absence of spoken words |
| 6. ABILITY TO UNDERSTAND OTHERS | a. UNDERSTANDS |
| b. USUALLY UNDERSTANDS — may miss part of message |
| c. SOMETIMES UNDERSTANDS — responds adequately to simple, direct communication |
| d. RARELY/NEVER UNDERSTANDS |
| 7. CHANGE IN COMMUNICATION/HEARING | a. No change |
| b. Improved |
| c. Determined |

*when box blank, must enter number or letter*
SECTION D. VISION PATTERNS

1. **VISION**
   - **ABLE to see in adequate light and with glasses if used**
     - **ADVERSE**—sees the detail, including regular print in newspapers/books.
     - **IMPROVED**—sees large print, but not regular print in newspapers/books.
     - **MODERATELY IMPAIRED**—limited vision not able to see newspaper headlines, but can identify objects.
     - **HIGHLY IMPAIRED**—object identification in question, but eyes appear to follow objects.
     - **SEVERELY IMPAIRED**—no vision or only light, colors, or shapes; eyes do not appear to follow objects.

2. **VISUAL LIMITATIONS/DIFFICULTIES**
   - **Sight** vision problems—decreased peripheral vision (e.g., leaves food on one side of tray); difficulty walking, bumps into people and objects, navigates placement of chair when sitting still.
   - Experience any of following: seeing halos or rings around lights; seeing flashes of light; seeing “curtains” over eyes.
   - **NONE OF ABOVE**

3. **VISUAL APPEARANCES**
   - **Glasses/contact lenses; magnifying glass**
   - **No**

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. **INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD**
   - **(Code for indicators observed in last 30 days, irrespective of the assessed cause)**
   - **0. Indicator not exhibited in last 30 days**
   - **1. Indicator of this type exhibited up to 5 days a week**
   - **2. Indicator of this type exhibited daily or almost daily (6-7 days a week)**

2. **VERBAL EXPRESSIONS OF DISTRESS**
   - **1. Resident made negative statements—e.g., “Nothing matters; I would rather be dead; What’s the use; Resignation, I’ve had it too long. Let me die!”**
   - **2. Repetitive questions—e.g., “Where do I go? What do I do?”**
   - **3. Repetitive verbalizations—e.g., “Tell me what to do, God help me!”**
   - **4. Persistent anger with self or others—e.g., “Why am I so sad?”**
   - **5. Self-denigration—e.g., “I am nothing; I am not worth anyone”**
   - **6. Expressions of what appears to be unrealistic fears—e.g., “I am going to get hit”**
   - **7. Loss of interest—e.g., withdrawal from activities of interest, including job, hobbies, leisure activities, family, and friends**

3. **LOSS OF INTEREST**
   - **a. Withdrawal from activities of interest**—e.g., no interest in long-standing activities or being with family/friends.
   - **b. Reduced social interaction**

SECTION F. PSYCHOSOCIAL WELL-BEING

1. **SENSE OF INITIATIVE/INVOLVEMENT**
   - At ease interacting with others.
   - At ease doing planned or structured activities.
   - At ease doing self-initiated activities.

2. **UNSETTLED RELATIONSHIPS**
   - Unhappy with roommate.
   - Unhappy with residents other than roommate.
   - Unhappy with family/friends.
   - Unhappy with close friends.

3. **PAST ROLES**
   - Strong identification with past roles and life status.
   - Expresses sadness in response to loss of status.
   - Resentful perceptions of daily routine.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. **ADL SELF-PERFORMANCE**
   - **(Code for resident’s performance over all shifts during last 7 days—not including any change)**
   - **0. INDEPENDENT—No help or oversight**
   - **1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days**
   - **2. LIMITED ASSISTANCE—Resident highly involved in activity; given physical help in guided maneuvering of limbs or non-weight-bearing assistance 3 or more times—**
   - **3. EXTENSIVE ASSISTANCE—White resident performed activity, over last 7-day period, help of following type(s) provided 3 or more times:**
     - **Weight-bearing support**—Full weight-bearing support.
     - **3 or more times**

2. **ACTIVITY DID NOT OCCUR during entire 7 days**
   - **0. No**
   - **1. Yes**

3. **BEHAVIORAL SYMPTOMS FREQUENCY IN LAST 7 DAYS**
   - **0. Behavior not exhibited in last 7 days**
   - **1. Behavior of this type occurred 1-2 days in last 7 days**
   - **2. Behavior of this type occurred 3 or more times in last 7 days**
   - **3. Behavior of this type occurred daily**

4. **BEHAVIORAL SYMPTOMS FREQUENCY IN LAST 7 DAYS**
   - **0. Behavior not present**
   - **1. Behavior was not easily altered**
   - **2. Behavior was easily altered**

5. **CHANGE IN BEHAVIORAL SYMPTOMS**
   - **Resident’s behavior status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days ago)**
   - **0. No change**
   - **1. Improved**
   - **2. Deteriorated**
2. BATHING

<table>
<thead>
<tr>
<th>Code of ability during test in the last 7 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.</td>
</tr>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
</tbody>
</table>

- Balance while standing
- Balance while sitting—position, trunk control

3. TEST FOR BALANCE

4. FUNCTIONAL LIMITATION IN RANGE OF MOTION

5. MODES OF LOCOMOTION

6. MODES OF TRANSFER

7. TASK SEGMENTATION

8. ADL FUNCTIONAL REHABILITATION POTENTIAL

9. CHANGE IN ADL FUNCTION

SECTION H. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL CATEGORIES

2. BOWEL CONTINENCE

3. BLADDER CONTINENCE

4. BOWEL ELIMINATION PATTERN

SECTION J. HEALTH CONDITIONS

1. PROBLEM CONDITIONS

INDICATORS OF FLUID STATUS

- Weight gain or loss of 3 or more pounds within a 7 day period
- Inability to lie flat due to shortness of breath
- Dry or output exceeds input
- Insufficient fluid; did NOT consume all fluids provided during last 3 days

OTHER

- Incontinence
- Edema
- Fever
- Hematuria
- Incontinence
- Nausea and vomiting
- Urinary tract infection
- Wound infection
- Respiratory infection
### SECTION M. SKIN CONDITION

<table>
<thead>
<tr>
<th>Numeric Identifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ULCERS (Due to any cause)</td>
<td>Record the number of ulcers at each ulcer stage—regardless of cause. If none present or at a stage, record &quot;0&quot; (zero). Only all that apply during last 7 days. Code 9 (or more) Requires full body exam.</td>
</tr>
<tr>
<td>a. Stage 1</td>
<td>Persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.</td>
</tr>
<tr>
<td>b. Stage 2</td>
<td>Partial thickness of skin layers that presents clinically as an abrasion, blister, or shallow crater.</td>
</tr>
<tr>
<td>c. Stage 3</td>
<td>Full thickness of skin is lost, exposing the subcutaneous tissue—presents as a deep crater with or without undermining of adjacent tissue.</td>
</tr>
<tr>
<td>d. Stage 4</td>
<td>Full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.</td>
</tr>
</tbody>
</table>

### SECTION K. ORAL/NUTRITIONAL STATUS

<table>
<thead>
<tr>
<th>1. ORAL PROBLEMS</th>
<th>Chewing problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. HEIGHT AND WEIGHT</td>
<td>Height loss—5% or more in last 30 days; or 10% or more in last 180 days</td>
</tr>
<tr>
<td>a. Weight loss—5% or more in last 30 days; or 10% or more in last 180 days</td>
<td>0. No</td>
</tr>
<tr>
<td>b. Weight gain—5% or more in last 30 days; or 10% or more in last 180 days</td>
<td>0. No</td>
</tr>
</tbody>
</table>

### SECTION L. ORAL/DENTAL STATUS

<table>
<thead>
<tr>
<th>1. ORAL STATUS AND DISEASE PREVENTION</th>
<th>Debris (soft, easily movable substances) present in mouth prior to going to bed at night. Has dentures or removable bridge.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Debris (soft, easily movable substances) present in mouth prior to going to bed at night.</td>
<td>Has dentures or removable bridge.</td>
</tr>
<tr>
<td>b. Somewhat natural teeth lost—does not have or does not use dentures (or partial plates).</td>
<td>Broken, loose, or carious teeth</td>
</tr>
<tr>
<td>c. Inflamed gums (gingiva); swollen or bleeding gums; oral abrasions; ulcers or erosions</td>
<td>Daily cleaning of teeth/dentures or daily mouth care—by resident or staff.</td>
</tr>
<tr>
<td>d. NONE OF ABOVE</td>
<td></td>
</tr>
</tbody>
</table>
5. **PREFERS CHANGE IN DAILY ROUTINE**

   - Code for resident preferences in daily routines:
     - a. Type of activities in which resident is currently involved:
       - Major change
     - b. Extent of resident involvement in activities:
       - Full bed rails on all sides of bed

   - Slight change
   - Major change

SECTION O. MEDICATIONS

1. **NUMBER OF MEDICATIONS**

   - (Record the number of different medications used in the last 7 days entered "0" if none used)

2. **NEW MEDICATIONS**

   - (Record the number of medications that were initiated during the last 90 days entered "0" if none used)

3. **INJECTIONS**

   - (Record the number of injections of any type received during the last 7 days entered "0" if none used)

4. **DAYS RECEIVED THE FOLLOWING MEDICATION**

   - a. Antipsychotic
   - b. Anxiolytic
   - c. Antidepressant
   - d. Hypnotic
   - e. Other...

SECTION P. SPECIALTREATMENTS AND PROCEDURES

1. **SPECIAL CARE—Check treatments or programs received during the last 14 days**

   - a. Ventilator or respirator
   - b. Chemotherapy
   - c. Dialysis
   - d. IV medication
   - e. Intravenous
   - f. Monitoring acute medical condition
   - g. Osmotic care
   - h. Oxygen therapy
   - i. Radiation
   - j. Suctioning
   - k. Trachonomy care
   - l. Transcutaneous
   - m. THERAPIES - Record the number of days and total minutes each of the following treatments was administered (at least 15 minutes a day in the last 7 calendar days entered "0" if none or less than 15 minutes a day in the last 7 calendar days)
     - a. Speech-language pathology and audiology services
     - b. Occupational therapy
     - c. Physical therapy
     - d. Respiratory therapy
     - e. Psychological therapy (by any licensed mental health professional)

2. **INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS**

   - Check all interventions or strategies used in last 7 days—no matter when received
     - a. Special behavior symptom evaluation program
     - b. Group therapy
     - c. Resident-specific behavior changes
     - d. Mood behavior patterns—e.g., providing bureau in which to rummage
     - e. Reorientation—e.g., settling

3. **NURSING REHABILITATION/RESTORATIVE CARE**

   - Record the number of days each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter "0" if none or less than 15 minutes a day)
     - a. Range of motion (passive)
     - b. Range of motion (active)
     - c. Range of motion (assistance)
     - d. Range of motion (active)
     - e. Range of motion (passive)
     - f. Range of motion (active)
     - g. Range of motion (assistance)
     - h. Range of motion (active)
     - i. Range of motion (passive)
     - j. Range of motion (active)
     - k. Range of motion (assistance)
     - l. Amputations/prostheses care
     - m. Amputations/prostheses care
     - n. Amputations/prostheses care
     - o. Amputations/prostheses care
     - p. Amputations/prostheses care
     - q. Amputations/prostheses care
     - r. Amputations/prostheses care
     - s. Amputations/prostheses care
     - t. Amputations/prostheses care
     - u. Amputations/prostheses care
     - v. Amputations/prostheses care
     - w. Amputations/prostheses care
     - x. Amputations/prostheses care
     - y. Amputations/prostheses care
     - z. Amputations/prostheses care

   - TRAINEE AND SKILL PRACTICE IN:
     - a. Communication
     - b. Social work
     - c. Physical therapy
     - d. Occupational therapy
     - e. Social worker
     - f. Speech-language pathologist
     - g. Speech-language pathologist
     - h. Speech-language pathologist
     - i. Speech-language pathologist
     - j. Speech-language pathologist
     - k. Speech-language pathologist
     - l. Speech-language pathologist
     - m. Speech-language pathologist
     - n. Speech-language pathologist
     - o. Speech-language pathologist
     - p. Speech-language pathologist
     - q. Speech-language pathologist
     - r. Speech-language pathologist
     - s. Speech-language pathologist
     - t. Speech-language pathologist
     - u. Speech-language pathologist
     - v. Speech-language pathologist
     - w. Speech-language pathologist
     - x. Speech-language pathologist
     - y. Speech-language pathologist
     - z. Speech-language pathologist

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1. **DISCHARGE POTENTIAL**

   - a. Resident expresses/indicates preference to return to the community
     - 0. No
     - 1. Yes
   - b. Resident has a support person who is positive to discharge
     - 0. No
     - 1. Yes
   - c. Stay projected to be of a short duration—discharge projected within 90 days (do not include extended discharge due to death)
     - 0. No
     - 1. Yes
   - Within 90 days
   - Discharge status uncertain

2. **OVERALL CHANGE IN CARE NEEDS**

   - Resident overall self-sufficiency has changed significantly as compared to status at 90 days ago (or since last assessment)
     - 0. No
     - 1. Yes
     - More support
     - More support
     - More support
     - More support

SECTION R. ASSESSMENT INFORMATION

1. **PARTICIPATION IN ASSESSMENT**

   - a. Resident
     - 0. No
     - 1. Yes
   - b. Family
     - 0. No
     - 1. Yes
     - 2. No family
   - c. Significant other
     - 0. No
     - 1. Yes
     - 2. No

2. **SIGNATURE OF PERSON COORDINATING THE ASSESSMENT**

   - a. Signature of RN Assessment Coordinator
     - Sign on above line
   - b. Date RN Assessment Coordinator signed as complete
     - Month
     - Day
     - Year

MDS 2.0 September, 2020
### SECTION I. THERAPY SUPPLEMENT FOR MEDICARE PPS

**1. SPECIAL TREATMENTS AND PROCEDURES**

| a. RECREATION THERAPY—Enter number of days and total minutes of recreation therapy administered (for at least 15 minutes a day) in the last 7 days (Enter 0 if none) |
|---|---|
| | (A) | (B) |
| Skip unless this is a Medicare 5 day or Medicare readmission return assessment. |

| b. ORDERED THERAPIES—Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service? |
|---|---|
| 0. No |
| 1. Yes |

If not ordered, skip to item 2

<table>
<thead>
<tr>
<th>c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?</th>
</tr>
</thead>
</table>

**2. WALKING WHEN MOST SELF-SUFFICIENT**

Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0, 1, 2, or 3 AND at least one of the following are present:

- Resident received physical therapy involving gait training (F.1.b.c)
- Physical therapy was ordered for the resident involving gait training (F.1.b)
- Resident received nursing rehabilitation for walking (P.3.f)
- Physical therapy involving walking has been discontinued within the past 180 days

Skip to item 3 if resident did not walk in last 7 days (FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARthest WITHOUT SITTING DOWN, INCLUDE WALKING DURING REHABILITATION SESSIONS)

| a. Furthest distance walked without sitting down during this episode. |
|---|---|---|---|
| 0. 0-150 feet |
| 1. 151-149 feet |
| 2. 150-50 feet |

| b. Time walked without sitting down during this episode. |
|---|---|---|---|
| 0. 1-2 minutes |
| 1. 3-4 minutes |
| 2. 5-10 minutes |

| c. Self-Performance in walking during this episode. |
|---|---|---|---|---|
| 0. INDEPENDENT—No help or oversight |
| 1. SUPERVISION—Oversight, encouragement or cueing provided |
| 2. LIMITED ASSISTANCE—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other non-weight bearing assistance |
| 3. EXTENSIVE ASSISTANCE—Resident received weight bearing assistance while walking |

| d. Walking support provided associated with this episode (code regardless of resident's self-performance classification). |
|---|---|
| 0. No setup or physical help from staff |
| 1. Setup help only |
| 2. One person physical assist |
| 3. Two+ persons physical assist |

| e. Parallel bars used by resident in association with this episode. |
|---|---|
| 0. No |
| 1. Yes |

**3. CASE MIX GROUP**

<table>
<thead>
<tr>
<th>Medicare</th>
<th>State</th>
</tr>
</thead>
</table>
SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

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).

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

B.                                                                                      2. Month  Day  Year

1. Signature of RN Coordinator for RAP Assessment Process

3. Signature of Person Completing Care Planning Decision

MDS 2.0 September, 2000
### MDS QUARTERLY ASSESSMENT FORM

**A1. RESIDENT NAME**
- **a. (First)**
- **b. (Middle initials)**
- **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)**

**A4. DATE OF REENTRY**
- Date of reentry from most recent temporary discharge to a hospital in last 30 days (or since last assessment or admission if less than 90 days)
  - **Month**
  - **Day**
  - **Year**

**A5. MEDICAL RECORD NO.**

**B1. COMATOSE**
- Persistent vegetative state (discontinue consciousness)
  - **0. No**
  - **1. Yes** (Skip to Section C)

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

**B4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING**
- (Note decisions regarding tasks of daily living)
  - **0. INDEPENDENT—decisions consistent/acceptable**
  - **1. MODERATELY IMPAIRED—decisions acceptable, supervision required**
  - **2. SEVERELY IMPAIRED—never made decisions**

**B5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/AWARENESS**
- (Code for behavior in 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 recent onset**
  - **2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

**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—miss some part/infant of message**
  - **2. SOMETIMES UNDERSTANDS—response often incorrect, sometimes misinterpreted, no direction communication**
  - **3. RARELY NEVER UNDERSTANDS**

**E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD**
- (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 5 days a week**
  - **2. Indicator of this type exhibited 6 days a week or almost daily (6 or 7 days a week)**

- **a. Resident made negative statements—e.g., “Nothing matters; I would rather be dead; What's the use? Regrets having lived so long; Life is no good”**
- **b. Repetitive questions—e.g., “Where do I go? What do I do?”**
- **c. Repetitive verbalizations—e.g., talking out for help ("I need help")**
- **d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at caretaker received**
- **e. Self deprivation—e.g., "I am nothing! I have no use to anyone"**

**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**
  - **1. Indicators present, indicators easily altered**
  - **2. Indicators present, not easily altered**

**E3. BEHAVIORAL SYMPTOMS**
- (For indicators observed in 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 recent onset**
  - **2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

**E4. SLEEP CYCLE ISSUES**
- (For indicators observed in 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 recent onset**
  - **2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

**E5. VERBAL EXPRESSIONS OF DISTRESS**
- (For indicators observed in 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 recent onset**
  - **2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

**E6. SLEEP CYCLE ISSUES**
- (For indicators observed in 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 recent onset**
  - **2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)
<table>
<thead>
<tr>
<th>Resident</th>
<th>Numeric Identifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>J5. STABILITY OF CONDITIONS</td>
<td>Conditions/Symptoms make resident's cognitive, ADL, mood or behavior status unstable (fluctuating, precarious, or deteriorating)</td>
</tr>
<tr>
<td>K2. WEIGHT CHANGE</td>
<td>a. Weight loss—5 % or more in last 30 days, or 10 % or more in last 180 days</td>
</tr>
<tr>
<td>K5. NUTRITIONAL APPROACHES</td>
<td>a. Feeding tube</td>
</tr>
<tr>
<td>M1. ULCERS</td>
<td>(Due to any cause)</td>
</tr>
<tr>
<td>M2. TYPE OF ULCER</td>
<td>(For each type of ulcer, code the highest stage in the last 7 days using codes in item M-1—e, IVDRS stages 1, 2, 3, 4)</td>
</tr>
<tr>
<td>M3. COMPLICATIONS</td>
<td>a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue</td>
</tr>
<tr>
<td>N1. TIME AWAKE</td>
<td>(Check appropriate time periods over last 7 days)</td>
</tr>
<tr>
<td>O1. NUMBER OF MEDICATIONS</td>
<td>(Record the number of different medications used in the last 7 days; enter &quot;0&quot; if none used)</td>
</tr>
<tr>
<td>O4. DAYS RECEIVED THE FOLLOWING MEDICATION</td>
<td>a. Antipsychotic</td>
</tr>
<tr>
<td>O5. DEVICES AND RESTRAINTS</td>
<td>a. Bed rails</td>
</tr>
<tr>
<td>P4.1. PROBLEM CONDITIONS</td>
<td>Dehydrated; output exceeds input</td>
</tr>
<tr>
<td>P4.2. PAIN SYMPTOMS</td>
<td>a. Frequency with which resident complains or shows evidence of pain</td>
</tr>
<tr>
<td>P4.3. ACCIDENTS</td>
<td>a. Hip fracture in last 180 days</td>
</tr>
</tbody>
</table>

### Functional Limitations in Range of Motion

<table>
<thead>
<tr>
<th>Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No limitation</td>
</tr>
<tr>
<td>1. Limitation on one side</td>
</tr>
<tr>
<td>2. Limitation on both sides</td>
</tr>
</tbody>
</table>

####MODES OF TRANSFER

<table>
<thead>
<tr>
<th>Check all that apply during last 7 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed rest or most of time</td>
</tr>
</tbody>
</table>

####Continence Self-Care Categories

<table>
<thead>
<tr>
<th>Code for resident's performance over all shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. CONTINUE Complete control (includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool)</td>
</tr>
<tr>
<td>1. USUALLY CONTINUE-BLADDER Incontinent episodes once a week or less; BOWEL, less than weekly</td>
</tr>
<tr>
<td>2. OCCASIONALLY CONTINUE-BLADDER, 2 or more times a week but not daily; BOWEL, 2 or more times a week</td>
</tr>
<tr>
<td>3. FREQUENTLY CONTINUE-BLADDER Tended to be incontinent daily, but some control present (e. g., on day shift); BOWEL, 2-3 times a week</td>
</tr>
</tbody>
</table>

####Bladder ContinenCe

| Control of bladder movement, with appliance or bowel continence programs, if employed |

####Bowel Elimination Pattern

| Fecal incontinence |
| NONE OF ABOVE |

####Aparatus and Programs

| Any scheduled toileting plan |
| Incontinence catheter |
| Ostomy present |
| External (condom) catheter |

####Infections

| Urinary tract infection in last 30 days |
| NONE OF ABOVE |

####Other Current Diagnoses and Codes

| Include only those diseases diagnosed in the last 30 days that have a relationship to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death |

####Problem Conditions

| Dehydrated; output exceeds input |
| Hallucinations |

####Pain Symptoms

<table>
<thead>
<tr>
<th>Code the highest level of pain present in the last 7 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency with which resident complains or shows evidence of pain</td>
</tr>
<tr>
<td>0. No pain (skip to J4)</td>
</tr>
<tr>
<td>1. Pain less than daily</td>
</tr>
<tr>
<td>2. Pain daily</td>
</tr>
</tbody>
</table>

####Accidents

| Hip fracture in last 180 days |
| Other fracture in last 180 days |

###MDS 2.0 September, 2000
MDS QUARTERLY ASSESSMENT FORM
(OPTIONAL VERSION FOR RUG-III)

A1. RESIDENT NAME

A2. ROOM NUMBER

A3. ASSESSMENT REFERENCE DATE

A4. DATE OF REENTRY

A5. MEDICAL RECORD NO.

B1. COMATOSE

B2. MEMORY

B3. MEMORY/RECALL ABILITY

B4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING

B5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/AWARENESS

C1. MAKING SELF UNDERSTOOD

C2. ABILITY UNDERSTAND OTHERS

C3. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

E2. MOOD PERSISTENCE

E3. BEHAVIORAL SYMPTOMS

E4. ADL SELF-PERFORMANCE

E5. ADL SUPPORT PROVIDED

E6. SELF-HELP SUPPORT

Numeric Identifier __

MDS 2.0 September, 2000
Resident

G1. WALK IN ROOM
How resident walks between locations in his/her room

G2. WALK IN CORRIDOR
How resident walks in corridor on unit

G3. LOCOMOTION ON UNIT
How resident moves between locations in his/her room and in corridor on same floor. If in wheelchair, self-sufficiency once in chair

G4. LOCOMOTION OFF UNIT
How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatment) if facility has
to only one floor; If resident moves to and from distant areas on the floor in wheelchair, self-sufficiency once in chair

G5. DRESSING
How resident puts on, fastens, and takes off all items of street clothing, including turning in personal possessions

G6. EATING
How resident eats or drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)

G7. TOILET USE
How resident uses the toilet room (or commode, bedpan, enema, transfer on/off toilets, cleanses perineum, manages ostomy or catheter, adjusts clothes

G8. PERSONAL HYGIENE
How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing in front of mirror, hands, and perineum

G9. BATHING
How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair)

G10. TEST FOR BALANCE
(See training manual)

G11. FUNCTIONAL LIMITATION IN RANGE OF MOTION
(See training manual)

G12. MOBILITY OF TRANSFER
(See all that apply during last 7 days)

G13. TASK SEGMENTATION
Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them

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

H2. BOWEL CONTINENCE
Control of bladder movement, with appliance or bowel continence programs, if employed

H3. APPLIANCES AND PROGRAMS
Any scheduled toileting plan

H4. BOWEL ELIMINATION PATTERN
Diarrhea

H5. STABILITY OF CONDITIONS
Conditions/diseases make resident cognitively, ADL, mood or behavior status unstable (e.g., drowsy, delirious, disoriented)

H6. ORAL PROBLEMS
Chewing problem

H7. WEIGHT AND HEIGHT
Record (a.) height in inches and (b.) weight in pounds. Use weight most recent measure in last 30 days; measure weight consistently in accord with standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, and in light clothing)

H8. WEIGHT CHANGE
a. Weight loss—5 % or more in last 10 days; or 10 % or more in last 180 days
b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days

J1. PROBLEM INDICATORS OF FLUID STATUS
Other

J2. PAIN SYMPTOMS
(a) Frequency with which resident complains or shows evidence of pain
b. Intensity of pain
(c) Time when pain is horrible or excruciating

J3. ACCIDENTS
Fall in past 30 days
Fall in past 31-180 days

J4. STABILITY OF CONDITIONS
Conditions/diseases make resident cognitively, ADL, mood or behavior status unstable (e.g., drowsy, delirious, disoriented)

J5. ORAL PROBLEMS
Chewing problem

J6. WEIGHT AND HEIGHT
Record (a.) height in inches and (b.) weight in pounds. Use weight most recent measure in last 30 days; measure weight consistently in accord with standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, and in light clothing)

J7. WEIGHT CHANGE
a. Weight loss—5 % or more in last 10 days; or 10 % or more in last 180 days
b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days

J8. STABILITY OF CONDITIONS
Conditions/diseases make resident cognitively, ADL, mood or behavior status unstable (e.g., drowsy, delirious, disoriented)

J9. ORAL PROBLEMS
Chewing problem

J10. WEIGHT AND HEIGHT
Record (a.) height in inches and (b.) weight in pounds. Use weight most recent measure in last 30 days; measure weight consistently in accord with standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, and in light clothing)

J11. WEIGHT CHANGE
a. Weight loss—5 % or more in last 10 days; or 10 % or more in last 180 days
b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days
### MDS 2.0 September, 2000

#### Resident

**K5. NUTRITIONAL APPROACHES**  
(Off all that apply in last 7 days)  
- Parenteral/IV  
- Feeding tube  

**M1. ULCERS**  
(Due to any cause)  
- A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.  
- A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.  
- A full thickness of skin is lost, exposing the subcutaneous tissue but not present as a deep crater.  
- 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 highest stage in the last 7 days using scale in item M1—i.e., [EERMINt stages 1, 2, 3, 4])  
- Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue  
- Stasis ulcer—open lesion caused by poor circulation in the lower extremities  

**M4. OTHER SKIN PROBLEMS OR LESIONS PRESENT**  
(Off all that apply during last 7 days)  
- Ablations, bruises, burns (second or third degree)  
- Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)  
- Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster  
- Skin desensitized to pain or pressure  
- Skin tears or cuts (other than surgery)  
- Surgical wounds  

**M5. SKIN TREATMENTS**  
(Off all that apply during last 7 days)  
- Pressure relieving device(s) for bed  
- Turning/repositioning program  
- Nutrition or hydration intervention to manage skin problems  
- Ulcer care  
- Surgical wound care  
- Application of dressings (with or without topical medications) other than to feet  
- Application of ointments/medications (other than to feet)  

**M6. FOOT PROBLEMS AND CARE**  
(Off all that apply during last 7 days)  
- Resides in one or more foot problems—e.g., corns, callouses, bunion, hammer toes, overlapping toes, pain, structural problems  
- Infection of the foot—e.g., osteitis, purulent drainage  
- Open lesions on the foot  
- Nails/callused trimmed during last 30 days  
- Received prophylactic or protective foot care (e.g., used special shoes, insoles, pads, toe separators)  
- Application of dressings (with or without topical medications)  

**N1. TIME AWAKE**  
(Off 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  
- Afternoon  

**N2. AVERAGE TIME INVOLVED IN ACTIVITIES**  
(When awake and not receiving treatments or ADL care)  
- Most—more than 2/3 of time  
- Little—less than 1/3 of time  
- None—0%  

**O1. NUMBER OF MEDICATIONS**  
(Record the number of different medications used in the last 7 days, enter “0” if none used)  

**O3. INJECTIONS**  
(Record the number of days injections of any type received during the last 7 days, enter “0” if none used)  

**O4. DAYS RECEIVED THE FOLLOWING MEDICATIONS**  
(Record the number of days during last 7 days, enter “0” if not used. Note—enter “0” for long acting needs used less than weekly)  
- Antipsychotic  
- Antianxiety  
- Antidepressant  
- Aripiprazole  
- Aripiprazole  

**P1. SPECIAL CARE TREATMENTS, PROCEDURES, AND PROGRAMS**  
**SPECIAL CARE**—Check treatments or programs received during the last 14 days  

**TREATMENTS**  
- Diaphoresis  
- Diaphoresis  
- Diaphoresis  
- Diaphoresis  

**PROGRAMS**  
- Diaphoresis  
- Diaphoresis  
- Diaphoresis  
- Diaphoresis  

**P3. NURSING REHABILITATION/RESTORATIVE CARE**  
Record the number of days each of the following rehabilitative or restorative techniques or practices was provided to the resident for more than or equal to 30 minutes per day in the last 7 days (Enter 0 if none)  

**P4. DEVICES AND RESTRAINTS**  
Use the following codes for last 7 days:  
- 0. Not used  
- 1. Used less than daily  
- 2. Used daily  
- 3. Used more than daily  

**P7. PHYSICIAN VISITS**  
In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident?  
(Enter 0 if none)  

**P8. PHYSICIAN ORDERS**  
In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident’s orders?  
Do not include order name rate without change.  
(Enter 0 if none)  

**Q2. OVERALL CHANGE IN CARE NEEDS**  
Resident’s overall level of self-sufficiency has changed significantly as compared to status of 30 days ago (or since last assessment if less than 30 days)  
- No change  
- Improved—receives fewer  
- Deteriorated—receives more support  

**R2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT**  
- A. Signature of RN Assessment Coordinator (sign on above line)  
- B. Date RN Assessment Coordinator signed as complete  

---

**Numeric Identifier**

- A. Ventilator or respirator
- B. Alzheimer's dementia special care unit
- C. Hospice care
- D. Radial unit
- E. Respiratory therapy
- F. Medical therapy
- G. Physical therapy
- H. Other

**DAYS MIN**

(A) (B)

---

**Month**

Day

Year
<table>
<thead>
<tr>
<th>A1. RESIDENT NAME</th>
<th>a. (First)</th>
<th>b. (Middle Initial)</th>
<th>c. (Last)</th>
<th>d. (Suffix)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A2. ROOM NUMBER</th>
<th>A3. ASSESSMENT REFERENCE DATE</th>
<th>a. Last day of MDS observation period</th>
<th>b. Original (o) or corrected copy of form (enter number of correction)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Month Day Year</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Month Day Year</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A4a. DATE OF REENTRY</th>
<th>Date of reentry from most recent temporary dischage to a hospital in last 90 days (or since last assessment or admission if less than 90 days)</th>
<th>Month Day Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A4b. MEDICAL RECORD NO.</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B1. COMATOSE</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Persistent vegetative state/no discernible consciousness)</td>
<td>No</td>
<td>1. Yes (Skip to Section 6)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B2. MEMORY</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-term memory OK—seems/appears to recall after 5 minutes</td>
<td>1. Memory problem</td>
<td></td>
</tr>
<tr>
<td>Long-term memory OK—seems/appears to recall long past</td>
<td>1. Memory problem</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B3. MEMORY RECALL ABILITY</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current session</td>
<td>That he/she is in a nursing home</td>
<td></td>
</tr>
<tr>
<td>Location of room</td>
<td>Staff nurses</td>
<td></td>
</tr>
<tr>
<td>Staff nurses</td>
<td>NONE OF ABOVE are recalled</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B4. COGNITIVE SKILLS FOR DAILY DECISION MAKING</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Made decisions regarding tasks of daily life</td>
<td>0. INDEPENDENT—decisions consistent/reasonable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. MODIFIED INDEPENDENCE—some difficulty in new situations only</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. MODERATELY IMPAIRED—decisions poor; custo/supervision required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. SEVERELY IMPAIRED—never made decisions</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING AWARENESS</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavior not present</td>
<td>Behavior present, not of recent onset</td>
<td></td>
</tr>
<tr>
<td>Behavior present, over last 7 days appears different from resident’s usual functioning (e.g., new onset or worsening)</td>
<td>EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)</td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MENTAL FUNCTION VARIES OVER COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C4. MAKING UNDERSTOOD</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expressing information content—however able</td>
<td>UNDERSTOOD</td>
<td></td>
</tr>
<tr>
<td>1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. RARELY UNDERSTOOD</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C6. ABILITY UNDERSTAND OTHERS</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding verbal information content—however able</td>
<td>UNDERSTANDS</td>
<td></td>
</tr>
<tr>
<td>1. USUALLY UNDERSTANDS—may miss some pertinent of message</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. RARELY UNDERSTANDS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Code for indicators observed in last 30 days, irrespective of the assumed cause)</td>
<td>3. Indicator not exhibited in last 30 days</td>
<td></td>
</tr>
<tr>
<td>1. Indicator of this type exhibited up to five days a week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Indicator of this type exhibited daily or almost daily (5–7 days a week)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E4. BEHAVIORAL SYMPTOMS</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(A) Behavioral symptom frequency by last 7 days</td>
<td>Behavior not exhibited in last 7 days</td>
<td></td>
</tr>
<tr>
<td>1. Behavior of this type occurred 1 to 2 days in last 7 days</td>
<td>Behavioral symptom frequency by last 7 days</td>
<td></td>
</tr>
<tr>
<td>2. Behavior of this type occurred 3 to 4 days in last 7 days</td>
<td>Behavioral symptom frequency by last 7 days</td>
<td></td>
</tr>
<tr>
<td>3. Behavior of this type occurred daily</td>
<td>Behavioral symptom frequency by last 7 days</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E5. BEHAVIORAL SYMPTOMS</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(B) Behavioral symptom severity by last 7 days</td>
<td>Behavior not present; OR behavior was easily altered</td>
<td></td>
</tr>
<tr>
<td>1. Behavior was not easily altered</td>
<td>Behavioral symptom severity by last 7 days</td>
<td></td>
</tr>
<tr>
<td>2. Behavior was easily altered</td>
<td>Behavioral symptom severity by last 7 days</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>G1. (B) ADL SUPPORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident’s self-performance classification)</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. No setup or physical help from staff</td>
<td>Setup help only</td>
<td></td>
</tr>
<tr>
<td>1. One person physical assist</td>
<td>Two+ persons physical assist</td>
<td></td>
</tr>
<tr>
<td>2. ADL activity itself did not occur during entire 7 days</td>
<td>ADL activity itself did not occur during entire 7 days</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>G2. MOOD PERSISTENCE</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td>One or more indicators of depression, and/or any mood were not easily altered by attempts to &quot;cheer up&quot;/console, or reassure resident over last 7 days</td>
<td>No mood</td>
<td></td>
</tr>
<tr>
<td>1. Indicators present, easily altered</td>
<td>2. Indicators present, not easily altered</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>G3. SAD, APATHETIC, ANXIOUS APPEARANCE</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sad, pained, worried facial expressions—</td>
<td>Crying, tearfulness</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>G4. REPEATED HEALTH COMPLAINTS</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Repetitive health complaints—(non-health related)</td>
<td>Repetitive incandescent complaints (non-health related)</td>
<td></td>
</tr>
<tr>
<td>Perseveringly seeks attention/</td>
<td>Repetitive restlessness, fidgeting, picking</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>G5. SLEEP CYCLES</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persistent mood in morning</td>
<td>Persistent mood in evening</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>G6. SAFETY ISSUES</th>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intrusions in usual sleep pattern</td>
<td>Intrusions in usual sleep pattern</td>
<td></td>
</tr>
</tbody>
</table>

| MDS 2.0 September, 2005 | Numeric Identifier |
Resident

<table>
<thead>
<tr>
<th>G1. WALK IN ROOM</th>
<th>How resident walks between locations in his/her room</th>
</tr>
</thead>
<tbody>
<tr>
<td>G2. WALK IN CORRIDOR</td>
<td>How resident walks in corridor on same floor. If in wheelchair, self-sufficiency once in chair.</td>
</tr>
<tr>
<td>G3. LOCOMOTION ON UNIT</td>
<td>How resident moves between locations in his/her room and adjacent room on same floor. If in wheelchair, self-sufficiency once in chair.</td>
</tr>
<tr>
<td>G4. LOCOMOTION OFF UNIT</td>
<td>If 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.</td>
</tr>
<tr>
<td>G5. DRESSING</td>
<td>How resident puts on, fastens, and takes off all items of street clothing, including wearing/undoing prostheses.</td>
</tr>
<tr>
<td>G6. EATING</td>
<td>How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition).</td>
</tr>
<tr>
<td>G7. TOILET USE</td>
<td>How resident uses the toilet room (or commode, bedpan, urinal). Transfer of toilet, cleansing, changes pads, manages incontinence or catheter, adjusts clothes.</td>
</tr>
<tr>
<td>J. PERSONAL HYGIENE</td>
<td>How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers).</td>
</tr>
</tbody>
</table>

G2. BATHING

How resident takes full body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair)

- (A) BATHING SELF PERFORMANCE codes appear below
  - 0. Independent—No help provided
  - 1. Supervision—Obligatory 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

G3. TEST FOR BALANCE (see training manual)

- 0. Maintained position as required in test
- 1. Unsteady, but able to rebalance without external support physically
- 2. Partial physical support during test; or stand (s/p) but does not follow directions for test
- 3. Not able to attempt test without physical help

- a. Balance while standing
- b. Balance while sitting—position, trunk control

G4. FUNCTIONAL LIMITATION IN RANGE OF MOTION

(A) RANGE OF MOTION

1. Limitation on one side
2. Limitation on both sides

(B) VOLUNTARY MOVEMENT

1. No loss
2. Partial loss
3. Full loss

- a. No
- 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
- Bed rails used for bed mobility or transfer

G7. TASK SEGMENTATION

Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them

A1. CONTINENCE SELF-CONTROL CATEGORIES

(Codes for resident's PERFORMANCE OVERALL 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 CONTINENT—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
- b. BLADDER CONTINENCE

C2. BOWEL ELIMINATION PATTERN

Diarrhea

- a. None
- b. Occasional
- c. Frequent

C3. WEIGHT CHANGE

- a. Weight loss—10% or more in last 30 days
- b. Weight gain—10% or more in last 30 days

H3. APPLIANCES AND PROGRAMS

- a. Indwelling catheter
- b. Ostomy present
- c. None of above

H11. DISEASES

- a. Endocrine/Metabolic/Nutritional
- b. Cardiovascular
- c. Psychiatric/Mood
- d. Neuronal
- e. Other

H12. INFECTIONS

- a. Antibiotic resistance infection
- b. Urinary tract infection in last 30 days
- c. Viral hepatitis
- d. Pneumonia
- e. Wound infection
- f. None of above

H13. OTHER CURRENT DIAGNOSES AND ICD-9 CODES

- a. Hemiplegia/Hemiparesis
- b. Multiple sclerosis
- c. Parkinson's disease
- d. Other

H14. STABILITY OF CONDITIONS

- a. Resident experiencing an acute episode or flare-up of a recurrent or chronic problem
- b. Resident stable
- c. None of above

H15. ORAL PROBLEMS

- a. Swallowing problem
- b. Pseudomonas positive
- c. None of above

H16. HEIGHT AND WEIGHT

- a. Height—Less than 5 feet 5 inches
- b. Weight—Less than 100 pounds
- c. None of above

H17. WEIGHT CHANGE

- a. Weight gain—10% or more in last 30 days
- b. Weight loss—10% or more in last 30 days
- c. None of above
### M.1. ULCERS (Due to any cause)

<table>
<thead>
<tr>
<th>Number of Ulcers</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Stage 1: A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.</td>
</tr>
<tr>
<td>b. Stage 2: A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow ulcer.</td>
</tr>
<tr>
<td>c. Stage 3: A full thickness skin loss, exposing the subcutaneous tissues - presents as a deep ulcer with or without undermining adjacent tissue.</td>
</tr>
<tr>
<td>d. Stage 4: A full thickness skin and subcutaneous tissue is lost, exposing muscle or bone.</td>
</tr>
</tbody>
</table>

### M.4. OTHER SKIN PROBLEMS OR LESIONS PRESENT

(For each type of ulcer; code for the highest stage in the last 7 days using codes in item M.1—e.g., Diabetic stages 1, 2, 3, 4)

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abrasions, bruises</td>
</tr>
<tr>
<td>Burns (second or third degree)</td>
</tr>
<tr>
<td>Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)</td>
</tr>
<tr>
<td>Skin devascularized to pain or pressure</td>
</tr>
<tr>
<td>Skin tears or cuts (other than surgery)</td>
</tr>
<tr>
<td>Surgical wounds</td>
</tr>
</tbody>
</table>

### M.5. SKIN TREATMENTS

(For each type of ulcer; code for the highest stage in the last 7 days using codes in item M.1—e.g., Diabetic stages 1, 2, 3, 4)

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure relieving device(s) for chair</td>
</tr>
<tr>
<td>Pressure relieving device(s) for bed</td>
</tr>
<tr>
<td>Turning/repositioning program</td>
</tr>
<tr>
<td>Nutrition or hydration intervention to manage skin problems</td>
</tr>
<tr>
<td>Ulcer care</td>
</tr>
<tr>
<td>Surgical wound care</td>
</tr>
<tr>
<td>Application of dressings (with or without topical medications) other than to feet</td>
</tr>
<tr>
<td>Application of creams/medications (other than to feet)</td>
</tr>
<tr>
<td>Other preventative or protective skin care (other than to foot)</td>
</tr>
</tbody>
</table>

### M.6. FOOT PROBLEMS AND CARE

(For each type of ulcer; code for the highest stage in the last 7 days using codes in item M.1—e.g., Diabetic stages 1, 2, 3, 4)

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, plantar fasciitis, problems with circulation of the foot—e.g., cellulitis, purulent drainage</td>
</tr>
<tr>
<td>Open lesions on the foot</td>
</tr>
<tr>
<td>Nails/calluses trimmed during last 60 days</td>
</tr>
<tr>
<td>Received preventative or protective foot care (e.g., used special shoes, inserts, boots, toe separators)</td>
</tr>
<tr>
<td>Application of dressings (with or without topical medications)</td>
</tr>
</tbody>
</table>

### M.7. TIME AWAKE

(For each type of ulcer; code for the highest stage in the last 7 days using codes in item M.1—e.g., Diabetic stages 1, 2, 3, 4)

<table>
<thead>
<tr>
<th>Time of Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning</td>
</tr>
<tr>
<td>Afternoon</td>
</tr>
<tr>
<td>Evening</td>
</tr>
<tr>
<td>None of Above</td>
</tr>
</tbody>
</table>

### P.1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilator or respirator</td>
</tr>
<tr>
<td>Oxygen therapy</td>
</tr>
<tr>
<td>Radiation therapy</td>
</tr>
<tr>
<td>Transfusions</td>
</tr>
</tbody>
</table>

### P.2. SPECIAL CARE—Check treatments or programs received during the last 14 days

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemotherapy</td>
</tr>
<tr>
<td>Dialysis</td>
</tr>
<tr>
<td>IV medication</td>
</tr>
<tr>
<td>Intake/output monitoring</td>
</tr>
<tr>
<td>Nutrition or hydration intervention</td>
</tr>
<tr>
<td>Ostomy care</td>
</tr>
<tr>
<td>Oxygen therapy</td>
</tr>
<tr>
<td>Radiation therapy</td>
</tr>
<tr>
<td>Transfusions</td>
</tr>
</tbody>
</table>

### P.3. NURSING REHABILITATION/RESTORATIVE CARE

(For each type of ulcer; code for the highest stage in the last 7 days using codes in item M.1—e.g., Diabetic stages 1, 2, 3, 4)

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Range of motion (passive)</td>
</tr>
<tr>
<td>Range of motion (active)</td>
</tr>
<tr>
<td>Splint or brace assistance</td>
</tr>
<tr>
<td>Eating or swallowing</td>
</tr>
<tr>
<td>Training in skills to return to the community</td>
</tr>
<tr>
<td>Bed mobility</td>
</tr>
<tr>
<td>Communication</td>
</tr>
<tr>
<td>Transfer</td>
</tr>
</tbody>
</table>

### P.4. DEVICES AND RESTRAINTS

(For each type of ulcer; code for the highest stage in the last 7 days using codes in item M.1—e.g., Diabetic stages 1, 2, 3, 4)

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed rails</td>
</tr>
<tr>
<td>Other bips (side rails)</td>
</tr>
<tr>
<td>Tourniquet</td>
</tr>
<tr>
<td>Limb restraint</td>
</tr>
<tr>
<td>Chair restraints</td>
</tr>
</tbody>
</table>

### P.7. PHYSICIAN VISITS

(For each type of ulcer; code for the highest stage in the last 7 days using codes in item M.1—e.g., Diabetic stages 1, 2, 3, 4)

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk</td>
</tr>
<tr>
<td>Dressing or grooming</td>
</tr>
<tr>
<td>Eating or swallowing</td>
</tr>
<tr>
<td>Amputation/prosthesis care</td>
</tr>
<tr>
<td>Communication</td>
</tr>
</tbody>
</table>

### P.8. PHYSICIAN ORDERS

(For each type of ulcer; code for the highest stage in the last 7 days using codes in item M.1—e.g., Diabetic stages 1, 2, 3, 4)

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month</td>
</tr>
<tr>
<td>Day</td>
</tr>
<tr>
<td>Year</td>
</tr>
</tbody>
</table>

### R.2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT

<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of RN Assessment Coordinator</td>
</tr>
</tbody>
</table>

(MDS 2.0 September, 2000)
**MINIMUM DATA SET (MDS) — VERSION 2.0**

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

**DISCHARGE TRACKING FORM** [do not use for temporary visits home]

**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**
   - 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.**
   - "K" if pending, "N" if not a Medicaid recipient

8. **REASONS FOR ASSESSMENT**
   - Note: Other codes do not apply to this form
   - a. Primary reason for assessment
   - b. Discharged—return not anticipated
   - c. Discharged prior to completing initial assessment

9. Signatures of Persons Who Completed a Portion of the Accompanying Assessment or Tracking Form
   - Signature and Title

**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/residential living group home
   - 4. Nursing home
   - 5. Acute care hospital
   - 6. Psychiatric hospital, MR/DD facility
   - 7. Rehabilitation hospital
   - 8. Other

**SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION**

**SECTION R. ASSESSMENT/DISCHARGE INFORMATION**

3. **DISCHARGE STATUS**
   - a. Codes for resident disposition upon discharge
   - 1. Private home/apt. with no home health services
   - 2. Private home/apt. with home health services
   - 3. Board and care/residential living
   - 4. Another nursing facility
   - 5. Acute care hospital
   - 6. Psychiatric hospital, MR/DD facility
   - 7. Rehabilitation hospital
   - 8. Deceased
   - 9. Other
   - b. Optional State Code

4. **DISCHARGE DATE**
   - Date of death or discharge
   - Month  
   - Day  
   - Year

= Key items for computerized resident tracking

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

MDS 2.0 September, 2000
### SECTION AA. IDENTIFICATION INFORMATION

1. **RESIDENT NAME**
   - a. (First) 
   - b. (Middle Initial) 
   - c. (Last) 
   - d. (Ln/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
   - 6. Other

5. **SOCIAL SECURITY AND MEDICARE NUMBERS**
   - 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 ASSESSMENT**
   - a. Primary reason for assessment
   - b. Reentry

9. **Signature of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form**
   - Signature and Title
   - Sections
   - Date

---

### SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

**DATE OF REENTRY**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Year</th>
</tr>
</thead>
</table>

**ADMITTED FROM**

- 1. Private home/apartment with no home health services
- 2. Private home/apartment with home health services
- 3. Board and care/assisted living/group home
- 4. Nursing home
- 5. Acute care hospital
- 6. Psychiatric hospital, MIRECC facility
- 7. Rehabilitation hospital
- 8. Other

**MEDICAL RECORD NO.**

- [ ]

---

**= Key items for computerized resident tracking**

[ ] When box blank, must enter number or letter

[ ] When letter in box, check if condition applies

---

MDS 2.0 September, 2000
SECTION U. MEDICATIONS—CASE MIX DEMO

List all medications that the resident received during the last 7 days. Include scheduled medications that are used regularly, but less than weekly.

1. **Medication Name and Dose Ordered.** Record the name of the medication and dose ordered.
2. **Route of Administration (RA).** Code the Route of Administration using the following list:
   - 1=oral (PO)
   - 2=subcutaneous (SQ)
   - 3=intranasal (IN)
   - 4=intravenous (IV)
   - 5=oral (PO)
   - 6=rectal (R)
   - 7=intramuscular (IM)
   - 8=intranasal (IN)
   - 9=oral (PO)
   - 10=other

3. **Frequency.** Code the number of times per day, week, or month the medication is administered using the following list:
   - PRN (as necessary)
   - 2D=twice daily
   - 3D=three times daily
   - 4D=four times daily
   - 5D=five times daily
   - 6D=six times daily
   - 7D=seven times daily
   - 8D=eight times daily
   - 9D=nine times daily
   - 10D=ten times daily
   - 11D=eleven times daily
   - 12D=twelve times daily
   - 13D=thirteen times daily
   - 14D=fourteen times daily
   - 15D=fifteen times daily
   - 16D=sixteen times daily
   - 17D=seventeen times daily
   - 18D=eighteen times daily
   - 19D=nineteen times daily
   - 20D=twenty times daily
   - 21D=twenty-one times daily
   - 22D=twenty-two times daily
   - 23D=twenty-three times daily
   - 24D=twenty-four times daily
   - 25D=twenty-five times daily
   - 26D=twenty-six times daily
   - 27D=twenty-seven times daily
   - 28D=twenty-eight times daily
   - 29D=twenty-nine times daily
   - 30D=thirty times daily
   - 31D=thirty-one times daily
   - 32D=thirty-two times daily
   - 33D=thirty-three times daily
   - 34D=thirty-four times daily
   - 35D=thirty-five times daily
   - 36D=thirty-six times daily
   - 37D=thirty-seven times daily
   - 38D=thirty-eight times daily
   - 39D=thirty-nine times daily
   - 40D=fourty times daily
   - 41D=fourty-one times daily
   - 42D=fourty-two times daily
   - 43D=fourty-three times daily
   - 44D=fourty-four times daily
   - 45D=fourty-five times daily
   - 46D=fourty-six times daily
   - 47D=fourty-seven times daily
   - 48D=fourty-eight times daily
   - 49D=fourty-nine times daily
   - 50D=fifty times daily
   - 51D=fifty-one times daily
   - 52D=fifty-two times daily
   - 53D=fifty-three times daily
   - 54D=fifty-four times daily
   - 55D=fifty-five times daily
   - 56D=fifty-six times daily
   - 57D=fifty-seven times daily
   - 58D=fifty-eight times daily
   - 59D=fifty-nine times daily
   - 60D=sixty times daily
   - 61D=sixty-one times daily
   - 62D=sixty-two times daily
   - 63D=sixty-three times daily
   - 64D=sixty-four times daily
   - 65D=sixty-five times daily
   - 66D=sixty-six times daily
   - 67D=sixty-seven times daily
   - 68D=sixty-eight times daily
   - 69D=sixty-nine times daily
   - 70D=seventy times daily
   - 71D=seventy-one times daily
   - 72D=seventy-two times daily
   - 73D=seventy-three times daily
   - 74D=seventy-four times daily
   - 75D=seventy-five times daily
   - 76D=seventy-six times daily
   - 77D=seventy-seven times daily
   - 78D=seventy-eight times daily
   - 79D=seventy-nine times daily
   - 80D=eighty times daily
   - 81D=eighty-one times daily
   - 82D=eighty-two times daily
   - 83D=eighty-three times daily
   - 84D=eighty-four times daily
   - 85D=eighty-five times daily
   - 86D=eighty-six times daily
   - 87D=eighty-seven times daily
   - 88D=eighty-eight times daily
   - 89D=eighty-nine times daily
   - 90D=ninety times daily
   - 91D=ninety-one times daily
   - 92D=ninety-two times daily
   - 93D=ninety-three times daily
   - 94D=ninety-four times daily
   - 95D=ninety-five times daily
   - 96D=ninety-six times daily
   - 97D=ninety-seven times daily
   - 98D=ninety-eight times daily
   - 99D=ninety-nine times daily

4. **Amount Administered (AA).** Record the number of tablets, capsules, suppositories, or liquid (any route) per dose administered to the resident. Code 999 for topicals, eye drops, inhalants and oral medications that need to be dissolved in water.

5. **PRN-number of days (PRN-n).** If the frequency code for the medication is "PR", record the number of times during the last 7 days each PRN medication was given. Code STAT medications as PRNs given once.

6. **NDC Codes.** Enter the National Drug Code for each medication given. Be sure to enter the correct NDC code for the drug name, strength, and form. The NDC code must match the drug dispensed by the pharmacy.

<table>
<thead>
<tr>
<th>1. Medication Name and Dose Ordered</th>
<th>2. RA</th>
<th>3. Freq</th>
<th>4. AA</th>
<th>5. PRN-n</th>
<th>6. NDC Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# MDS MEDICARE PPS ASSESSMENT FORM
## (VERSION JULY 2002)

### A1. RESIDENT NAME
- **First Name:** 
- **Middle Initial:** 
- **Last Name:** 
- **Suffix:**

### A2. RESIDENT HISTORY 5 YEARS PRIOR TO ENTRY
- a. Prior stay at this nursing home
- b. Stay in other nursing home
- c. Other residential facility—board and care home, assisted living, group home
- d. MH/psychiatric setting
- e. MO/DID setting
- f. NONE OF ABOVE

### A3. ASSESSMENT REFERENCE DATE
- **Month:** 
- **Day:** 
- **Year:**

### A4. DATE OF REENTRY
- Data of reentry from most recent temporary discharge to a hospital in the last 90 days (or since last assessment or admission if less than 90 days)
- **Month:** 
- **Day:** 
- **Year:**

### A5. MARRITAL STATUS
- 1. Never married
- 2. Married
- 3. Widowed
- 4. Separated
- 5. Divorced

### A6. MEDICAL RECORD NO.
- [ ]

### A7. ADVANCED DIRECTIVES
- (For those items with supporting documentation in the medical record, check all that apply)
- a. Do not resuscitate
- b. Do not hospitalize

### B1. COMATOSE
- (Paresthesia, vegetative state, no discernible consciousness)
- **0. No**
- **1. Yes** (Yes, skip to Section G)

### B2. MEMORY
- (Recall of what was learned or learned)
- a. Short-term memory OK—seems to recall after 5 minutes
- b. Long-term memory OK—seems to recall long past
- c. Memory OK—Memory problem

### B3. MEMORY/RECALL ABILITY
- (Check all that resident was normally able to recall during last 7 days)
- a. Current season
- b. Location of own room
- c. Staff names/face
- d. That he/she is in a nursing home
- e. NONE OF ABOVE are recalled

### B4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING
- (Medications decisions regarding tasks of daily life)
- a. Independent—decisions consistent/reasonable
- b. Moderately impaired—decisions poor, custodial supervision required
- c. Severely impaired—newly impaired decisions

### B5. INDICATORS OF DELIRIUM—PERIODIC DISORDERS 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]
- a. Behavior not present
- b. Behavior present, not of recent onset
- c. Behavior present, not of recent onset
- d. Behavior present, not of recent onset

### C1. MAKING SELF UNDERSTOOD
- Expressing information content—however able
- a. Understood
- b. Unable to understand

### C2. ABILITY TO UNDERSTAND OTHERS
- Understanding verbal content—however able
- a. Understands
- b. Unable to understand

### D1. VISION
- Ability to see in adequate light and with glasses if used
- a. Adequate—sees fine detail, including regular print in newspapers/books
- b. Moderately impaired—limited vision; not able to see newspaper headlines, but can identify objects
- c. Highly impaired—object identification in question, but eyes appear to follow objects
- d. Severely impaired—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects

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

### VERBAL EXPRESSIONS OF DISTRESS
- a. Resident makes 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., "I'm nothing; I'm of no use to anyone"
- 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"
- 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 concerns with body functions
- i. Repetitive anxiety complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedule, meals, laundry, clothing, relationship issues
- j. Unpleasant mood in morning
- k. Inconsolable change in usual sleep pattern

### SAD, APATHETIC, ANXIOUS APPEARANCE
- a. Sad, pairs, worried facial expressions—e.g., furrowed brows
- b. Crying, tearfulness
- c. Repetitive physical movements—e.g., pacing, hand waving, restlessness, fidgeting, picking

### LOSS OF INTEREST
- a. Withdrawing from activities of interest—e.g., no interest in long-standing activities or being with family/friends
- b. 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
- a. No mood
- b. Indicators present, easily altered
- c. Indicators present, not easily altered

---

**MDS 2.0 PPS July 2002**
### Resident Identification

#### 13. OTHER CURRENT DIAGNOSES AND ICD-9 CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Inability to lie flat due to shortness of breath</td>
</tr>
<tr>
<td>b.</td>
<td>Recurrent tung last 90 days</td>
</tr>
<tr>
<td>c.</td>
<td>Insufficient fluid; did NOT consume all fluids provided during last 3 days</td>
</tr>
<tr>
<td>d.</td>
<td>Weight gain of 5% or more in last 30 days; or 10% or more in last 180 days</td>
</tr>
<tr>
<td>e.</td>
<td>Shortness of breath</td>
</tr>
<tr>
<td>f.</td>
<td>Rash other than ulcers, rashes, cuts (e.g., cancer lesions)</td>
</tr>
<tr>
<td>g.</td>
<td>Pressure relieving device(s) for chair</td>
</tr>
<tr>
<td>h.</td>
<td>Pressure relieving device(s) for bed</td>
</tr>
<tr>
<td>i.</td>
<td>Prevention or protective foot care (other than to feet)</td>
</tr>
<tr>
<td>j.</td>
<td>Prone positioning program</td>
</tr>
<tr>
<td>k.</td>
<td>Application of dressings (with or without topical medications) other than to feet</td>
</tr>
<tr>
<td>l.</td>
<td>Ongoing wound care program</td>
</tr>
<tr>
<td>m.</td>
<td>Pressure ulcer-any lesion caused by pressure resulting in damage of underlying tissue</td>
</tr>
<tr>
<td>n.</td>
<td>Ulcer care</td>
</tr>
<tr>
<td>o.</td>
<td>Application of ointments/medications (other than to feet)</td>
</tr>
<tr>
<td>p.</td>
<td>Treatment or program of other preventive or protective skin care (other than to feet)</td>
</tr>
<tr>
<td>q.</td>
<td>NONE OF ABOVE</td>
</tr>
</tbody>
</table>

#### 14. ACCIDENTS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Hip fracture in last 180 days</td>
</tr>
<tr>
<td>b.</td>
<td>Other fracture in last 160 days</td>
</tr>
<tr>
<td>c.</td>
<td>NONE OF ABOVE</td>
</tr>
</tbody>
</table>

#### 15. STABILITY OF CONDITIONS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—fluctuating, precipitous, or deteriorating</td>
</tr>
<tr>
<td>b.</td>
<td>Resident experiencing an acute episode or flare-up of a recurrent or chronic problem</td>
</tr>
<tr>
<td>c.</td>
<td>End-stage disease, 6 or fewer months to live</td>
</tr>
<tr>
<td>d.</td>
<td>NONE OF ABOVE</td>
</tr>
</tbody>
</table>

#### 16. FOOT PROBLEMS AND CARE

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems</td>
</tr>
<tr>
<td>b.</td>
<td>Infection of the foot—e.g., cellulitis, purulent drainage</td>
</tr>
<tr>
<td>c.</td>
<td>Open lesions on the foot</td>
</tr>
<tr>
<td>d.</td>
<td>Nails/callosities trimmed during last 90 days</td>
</tr>
<tr>
<td>e.</td>
<td>Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)</td>
</tr>
<tr>
<td>f.</td>
<td>Application of dressings (with or without topical medications) other than to feet</td>
</tr>
<tr>
<td>g.</td>
<td>NONE OF ABOVE</td>
</tr>
</tbody>
</table>

#### 17. NUTRITIONAL APPROACHES

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Parenteral IV</td>
</tr>
<tr>
<td>b.</td>
<td>Feeding tube</td>
</tr>
</tbody>
</table>

#### 18. PARENTERAL OR ENTERAL INTAKE

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days</td>
</tr>
<tr>
<td>b.</td>
<td>Code the average fluid intake per day by IV or tube in last 7 days</td>
</tr>
</tbody>
</table>

#### 19. UCERS

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Stage 1: A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.</td>
</tr>
<tr>
<td>b.</td>
<td>Stage 2: A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.</td>
</tr>
<tr>
<td>c.</td>
<td>Stage 3: A full thickness of skin is lost, exposing the subcutaneous tissues—presents as a deep crater with or without undermining adjacent tissues.</td>
</tr>
<tr>
<td>d.</td>
<td>Stage 4: A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.</td>
</tr>
</tbody>
</table>

#### MDS 2.0 PPS July 2002
P1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

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

[Note: count only post admission therapies]

(A) # of days administered for 15 minutes or more

(B) Total # of minutes provided in last 7 days

d. Physical therapy

e. Speech - language pathology and audiology services

(A) (B)

P2. PHYSICIAN ORDERS

a. PHYSICIAN ORDERS - In the last 14 days (or since admission), how many days has the physician ordered any of the following therapies to begin in the first 14 days of stay - physical therapy, occupational therapy, or speech pathology service?

0. No

1. Yes

P3. DISCHARGE POTENTIAL

a. RESIDENT EXPRESS INDICATES PREFERENCE TO RETURN TO THE COMMUNITY

0. No

1. Yes

c. Stay projected to be of a short duration - discharge projected within 90 days (do not include expected discharge due to death)

0. No

1. Within 30 days

2. Within 60 days

3. Discharge status uncertain

P4. OVERALL CHANGE IN CARE NEEDS

a. 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. Declined - receives more support

P5. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT

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

b. Date RN Assessment Coordinator signed as complete

Month Day Year

T1. SPECIAL TREATMENTS AND PROCEDURES

b. ORDERED THERAPIES - Has physician ordered any of the following therapies to begin in the first 14 days of stay - physical therapy, occupational therapy, or speech pathology service?

0. No

1. Yes

c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.

d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered.

T3. CASE MIX GROUP

Medicare

State

MDS 2.0 PPS July 2002
APPENDIX B
QUALITY OF LIFE ASSESSMENT
RESIDENT INTERVIEW

Facility Name: ____________________________  Provider Number: ___________________
Resident Name: ____________________________  Resident Identifier: ___________________
Surveyor Name: ____________________________  Discipline: ____________________________
Surveyor Number: ____________________________  Interview Dates/Times: __________________

Instructions:
For question 1, if you are meeting with the resident in a location away from the resident's room, visit the room before the interview and note anything about the room that you want to discuss. For question 7, review the RAI to determine the ADL capabilities of this resident.

Introduce yourself and explain the survey process and the purpose of the interview using the following concepts. It is not necessary to use the exact wording.

"[Name of facility] is inspected by a team from the [Name of State Survey Agency] periodically to assure that all residents receive good care. While we are here, we make a lot of observations, review the nursing home's records, and talk to residents to help us understand what it's like to live in this nursing home. We appreciate your taking the time to talk to us."

"We ask certain questions because we want to know whether you have a say in decisions affecting your nursing and medical care, your schedule and the services you receive at this facility. We want to know how you feel about your life here and whether the facility has made efforts to accommodate your preferences."

"If it is all right with you, I'd like to meet with you again later. That will give you time to think things over and to provide additional information later."

In asking the following questions, it is not necessary to use the exact wording. However, do use complete questions, not one-word probes.

Get the resident to talk about actual situations and examples by using open-ended probes, such as: "Can you tell me more about that?" or "How is that done here?" Avoid asking leading questions which suggest a certain response.

If a resident gives a response to any question that indicates there may be a concern with facility services, probe to determine if the resident has communicated the problem to facility staff and what their response was.

1. ROOM: (F177, 201, 207, 242, 250, 252, 256, 257)
   A good approach for initiating this discussion is to make a comment about something you have noticed about the resident's room, for example, "I notice that you have a lot of plants in your room."

Please tell me about your room and how you feel about it.
Do you enjoy spending time in your room?
Is there enough light for you?
Is the room temperature comfortable?
Have you lived in a different room in the facility?
   (If yes) What was the reason for the room change?

Did you have a choice about changing rooms?
Where was your other room? What was it like?
Is there anything you would like to change about your room?
   (If yes) Have you talked to the facility about this?
How did they respond?
RESIDENT INTERVIEW

2. ENVIRONMENT: (F252, 258)
I realize that being in a nursing home is not like being in your own home, but do staff here try to make this facility seem homelike?
We've already talked about your room. How about other places you use, like the activities room and dining room? Do they seem homelike to you?

Is there anything that would make this facility more comfortable for you?
Is it generally quiet or noisy here?
What about at night?
Is the facility usually clean and free of bad smells?

3. PRIVACY: (F164, 174)
Are you a person who likes to have privacy sometimes?
Are you able to have privacy when you want it?
Do staff and other residents respect your privacy?
Do you have a private place to meet with visitors?

(If no phone in room) Where do you make phone calls?
Do you have privacy when you are on the phone? (If the resident indicates any problems with privacy, probe for specific examples. Ask if they talked to staff and what was their response.)

4. FOOD: (F365)
Tell me about the food here.
Do you have any restrictions on your diet?
How does your food taste?
Are you served foods that you like to eat?
Are your hot and cold foods served at a temperature you like?

Have you ever refused to eat something served to you?
(If yes) Did the facility offer you something else to eat?
(If the resident refused a food and did not get a substitute) Did you ask for another food? What was the facility's response?

5. ACTIVITIES: (F242, 248)
How do you find out about the activities that are going on?
Are there activities available on the weekends?
Do you participate in activities?
(If yes) What kinds of activities do you participate in?
(If resident participates) Do you enjoy these activities?

(If resident does not participate, probe to find out why not.)
Is there some activity that you would like to do that is not available here?
(If yes) Which activity would you like to attend?
Have you talked to anybody about this? What was the response?
6. STAFF: (F223, 241) 
Tell me how you feel about the staff members at this facility. Do they treat you with respect? 
Do you feel they know something about you as a person? 
Are they usually willing to take the time to listen when you want to talk about something personal or a problem you are having? 
Do they make efforts to resolve your problems? 

Has any resident or staff member ever physically harmed you? 
Has any resident or staff member ever taken anything belonging to you without permission? 
(If yes) Can you tell me who did this? 
Has a staff member ever yelled or sworn at you? 
(If yes) Please describe what happened. 
Can you tell me who did this? Did you report this to someone? 
(If yes) How did they respond?

7. ADLs: (F216, 311, 312) 
(Tailor this question to what you have observed and what is noted in the MDS about ADL capabilities of this resident.) For example: I see that your care plan calls for you to dress with a little help from staff. How is that working for you? 

Do you feel that you get help when you need it? 
Do staff encourage you to do as much as you can for yourself?

8. DECISIONS: (F154, 242, 280) 
Here at this facility, are you involved in making choices about your daily activities? 
Are you involved in making decisions about your nursing care and medical treatment? 
(If not, probe to determine what these choices and decisions are, and relate this information to necessary restrictions that are part of the resident's plan of care.) 
Do you participate in meetings where staff plan your activities and daily medical and nursing care? 

If you are unhappy with something, or if you want to change something about your care or your daily schedule, how do you let the facility know? 
Do you feel the staff members listen to your requests and respond appropriately? 
If the staff are unable to accommodate one of your requests, do they provide a reasonable explanation of why they cannot honor the request? 
Can you choose how you spend the day? 
Have you ever refused care or treatment (such as a bath or certain medication)? 
(If yes) What happened then?
RESIDENT INTERVIEW

9. MEDICAL SERVICES: (F156, 163, 164, 250, 411, 412)
   Who is your physician?
   Did you choose your physician yourself?
   (If no, probe for details about who selected the physician and why the resident did not do it.)
   Are you satisfied with the care provided by your physician?
   Can you see your doctor if you need to?
   Do you see your physician here or at the office?
   (If they say here) Where in the facility does your doctor see you?
   Do you have privacy when you are examined by your physician?
   (If they say they go to the office) How do you get to the office?
   Do facility staff help you make doctor's appointments and help you obtain transportation?
   Can you get to see a dentist, podiatrist, or other specialist if you need to?

10. (Write here any special items not already discussed that you have noted about this resident or about the facility that you would like to discuss with the resident.)

11. Is there anything else you would like to talk about regarding your life here?

Thank the resident. Review your notes from this interview and determine if there are any concerns you need to investigate further. Share any problems you have found with the team so they may keep them in mind during the remainder of the survey.
QUALITY OF LIFE ASSESSMENT

GROUP INTERVIEW

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th>Surveyor Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Number:</td>
<td>Surveyor Number:</td>
</tr>
<tr>
<td>Interview Dates/Times:</td>
<td>Discipline:</td>
</tr>
<tr>
<td>Residents Attending:</td>
<td></td>
</tr>
</tbody>
</table>

**Instructions:**
Introduce yourself to the group and explain the survey process and the purpose of the interview using the following concepts. It is not necessary to use the exact wording.

"[Name of facility] is inspected by a team from the [Name of State Survey Agency] periodically as one part of a process in which we evaluate the quality of life and quality of care in this facility.

While we are here, we make observations, look over the facility's records, and talk to residents about life in this facility.

We appreciate you taking the time to talk to us.

We would like to ask you several questions about life in the facility and the interactions of residents and staff."

1. **RULES: (F151, 242, 243)**
   - Tell me about the rules in this facility.
   - For instance, rules about what time residents go to bed at night and get up in the morning?
   - Are there any other facility rules you would like to discuss?
   - Do you as a group have input into the rules of this facility?
   - Does the facility listen to your suggestions?

2. **PRIVACY: (F164, 174)**
   - Can you meet privately with your visitors?
   - Can you make a telephone call without other people overhearing your conversation?
   - Does the facility make an effort to assure that privacy rights are respected for all residents?
### GROUP INTERVIEW

**3. ACTIVITIES:** (F242, 248)

Activities programs are supposed to meet your interests and needs. Do you feel the activities here do that?  
(If no, probe for specifics.)  
Do you participate in the activities here?  
Do you enjoy them?  
Are there enough help and supplies available so that everyone who wants to can participate?  
Do you as a group have input into the selection of the activities that are offered?  
How does the facility respond to your suggestions?  

Is there anything about the activities program that you would like to talk about?  
Outside of the formal activity programs, are there opportunities for you to socialize with other residents?  
Are there places you can go when you want to be with other residents?  
(If answers are negative) Why do you think that occurs?  

**4. PERSONAL PROPERTY:** (F252)

Can residents have their own belongings here if they choose to do so?  
What about their own furniture?  
How are your personal belongings treated here?  

Does the facility make efforts to prevent loss, theft, or destruction of personal property?  
Have any of your belongings ever been missing?  
(If anyone answers yes) Did you talk to a staff member about this? What was their response?  

**5. RIGHTS:** (F151, 153, 156, 167, 168, 170, 280)

How do residents here find out about their rights — such as voting, making a living will, getting what you need here?  
Are you invited to meetings in which staff plan your nursing care, medical treatment and activities?  
Do you know that you can see a copy of the facility's latest survey inspection results?  
Where is that report kept here?  

Do you know how to contact an advocacy agency such as the ombudsman office?  
Do you know you can look at your medical record?  
Have any of you asked to see your record? What was the facility's response?  
Has anyone from the facility staff talked to you about these things?  
Tell me about the mail delivery system here.  
Is mail delivery prompt? Does your mail arrive unopened daily?  

**6. DIGNITY:** (F223, 241)

How do staff members treat the residents here, not just yourselves, but others who can't speak for themselves?  
Do you feel the staff here treat residents with respect and dignity?  

Do they try to accommodate residents' wishes where possible?  
(If answers are negative) Please describe instances in which the facility did not treat you or another resident with dignity. Did you talk to anyone on the staff about this? How did they respond?
GROUP INTERVIEW

7. ABUSE AND NEGLECT: (F223)
Are you aware of any instances in which a resident was abused or neglected?
Are you aware of any instances in which a resident had property taken from them by a staff member without permission?
(If yes) Tell me about it. How did you find out about it?
Are there enough staff here to take care of everyone?
(If no) Tell me more about that.

We are willing to discuss any incidents that you know of in private if you would prefer. If so, just stop me or one of the other surveyors anytime, and we'll listen to you.

8. COSTS: (F156, 207)
Are residents here informed by the facility about which items and services are paid by Medicare or Medicaid and which ones you must pay for?
If there was any change in these items that you must pay for, were you informed?

Are you aware of any changes in the care any resident has received after they went from paying for their care to Medicaid paying?
(If answers suggest the possibility of Medicaid discrimination, probe for specific instances of differences in care.)

9. BUILDING: (F256, 257, 258, 463, 465, 483)
I'd like to ask a few questions about the building, including both your bedroom and other rooms you use such as the dining room and activities room.
Is the air temperature comfortable for you?
Is there good air circulation or does it get stuffy in these rooms?

What do you think about the noise level here? Is it generally quiet or noisy? How about at night?
Do you have the right amount of lighting in your room to read or do whatever you want to do?
How is the lighting in the dining rooms and activity rooms?
Do you ever see insects or rodents here?
(If yes) Tell me about it.

10. FOOD: (F364, 365, 367)
The next questions are about the food here.
Is the flavor and appearance of your food satisfactory?
Outside of the dietary restrictions some of you may have, do you receive food here that you like to eat?
If you have ever refused to eat a particular food, did the facility provide you with something else to eat? (If no, probe for specifics.)
Is the temperature of your hot and cold foods appropriate?
Are the meats tender enough?

About what time do you receive your breakfast, lunch, and dinner?
Are the meals generally on time or late?
What are you offered for a bedtime snack?
If you ever had a concern about your food, did you tell the staff? What was their response?
RESIDENT INTERVIEW

11. COUNCIL: (F243)
(If you are speaking with a resident council)
Does the facility help you with arrangements for council meetings?
Do they make sure you have space to meet?
Can you have meetings without any staff present if you wish?

How does the council communicate its concerns to the facility?
How does the administrator respond to the council's concerns?
If the facility cannot accommodate a council request, do they give you a reasonable explanation?

12. GRIEVANCES: (F165, 166)
Have any of you or the group as a whole ever voiced a grievance to the facility?
How did staff react to this?
Did they resolve the problem?

Do you feel free to make complaints to staff? If not, why not (probe for specific examples)?

13. Identify here any issues you would like to discuss with the group that have not been covered in the questions above.

14. Is there anything else about life here in the facility that you would like to discuss?

Thank the group for their time. After the interview, follow up on any concerns that need further investigation. Document your follow up on Resident Review or Supervisor Notes Worksheets. Share these concerns with the team.

Form CMS-806B (7-95)
QUALITY OF LIFE ASSESSMENT
FAMILY INTERVIEW

Facility Name: ____________________________  Resident Name: ____________________________
Provider Number: ____________________________  Resident Identifier: ____________________________
Surveyor Name: ____________________________  Person Interviewed: ____________________________
Surveyor Number: __________  Discipline: _______  Relationship to Resident: ____________________________
Method of Contact: In person □  Phone □  Interview Dates/Times: ____________________________

Instructions:
This interview is intended to be conducted with a person (family, friend or guardian) who is the one acting on behalf of the resident and authorizing care. Prior to the interview, complete as many questions as you can through review of the resident assessment, care plan and any activities or social service assessment. Adapt these questions and probes as necessary to make them applicable to this resident.

Introduce yourself and explain the survey process and the purpose of the interview using the following concepts. It is not necessary to use the exact wording.

"[Name of facility] is inspected by a team from the [Name of State Survey Agency] periodically to assure that residents receive quality care. While we are here, we make observations, review the nursing home's records, and talk to residents and family members or friends who can help us understand what it's like to live in this nursing home. We appreciate your taking the time to talk to us.

We ask these questions because we want to know about your opportunity for involvement in decision about ______'s care and schedule, your views on services he/she receives here, and in general, what you think of the facility. We want to know if the facility has obtained information about ______'s past and current preferences in order to provide the highest quality of care. We also want to find out about the admission process and what the facility discussed with you about costs and payment for ______'s stay here.

Question 1 below screens the family member to see if she/he knows the resident well enough to complete the rest of the interview. Based on answers to question 1, decide whether you can complete the interview, complete it partially if the family member knows some things, or conclude the interview. If you decide you must conclude this interview, ask a general question that lets the family member say what they wish to say about the facility such as: "Is there anything you would like to tell me about this facility and how your relative is treated?"

1. (Ask about the nature and extent of the relationship between interviewee and resident both prior to and during nursing home residence):
With whom did your relative/friend live before coming to the nursing home? (If the resident did not live with this person) About how often did you see her/him?

How often do the resident and you see each other now?

Are you familiar with ______'s preferences and daily routines when he/she was more independent and more able to make choices and express preferences? (If the resident has had a lifelong disability, ask about choice and preferences prior to moving to this facility. Adapt question 2 and 3 also.)
FAMILY INTERVIEW

To the extent that the interviewee is knowledgeable about the resident's past life, ask the following:

2. I have some questions about ________'s life-style and preferences when she/he was more independent and able to express preferences. Would you tell me about:

Did he/she enjoy any particular activities or hobbies?  
Eating habits, food likes and dislikes;
Was she/he social or more solitary?  
Sleeping habits, alertness at different times of the day;
Types of social and recreational activities;  
Religious/spiritual activities;
Eating habits, food likes and dislikes;
Sleeping habits, alertness at different times of the day;
Religious/spiritual activities;
Work, whether in or out of the home;
Things that gave him/her pleasure.

3. The next questions are about the resident's lifelong general personality. How would you describe:

General manner; for example, was she/he thought to be quiet, happy, argumentative, etc.?  
Characteristic ways of talking — was she/he talkative or usually quiet, likely to express herself/himself or not?
How she/he generally adapted to change, prior to the current disability. How, for example, did the resident react to moving to a new residence, to losing a loved one, and to other changing life situations?

4. Have any of the preferences and personality characteristics that you told me about changed, either due to a change in her/his condition or due to relocation to this facility?

Have her/his daily routines and activities changed in a substantial way since moving here?  
(If yes) Please describe these differences.
QUALITY OF LIFE ASSESSMENT
OBSERVATION OF NON-INTERVIEWABLE RESIDENT

1. Special items to observe:

2. RESIDENT AND ENVIRONMENT:
   Physical condition of resident (comfort, positioning, etc.) (F246)
   Appearance (grooming and attire) (F241)
   Physical environment (comfort, safety, privacy, infection control, stimulation, personal belongings, homelike) (F164, 246, 252, 441, 444, 459)
   Level of assistance received. Note instances of too much or too little and resulting problem (e.g., violation of dignity). (F241, 309-312)
   Privacy afforded when care is given (F164)
   Use of restraints and/or other restrictions on behavior (F221)
   Do staff intervene to assist resident if there is a problem and the resident tries to indicate this? (F312)

3. DAILY LIFE:
The agreement of the daily schedule and activities with assessed interests and functional level (Note during activities if cues/prompts and adapted equipment are provided as needed and according to care plan.) (F242, 255)
   Restriction of choices that the resident can make (e.g., resident reaching out for a drink or pushing away food or medication and facility response) (F155, 242)
   Consistency of TV or radio being on or off with assessed interests (F242, 280)

4. INTERACTIONS WITH OTHERS:
   Do staff individualize their interactions with this resident, based on her/his preferences, capabilities, and special needs? (F241, 246)
   What is the resident's response to staff interactions (smiling, attempting to communicate, distressed, anxious, etc.)? (F241, 246)
   Do staff try to communicate in a reassuring way? (Note staff tone of voice and use of speech.) While staff are giving care, do they include resident in conversation or do staff talk to each other as if resident is not there? (F241, 223)
   Evidence of a roommate problem that could be addressed by the facility (F250)
   Consistency of opportunities for socializing with regard to assessed interests and functional level (Note time and situations when isolated.) (F174, 242, 248, 250)
   Location of resident: segregated in some way, in a special unit, or fully integrated with other residents (Note any adverse consequences for resident.) (F223)

Use the Resident Review or Surveyor Notes Worksheet to follow-up on any concerns. Share any concerns with the team.

Form CMS-806C (07/95)
5. (For all the items below: If the family member describes any problems, probe for specific information. Ask if they have talked to staff, and what was the facility's response. If the resident's payment source changed from private pay or Medicare to Medicaid, inquire if there were any changes in any of the following after the payment source changed.)

Please share with me your observations, either positive things or concerns, about all of the following items. If you have no information about these issues that is OK.

- Meals and snacks (F242, 310, 365, 366, 367)
- Routines and activities (F242, 245, 248)
- Visitor policies and hours, privacy for visits when desired (F164, 172)
- Care by nursing home staff (F241, 309–312)
- Noise level of the facility (F258)
- Privacy when receiving care (F164)
- Transfers (F177, 201, 203–207)
- Security and personal property (F159, 223, 252)
- Cleanliness and odor (F252–254)

6. Did you participate in the admission process?
   (If yes) Were you told anything about using Medicare or Medicaid to pay for _____'s stay here?
   (If yes) What did they tell you?
   (If resident's care is being paid by Medicaid) Were you asked to pay for any extras above the Medicaid rate?
   (If yes) What were these? Did you have a choice about receiving these services?
   When your relative/friend moved here, did the facility ask you to pay out of your savings or your relative's savings? (F156, 208)

7. Are you the person who would be notified if _____'s condition changed. (If yes) Have you been notified when there have been changes in your relative's condition? Are you involved in _____'s care planning? (F157)

8. "Is there anything else that I have not asked that is important to understand about _________'s everyday life here?"

When finished: “Thank you for your help. You will be able to examine a copy of the results of this survey in about ___ days.”
APPENDIX E
Appendix A
Quality Improvement Pathway:
Quality of Care

Resident Identifier: __ Date of Triggering Event: __

Quality Improvement Area:
- Sensory Impairments
- Behavior
- Medications
- Limited Nursing Services

Activities of Daily Living:
- Skin Integrity
- Nutrition
- Infections

OBSERVATIONS:
Resident:
- Interviewable (past history)? YES NO
- Responds appropriately to questions? YES NO
- Observable care issue? YES NO

Type of issue?
- Vision
- Hearing
- Speech
- Wanders
- Depressed
- Anxious
- Combative
- Weight Loss
- Hydration
- Infections
- Limited Nursing Services
- Other

Oral Hygiene
- Bathing
- Grooming
- Dressing
- Eating
- Incontinence
- Mobility
- Pressure Ulcer
- Stasis Ulcer
- Med Category
- Missing Meds
- Med Changes

Environment:
Potential Care Issues: YES NO

Contributing Factors:
Staff/Resident Interactions:
Potential Issues: YES NO

INTERVIEWS:
Resident/Family:
1. Can you tell us about the care issue? YES NO
   Memory of care issue:
2. Did you report this care issue to anyone? YES NO
   If no, who did?________________________________
3. Do you feel your care needs are met here? YES NO
4. What can we do to improve your care?

Facility Staff:
1. Can you tell us about the care issue? YES NO
   Memory of care issue:
   2. Did you report the care issue to anyone? YES NO
      If no, who did?________________________________
   3. Do you feel that this resident's care needs are met here? YES NO
   4. What can we do to improve the resident's care here?

Others Contacted:
1. Can you tell us about the care issue? YES NO N/A
   Memory of care issue:
   2. Did you report the care issue to anyone? YES NO N/A
      If no, who did?________________________________
   3. Do you feel that this resident's care needs are met here? YES NO N/A
   4. What can we do to improve the resident's care here?

RECORD REVIEW:
Resident:
1. Was the care issue documented? YES NO
2. Were the following assessed: What happened? YES NO
   Date/time noted? YES NO
   Where? YES NO
   How? YES NO
3. Did the care issue result in resident harm? YES NO
   No Harm __________
   Potential Harm __________
   Actual Harm __________
4. Were contributing factors identified? YES NO N/A
   Resident change of condition? YES NO N/A
   Environmental hazards? YES NO N/A
   Staffing? YES NO N/A
5. Were preventive measures initiated? YES NO
6. Could the care issue be prevented? YES NO
7. Was the physician notified? YES NO N/A
8. Was the family/significant others notified? YES NO N/A
9. Was the Complaint Resolution Unit notified? YES NO N/A
10. Does resident have a previous history of similar issues?  
   YES  NO

11. Was a pattern of care issues identified?  
    YES  NO

12. Was the individual resident plan changed?  
    YES  NO

13. Were planned changes implemented?  
    YES  NO

14. Did initiated changes protect the resident from harm?  
    YES  NO

15. Has the care issue recurred?  
    YES  NO

Facility:
1. Was the care issue documented in a log?  
   YES  NO  N/A

2. Was an incident report completed?  
   YES  NO  N/A

3. Was a response to information contained in the incident report evident?  
   YES  NO  N/A

4. Was a policy/procedure related to the care issue evident?  
   YES  NO

5. Was the policy/procedure followed?  
   YES  NO  N/A

6. Were changes initiated in the policy/procedure related to this care issue?  
   YES  NO  N/A

7. Were other residents at risk for similar care issues identified?  
   YES  NO

8. Is the resident currently at risk for harm?  
   YES  NO

If yes:  
   Potential Harm       Actual Harm

IDENTIFY FACILITY PRACTICE NEEDING QUALITY IMPROVEMENT ACTION:
### Appendix B

## Quality Improvement Pathway:

**Quality of Life**

<table>
<thead>
<tr>
<th>Resident Identifier:</th>
<th>Date of Triggering Event:</th>
</tr>
</thead>
</table>

### Quality Improvement Area:

- Admission Services Provided
- Environment
- Staff

### OBSERVATIONS:

**Resident:**

- Interviewable (past history)?
  - YES | NO
- Responds appropriately to questions?
  - YES | NO
- Observable quality-of-life issue?
  - YES | NO

**Type of issue?**

- Assessment
- Admission Agreement
- House Rules
- Visitors
- Mail
- Voting
- Finances
- Transfer/Discharge
- Grievances
- Food Preferences
- Food Quality
- Food Temperature
- Snacks
- Activities
- Health Services
- Physical Restraints
- Resident Plan

- Personal Belongings
- Room Choice
- Roommate
- Water Temperatures
- Noise
- Odors
- Cleanliness
- Missing Items
- Dignity
- Respect
- Choice
- Privacy
- Accommodation of Needs
- Abuse
- Neglect
- Chemical Restraints

### Environment:

- Potential Quality-of-Life Issues: YES | NO

### Contributing Factors:

### Staff/Resident Interactions:

- Potential Issues: YES | NO
INTERVIEWS:

Residents/Family:
1. Can you tell us about this quality-of-life issue? [YES NO]

Memory of issue:
2. Did you report this quality-of-life issue? [YES NO]
   If no, who did? ___________________________
3. Do you feel your quality-of-life needs are met here? [YES NO]
4. What can we do to improve your quality of life?

Facility Staff:
1. Can you tell us about the quality-of-life issue? [YES NO]

Memory of issue:
2. Did you report the quality-of-life issue? [YES NO]
   If no, who did? ___________________________
3. Do you feel that this resident’s quality-of-life needs are met here? [YES NO]
4. What can we do to improve the resident’s quality of life here?

Others Contacted:
1. Can you tell us about the quality-of-life issue? [YES NO N/A]

Memory of issue:
2. Did you report the quality-of-life issue? [YES NO N/A]
   If no, who did? ___________________________
3. Do you feel that this resident’s quality-of-life needs are met here? [YES NO N/A]
4. What can we do to improve the resident’s quality of life here?

RECORD REVIEW:

Resident:
1. Was the quality-of-life issue documented? [YES NO]
2. Were the following assessed: What happened? [YES NO]
   Date/time noted? [YES NO]
   Where? [YES NO]
   How? [YES NO]
3. Did the quality-of-life issue result in resident harm? [YES NO]
   No Harm
   Potential Harm
   Actual Harm
4. Were contributing factors identified? [YES NO N/A]
   Resident change of condition? [YES NO N/A]
   Environmental hazards? [YES NO N/A]
   Staffing?
Pathways to Quality Improvement for Boarding Homes

<table>
<thead>
<tr>
<th></th>
<th>5. Were preventive measures initiated?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6. Could the quality-of-life issue be prevented?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>7. Was the physician notified?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>8. Was the family/significant others notified?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>9. Was the Complaint Resolution Unit notified?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>10. Does resident have a previous history of similar issues?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>11. Was a pattern of quality-of-life issues identified?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>12. Was the individual resident plan changed?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>13. Were planned changes implemented?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>14. Did initiated changes protect the resident from harm?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>15. Has the quality-of-life issue recurred?</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

Facility:

<table>
<thead>
<tr>
<th></th>
<th>1. Was the quality-of-life issue documented in a log?</th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Was an incident report completed?</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>3. Was a response to information contained in the incident report evident?</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>4. Was a policy/procedure related to the quality-of-life issue evident?</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>5. Was the policy/procedure followed?</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>6. Were changes initiated in the policy/procedure due to this issue?</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>7. Were other residents at risk for similar quality-of-life issues identified?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Is the resident currently at risk for harm?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>

If yes:

- Potential Harm
- Actual Harm

IDENTIFY FACILITY PRACTICE NEEDING QUALITY IMPROVEMENT ACTION:
Appendix C

Quality Improvement Pathway:
Resident Safety

Resident Identifier: ___________________________ Date of Triggering Event: __________

Quality Improvement Area:
- Falls
- Elopement
- Medication Error
- Altercations
- Changed Condition
- Other

OBSERVATIONS:

Resident:
- Interviewable (past history)?
- Responds appropriately to questions?
- Observable injury?
- Origin known?
- Type of injury?

- Fractures
- Bruises
- Skin Tears
- Lacerations
- Burns
- Mobility?

Environment (Location of Incident):
- Independent Assistance Required

Potential Safety Issues: ___________________________

- Environment
- Contributing Factors:

Staff/Resident Interactions:
- Potential Issues:

INTERVIEWS:

Resident/Family:
1. Do you recall what happened? ___________________________

- Memory of event:
2. Did you report this to anyone? ___________________________

- If no, who did?
3. Do you feel safe here? ___________________________

- 4. What can we do to make you feel safer here?
Facility Staff:

1. Do you recall what happened?  
   Memory of event:
   YES  NO
2. Did you report the event to anyone?  
   YES  NO
3. Do you feel that this resident is safe here?  
   YES  NO
4. What can we do to make it safer for the resident?

Others Contacted:

1. Do you recall what happened?  
   Memory of event:
   YES  NO  N/A
2. Did you report the event to anyone?  
   YES  NO  N/A
3. Do you feel that this resident is safe here?  
   YES  NO  N/A
4. What can we do to make it safer for the resident?

**RECORD REVIEW:**

Resident:

1. Was the triggering event documented?  
   YES  NO
2. Were the following assessed: Date/time occurred?  
   What happened?
   WHERE?
   How?
   YES  NO  N/A
3. Did the triggering event result in resident harm?  
   No Harm
   Potential Harm
   Actual Harm
   YES  NO
4. Were contributing factors identified?  
   Resident Change of Condition?  
   Environmental Hazards?  
   Staffing?
   YES  NO  N/A
5. Were preventive measures initiated?  
   YES  NO  N/A
6. Could the triggering event be prevented?  
   YES  NO
7. Was the physician notified?  
   YES  NO  N/A
8. Was the family/significant others notified?  
   YES  NO  N/A
9. Was the Complaint Resolution Unit notified?  
   YES  NO  N/A
10. Does resident have a previous history? (incidents)  
    YES  NO
11. Was a pattern of triggering events assessed?  
    YES  NO
12. Was the individual resident plan changed?  
    YES  NO
13. Were planned changes implemented?  
    YES  NO
14. Did initiated changes protect the resident from harm?  
    YES  NO
15. Has the triggering event recurred?  
    YES  NO
<table>
<thead>
<tr>
<th>Facility:</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Was the triggering event documented in a log?</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td>2. Was an incident report completed?</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td>3. Was a response to information contained in the incident report evident?</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Was a policy/procedure related to the triggering event evident?</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td>5. Was the policy/procedure followed?</td>
<td>YES</td>
<td>NO</td>
<td>N/A</td>
</tr>
<tr>
<td>6. Were changes initiated in the policy/procedure due to this triggering event?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>7. Were other residents at risk for similar triggering events identified?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>8. Is the resident currently at risk of harm?</td>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>If yes: Potential Harm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actual Harm</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IDENTIFY FACILITY PRACTICE NEEDING QUALITY IMPROVEMENT ACTION: