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COHORT STUDY OF PAIN BEHAVIORS IN THE ELDERLY RESIDING IN SKILLED NURSING CARE

by

ALLISON H. BURFIELD M.S.N. University of Central Florida, 2006

A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy in Nursing in the College of Nursing at the University of Central Florida Orlando, Florida

Spring Term 2009

Major Professor: Mary Lou Sole

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ABSTRACT

An integral concern across care settings is the prompt intervention for patients suffering with pain. Long-term care (LTC) settings present with unique challenges to assess and manage pain in resident populations. Pain assessment is especially challenging, because residents have varying degrees of cognition to communicate their pain, and clinician/staff knowledge of pain symptoms may be lacking. The purpose of this research was to improve the measurement of pain and outcomes of care for the elderly residing in skilled nursing care, especially those with cognitive-impairment. The specific aims of this study were to: 1) Determine the magnitude of the relationship between pain behaviors and a measurement model hypothesized for pain; 2) Test the construct validity of a pain measurement model; 3) Examine the concomitance of pain and cognition in a three-year longitudinal analysis. The research questions answered: 1) Is there a difference in the prevalence of pain in cognitively intact versus cognitively-impaired residents; 2) Can a theoretically derived model of pain aid in detecting pain across all cognitive levels; and 3) Do pain and cognitive status concomitantly correlate? The goal was to examine the covariance model of concomitance of pain and cognition to more accurately construct theoretical models of pain to then include additional resident care factors in future research.

Traditional self-reports of pain are often under-assessed and under-treated in the cognitively-impaired (CI) elderly resident. Having additional measures to detect pain beyond self-reports of pain intensity and frequency increases the likelihood of detecting pain in populations with complex symptom presentation. Data collected from skilled nursing facilities offer exceptional opportunities to study resident demographics, characteristics, symptoms, medication use, quality indicators, and care outcomes. The Minimum Data Set-Resident Assessment Instrument (MDS-RAI) 2.0, a nationally required resident assessment tool, must be

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completed on every resident in a Medicare LTC facility within 14 days of admission, quarterly, annually and with significant changes in resident status. Because the MDS is widely used and recognized in LTC settings, core items from MDS [i.e., pain frequency (J2a) and pain intensity (J2b)] along with additional MDS items hypothesized to signify pain were analyzed in the pilot measurement model. Ten core items from MDS were used: 1) Inappropriate behavior frequency (E4da); 2) Repetitive physical movements; 3) Repetitive verbalizations (E1c); 4) Sad facial expressions (E11); 5) Crying (E1m); 6) Change in mood (E3); 7) Negative statements (E1a); 8) Pain frequency (J2a); 9) Pain intensity (J2b); and 10) Cumulative pain sites scores. All indicators of pain were significant at the p<.01 level.

A longitudinal cohort design was used to answer if a concomitance exists between pain and cognition. Data were collected from MDS annual assessments from 2001, 2002 and 2003 for residents across the United States. The sample consisted of 56,494 residents age 65 years and older with an average age of 83 ± 8.2 years. Descriptive statistics, ANOVA and a covariance model were used to evaluate cognition and pain at the three time intervals.

ANOVA indicated a significant effect (p<.01) for pain and cognition with protected ttests indicating scores decreased significantly over time with resident measures of pain and cognition. Results from this study suggest that: 1) Using only pain intensity and frequency, pain prevalence was found in 30% of the pilot population, while 47.7% of cognitively intact residents had documented pain and only 18.2% of the severely CI had documented pain, supporting previous research that pain is potentially under-reported in the CI; 2) Parsimonious measurements models of pain should include dimensions beyond self-reports of pain (i.e., cognitive, affective, behavioral and inferred pain indicators); 3) Model fit was improved by using specific MDS items in the pain construct; 4) Longitudinal analysis revealed relative stability for

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pain and cognition measures over time (e.g., larger stability or consistency was found in cognitive measures than the measures of pain over the three-year period); 5) Crossed-legged effects between pain and cognition were not consistent; 6) A concomitant relationship was not found between pain and cognition. The relationship was significant (p<.01), but associations were weak (r=0.03 to 0. 08). Pain or cognition should not be used as a predictor of the other in theoretical models for similar populations.

The MDS is a reliable instrument to follow resident attributes, quality of care, and patient outcomes over time. The development of more accurate assessments of pain may improve resident care outcomes. Ineffectively intervening on the pain cycle is posited to cause secondary unmet needs that affect the resident's quality of life. Findings support the importance of improving clinical outcomes in the management of pain in the elderly residing in long-term care. Deficits in the treatment of pain highlight the impetus to support health policy change that includes pain treatment as a top health priority and a quality indicator for federally funded programs supporting eldercare.

This dissertation is dedicated to my husband without whose love, support and patience, this dissertation would not have been possible. Thank you also to my parents for their limitless words of encouragement and believing that education beyond all else is so important.

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LIST OF ACRONYMS/ABBREVIATIONS

ACRONYM	Definition of Acronym
ADL	Activities of Daily Living
AGS	American Geriatrics Society
AHQA	American Health Quality Association
ASPMN	American Society for Pain Management Nursing
CI	Cognitively-impaired
CMS	Centers for Medicare and Medicaid
	Consequences of Need-Driven, Dementia-
C-NDB	Compromised Behavior
CPS	Cognitive Performance Scale
DRP	Drug-related Problem
HR-QOL	Health Related Quality of Life
IRB	Institutional Review Board
LTC	Long-Term Care
MDS-RAI	Minimum Data Set-Resident Assessment Instrument
MMSE	Mini-Mental State Examination (Folstein)
NDB	Need-Driven, Dementia-Compromised Behaviors
NHQI	Nursing Home Quality Initiative
NIH	National Institute of Health
NSAID	Nonsteriodal Anti-Inflammatory Drug
PS	Pain Scale
QI	Quality Improvement
QOL	Quality of Life
RAP	Resident Assessment Protocol
SNF	Skilled Nursing Facility
TJC	The Joint Commission; formally known as Joint
	Commission on Accreditations of Healthcare
	Organizations (JCAHO)
	\sim $\langle \rangle$

CHAPTER 1: INTRODUCTION

The management of pain is a primary healthcare concern across all age groups and social strata.¹ The goal of pain management is to lessen pain and relieve discomfort and suffering. Pain management in nursing home residents is a major concern to policy makers and those who care for the elderly, because despite efforts to improve care, pain continues to be under-assessed and under-treated. It is estimated that 49-83 % of 1.8 million nursing home residents suffer with chronic daily pain.²⁻⁴ Cognitively-impaired individuals, who are confined to skilled nursing care, are at the highest risk for inadequate pain management. Research on assessment and treatment of pain for cognitively-impaired residents lacks consistent documentation and interventions.⁵⁻¹⁴ Pain is not assessed consistently or well in the cognitively-impaired elderly, resulting in under-treatment. Assessing pain in the elderly with advanced stages of cognitive decline is difficult related to decreasing ability, or inability to communicate their pain verbally.

Action plans in fall 2008 from the Centers for Medicare and Medicaid (CMS) recognized a system-wide inability to provide for appropriate pain relief measures for the elderly. Revisions of the regulatory requirements for pain management were slated to change in the *Interpretive Guidance to Surveyors for Long Term Care Facilities* to correct for these deficits.¹⁵ Essential in strategic planning was the alignment of measures to match federal surveys and certification priorities. Missing in care protocols was how to improve assessment and treatments with common quality indicators, when vital pain information is lacking from these surveys. The Minimum Data Set-Resident Assessment Instrument (MDS-RAI), used nationwide in Medicare funded facilities, contains items to extrapolate pain states, but does not document interventions taken to treat pain. A MDS-RAI instrument to measure pain in the cognitively-impaired resident does not exist to date.

Specific Aims

The purpose of this study was to improve the measurement of pain and outcomes of care for the elderly residing in skilled nursing care, especially those who are severely cognitivelyimpaired. Pain behaviors will be analyzed using data from the MDS-RAI. Three specific aims guided the study:

1) Determine the magnitude of the relationship between pain behaviors and a measurement model hypothesized for pain.

2) Test the construct validity of a pain measurement model.

3) Examine the concomitance of pain and cognition in a three-year longitudinal analysis.The research questions answered:

1) Is there a difference in the prevalence of pain in cognitively intact versus cognitivelyimpaired residents?

2) Can a theoretically derived model of pain aid in detecting pain across all cognitive levels?

3) Do pain and cognitive status concomitantly correlate?

This study obtained point-in-time resident data to develop a model assessing pain in the elderly. A large dataset stratified by subgroups was to answer the research questions and increase the generalizability of the findings beyond the smaller scale studies conducted to date on pain behaviors. The long-term benefit to health policy offers quantifiable methods to measure pain for this population, serving as a foundation to implement changes in care management, and enable assessments that provide relevant data to determine treatment regimens for this vulnerable population.

Significance

Care environments should strive to promote holistic, resident-centered care to ensure quality of life.¹⁶ Negative behaviors in the care environment that can be correctly identified may improve health outcomes and reduce complications to enable cost-savings from using appropriate interventions, and help reduce caregiver burden and burnout.¹⁷ Understanding the patterns and associations of pain behaviors improves the ability to more accurately anticipate care needs and improve the resident's quality of life. Pain is an abstract, intangible concept, experienced by an individual. Multiple signs or indicators may be an expression of that pain. Categorizing indicators of the latent construct, pain, would add significant value to assessing pain more accurately.

Pain that is promptly identified and treated at an early onset may stop the pain cycle and lessen the event of disruptive behaviors. If pain behaviors are intervened upon at an earlier stage, suffering could be lessened and secondary co-morbid complications might not occur. Decreasing pain and its associated behaviors could lessen disruptions to staff or other residents, increasing unit/facility safety and improving group dynamics. Pain needs met with timely interventions may decrease resident wandering or other physically aggressive behaviors, improve resident safety and reduce the incident of falls.¹⁸ Cost savings would occur by the use of more efficacious interventions based on the resident's needs, not just the needs of the staff to reduce unit disruptions.^{19, 20} Behaviors managed with appropriate interventions might prevent transfer of a resident to a higher level of care to regain unit order.²¹ Staff can be empowered to correctly interpret pain behaviors, which may reduce burnout from routinely dealing with combative residents.¹⁹

Lacking are research findings based on large-scale data to gain general perspectives across resident types to link pain behaviors. Research evaluating pain behaviors answers valuable questions to form links between symptoms, behaviors, and resident quality of life to study why gaps in care exist and to then discover patterns in secondary needs (e.g., depression, weight loss, decreased activity, functional declines, or immuno-compromised states).²²

Background

Theoretical Framework

The theoretical framework defines and describes the presenting problem, and models the processes producing the presenting problem behaviors related to assessment of pain in cognitively-impaired elders. Using a theoretically-derived framework allows researchers to incorporate background and proximal factors to explain pain behaviors.

This study integrated the Consequences of Need-Driven Behaviors as the theoretical framework. Need-driven, dementia-compromised behaviors (NDB) are the behaviors a resident displays to communicate underlying needs. Algase and colleagues ²³ developed the first model of needs-driven behaviors (Figure 1.1). The expression of NDBs is specific to the individual and dependent upon background and proximal factors. Background factors include neurological, cognitive, psychosocial and general health causes. The proximal factors vary greatly and are dependent upon environmental and personal causes, like unit staffing, or pain with movement. Proximal factors are the most likely to cause NDBs. Using the NDB as the foundational framework for this research enables one to draw a link between cognitively-impaired residents (background factor) and proximal factors, like pain, to understand why NDBs occur. This process allows the clinician to isolate actions with the highest probability of triggering the

behaviors.²³ From this knowledge, the most efficacious, targeted interventions for the needdriven, dementia-compromised behaviors can be made.¹⁷

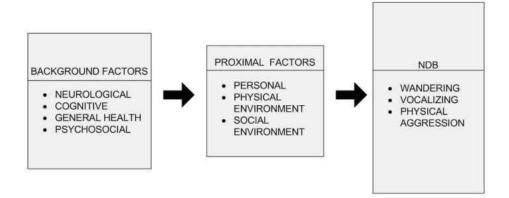


Figure 1.1. Reprinted with Permission, Algase et.al.²³ Factors Affecting NDB

The Consequences of Need-Driven, Dementia-Compromised Behavior (C-NDB) extend the original NDB adding secondary needs that arise from primary needs not being met.²⁴ The darkened circles of Figure 1.2 include Algase's model with the additional concepts added by the extension of C-NDB. Kovach expands the model to include outcomes or consequences of NDBs. The resident expressing the needs behaviors (i.e. primary NDB) after a period have additional needs stemming from the original needs not being met. The unmet needs affect resolution of the primary NDB through additional care, personal, and contextual factors. Care factors describe how the NDB influences the caregiver's ability to anticipate resident needs and can cause caregiver burnout. Personal factors describe resident characteristics like affect (facial expressions), and the physical and functional status of the individual. Contextual factors clarify how environmental stressors caused by unit disruptions might increase resident transfers to higher levels of care in order to restore calm to care units.

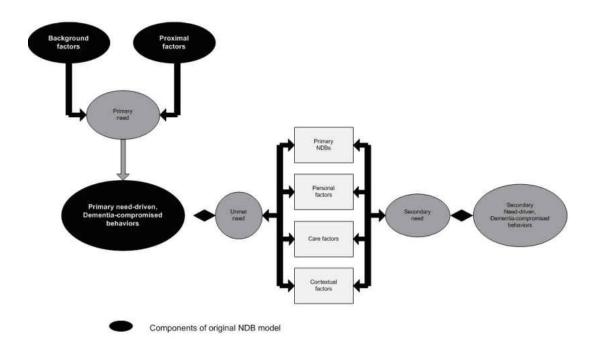


Figure 1.2. Reprinted with Permission, Kovach et. al.²⁴ Model of C-NDB

Of primary interest in the C-NDB model are cascading effects. Cascading effects are not shown in Kovach's model, but are an integral aspect of explaining the connection between proximal/background factors, primary needs, primary need-driven behaviors, outcomes of unmet needs, secondary needs, and the arising secondary need-driven behaviors. Cascading effects are a result of proceeding stages of unmet needs (Table 1.1).

 Table 1.1. Example of Cascading Effects

Proximal or background factors	Primary Need	Primary NDB	Outcomes of unmet needs	Secondary need	Secondary NDB
Pain	Analgesic	Yelling, stated pain, bracing affected area, hitting	 Fall with fractured hip Loss of mobility 	 Analgesic Increased need for assistance with ADLs Pressure ulcer 	 Loss of appetite, weight loss Irritability
Constipation	 Increased activity Fluids Laxative High fiber diet 	Agitation, wandering, restlessness	 Increased unit disruption Social isolation Abdominal bloating and discomfort 	 Increased socialization Medication for anxiety and bloating 	Increased wandering and aggression

The primary problem is the caregiver's inability to comprehend needs and the inability of the person to make his/her needs known (Figure 1.3). Need driven behaviors are distracters to the real problem of underlying pain. Because a standardized behavioral tool to assess pain does not exist, the uniformity of skill to detect pain is quite difficult for clinicians and ancillary support staff. The complexity of cascading behaviors, as an overlay of behavioral symptoms, is a difficult problem to solve. The observer who is able to understand resident behaviors as sign of needs that are not being met, could lessen interpreting these behaviors simply as an aggravating, disruptive resident.

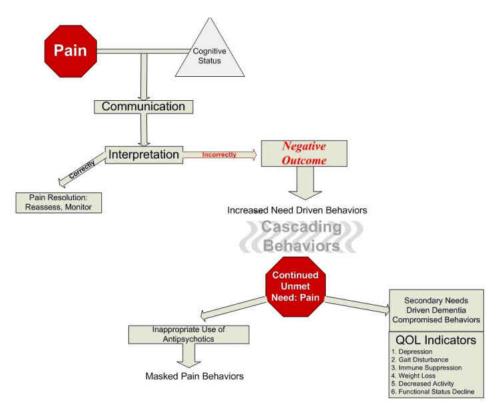


Figure 1.3. Theoretical Framework©, Allison Burfield

Residents labeled as difficult are often physically or chemically restrained to control unruly behaviors. The administration of antipsychotics or other psychotropic medications masks pain behaviors and further dulls the resident's ability to communicate their needs, which is potentially the last line of defense the resident could use to express pain. Treatment planning for residents requires multidisciplinary coordination and perseverance in finding underlying sources of discomfort.¹⁹ Long-term neglect of pain from unmet needs without treatment results in the resident progression to acute states of delirium, hallucinations, delusions, and further declines in cognitive state.

Concepts of the Framework

The theoretical framework for this study integrated the NDB model and the C-NDB. In the figure 1.3, pain is depicted as a proximal factor, and cognitive status describes the resident's background state. A combination of pain and the resident's cognitive state influence the

intensity and method of communication. The staff interprets these factors, resulting in either resolution of the resident's pain, or incorrect interpretation of the pain behaviors. Incorrect interpretation causes negative outcomes in the resident's care and increased need driven behaviors with a cascade of behaviors/effects. The resident's pain remains unresolved, but pain behaviors escalate. To manage the perceived difficult behaviors and unit disruptions, residents are given antipsychotic medications, which further mask pain behaviors. Secondary needs-driven dementia compromised behaviors (consequences) arise, because of the long-term effects of underlying unresolved discomfort, decreasing the resident's quality of life.

Pain

Starting at pain as the primary need in the proposed model (Figure 1.3), this symptom describes a state of physical suffering or discomfort. Pain is a subjective experience, and it is difficult for others to infer the qualities of pain that are felt by an individual. The treatment of pain usually depends on one's ability to express the magnitude of discomfort verbally and to receive some type of intervention.²⁵ Facial reactions to pain become increasingly important to interpret as self-reporting abilities diminish with cognitive decline.²⁶ Pain causes disruptive behavioral outbursts in the severely cognitively-impaired.²⁷ Residents who are more cognitively intact use a progressive level of verbal cues to express pain.²⁷ Evidence shows that as the resident's cognitive status declines, more physical behaviors start to occur to express pain. The caregiver must not simply treat behaviors as disruptions to daily routines, but a deeper issue of unmet needs.²⁸ A better understanding of pain behaviors could assist in changing health provider attitudes and responses from annoyance with "disruptive behaviors" to resident-focused, symptom resolution.²⁹

Traditional tools like self-reporting pain scales are not effective as the sole means to measure pain in individuals, who are unable to verbally communicate their pain, such as those with cognitive impairment. Tools that incorporate self-reporting, observational, psycho-affective, trace correlations to disturbances in activities of daily living, and are easy for the clinician to use, have the most pragmatic utility as a standardized tool.³⁰⁻³²

Cognition

Cognitive status is the condition of the resident's conscious intellectual activity like reasoning, remembering and thinking. The resident's cognitive status determines the ability and at what level the resident communicates with others. Cognitive decline often follows a close association with functional decline, so adding information about the role of long-term unmet needs can help clarify how proximal factors influence this relationship.³³ Appropriate interventions may result in the delay of functional disability and cognitive decline.³⁴ The antecedent and consequences in the triad of pain, cognitive status, and functional decline are difficult to determine. Pain as a precipitating factor along with the resident's cognitive status can help explain why the resident communicates in they manner he/she does, and why caregivers might infer these cues correctly or incorrectly.

Communication and Interpretation

Communication is a two-way process. The communicator sends information to the receiver, who interprets verbal and nonverbal cues. In the absence of explicit verbal directions, the individual uses body language and existing verbal sounds to infer meaning. The elderly with

impaired cognition use behaviors to communicate in the absence of the ability to verbally state their needs, because of a combination of impaired cognitive functioning and neurological damage from the progression of disease.^{35, 36}

Clinicians report difficulty in categorizing pain in cognitively-impaired residents.^{7, 20, 37-39} A recent state of the science report on pain management suggests that an increased awareness of what pain is, would facilitate and improve the assessment and management of pain for this population.⁴⁰ Knowledge of pain behaviors enables the clinician to be able to more accurately assess and interpret symptoms and intervene in the pain cycle.

Need-Driven Behaviors

Need-driven behaviors occur, because primary needs are not being met. Unresolved pain, when not intervened, turns into a negative consequence by incorrectly interpreting behavioral signals. Disruptive behaviors common in residents with dementia, lead to negative consequences, like continued pain or the use of physical or chemical restraints.⁴¹ Ideally, identification of primary need driven behaviors would result in immediate action-resolution and a decrease in dysfunctional behaviors. Personal factors may compound need driven behaviors such as limitations in mobility, depressed mood, or declines in functional state. Additional care factors may exacerbate ignored need driven behaviors like staffing levels, staff burnout, or other unit disturbances. Caregiver burnout and an inability to provide anticipatory care occur on high stress units.³⁶ Contextual factors of the environment, like unit and caregiver stress, also influence care given to other residents and may lead to a quicker transition of disruptive residents to higher levels of care.

Cascading Behaviors (Consequence)

Continued unmet needs result in secondary needs occurring. Cascading behaviors (effects) happen when the resident's individual needs have not been met, resulting in new needs and behavioral symptoms.²⁴ Kolanowski and Litaker ¹⁷ have posited that treatments tailored to meet individual needs can improve behavioral symptoms. This theory also explains why certain factors produce behavioral symptoms and specific treatments resolve behavioral sources, not just the symptoms.

Inappropriate Medication Use

Current black box warnings administered from the Food and Drug Administration (FDA)⁴² caution the use of antipsychotics in the elderly. The wide-spread administration of antipsychotics in nursing homes can be an indicator of inadequate staffing and can trigger quality of care concerns for facility-staff case mix.⁴³ Antipsychotics mask pain behaviors and also cause other co-morbid complications such as hospital admission or death.^{18, 34, 44-46} Evidence is lacking to support the use of antipsychotics to manage behavioral symptoms in the elderly.⁴⁶ In addition, the resident should also be monitored for polypharmacy to reduce medication side effects. The focus becomes treating the real underlying problem and not perpetuating drug-related problems (DRP) like polypharmacy from treating medication side effects, or continuing incorrect medications.⁴⁷

The elderly residing in skilled care are vulnerable, because of their reliance on the facilities to be able to deliver and anticipate their care needs. Serial trial interventions targeting the use of accurate interventions resolve resident pain and pain behaviors in late stage dementia.⁴⁸ Public policy should sustain an ongoing evaluation of interventions targeted at behavioral treatments. The use of the C-NDB model shows how behaviors are mediated through

appropriate interventions, or exacerbated by inappropriately treating and interpreting symptoms.²⁴

Quality of Life Indicators

As the resident's cognition declines, the incidence of secondary unmet needs is postulated to increase from the inability of the resident to communicate needs. Primary and secondary unmet needs decrease the resident's quality of life, and cause disruptive behaviors resulting in staff burnout and a toxic unit environment, affecting other residents. An innovative aspect of this study is the investigation of associations between pain and quality of life measures, validating a temporal sequence of events to improve the understanding of related, moderating, and intervening variables.³⁶ Indicators of poor outcomes for quality of life measures are depression, gait disturbance, immune suppression, weight loss, decreased activity, and functional decline.

Overview

This dissertation followed the University of Central Florida's nontraditional format developing three separate manuscripts focusing on a state of the science of pain management in the elderly, a pilot of the pain measurement model, and a longitudinal study of the concomitance of pain and cognition. The state of the science entitled, *How Do We Ensure Pain is Properly Assessed and Treated in the Elderly? A State of the Science Review*, examined and synthesized the literature for pain concepts, clinical practice guidelines, and the state of the science in the assessment and management of pain in the elderly residing in LTC. The second manuscript, *A Pilot Study of Pain Measurement Models Using the MDS-RAI 2.0*, evaluated the relationship between hypothesized pain behaviors and a measurement model proposed for pain, derived from

the Minimum Data Set-Resident Assessment Instrument (MDS-RAI) 2.0. The third manuscript entitled, *A Study of Longitudinal Data Examining Concomitance of Pain and Cognition in an Elderly Long-Term Care Population*, examined if a concomitant relationship exists between cognition and pain in an elderly population residing in long-term care.

CHAPTER 2: HOW DO WE ENSURE PAIN IS PROPERLY ASSESSED AND TREATED IN THE ELDERLY? A STATE OF THE SCIENCE REVIEW

Introduction

In 2006, a coalition of long-term care providers, caregivers, quality and medical improvement experts, government agency representatives, and consumers launched a proposal to promote Quality First, a Nursing Home Quality Initiative (NHQI).⁴⁹ Five of the eight NHQI recommendations focus on pain management. The remaining items are a result of poorly managed pain, or pain behaviors. A state of the science review examining pain in the elderly, those most vulnerable, can clarify what science has achieved in building our knowledge of pain management for the elderly and opportunities to advance care.

Background

Pain management is a common health concern across all ages. Of approximately 1.8 million residents living in skilled nursing care facilities, an estimated 49-83% experience chronic pain.^{2, 4, 50} Despite decades of research on pain management in nursing homes, research findings consistently indicate pain is poorly assessed and managed in long-term care, especially for those with impaired cognition.

Pain negatively affects the individual's ability to function, live independently and enjoy an overall quality of life.⁵¹ Pain is linked to depression, decreased socialization, an inability to sleep, weight loss, gait disturbances, immune suppression, and increased rates of morbidity.^{22, 52} Pain treatment in long-term care facilities is complex, because residents have varying degrees of cognitive function. It is essential to implement correct interventions to manage pain. However, healthcare providers must possess the knowledge of how to assess pain across a spectrum of

residents with varying levels of cognitive competency. This review examines and synthesizes the literature of pain concepts, clinical practice guidelines, and current assessment and management strategies of the elderly residing in long-term care.

Significance to Clinical Practice

Considerable anecdotal evidence exists on pain in the older adult, but relatively few studies focus on cognitively-impaired (CI) residents. Ethical and moral considerations should be given to treating pain in those unable to communicate. Legal consequences are significant when pain is not adequately assessed and treated.⁵³⁻⁵⁶ The Joint Commission (TJC) requires the close monitoring of pain management and evaluates institutions on the appropriateness of the interventions taken. ^{57, 58} The American Health Quality Association (AHQA) regularly publishes plans for improving pain management developed by exemplary healthcare organizations. The Centers for Medicare and Medicaid Services (CMS) collect data on all residents in Medicare facilities, which has significant potential to monitor how pain is being assessed and managed.⁵⁹

Performing a thorough assessment of pain in cognitively-impaired residents with behavioral changes cannot be underestimated.⁶⁰ Cognitively-impaired residents may struggle with communicating their needs. The use of verbal reports as the sole means of detecting pain, can significantly lessen a clinician's ability to accurately detect it.^{6, 61-66} The severely cognitively-impaired are at the highest risk for untreated pain, because of an inability to give responses to direct inquiries of their comfort. Even for those who are able to report pain, analgesic interventions are still not consistently given, even with direct reports of pain.⁶⁷

Clinicians can determine the best guidelines for practice by identifying aspects of pain assessment and treatment that exemplify quality patient outcomes.⁶¹ This requires a synthesis of

the most current information on successful methods to assess and manage pain to measure the effectiveness of interventions taken.

Method

This review summarizes the assessment, treatment and management of pain in residents living in long-term care, and addresses the factors contributing to the under-assessment and under-treatment of pain, and behaviors linked with unresolved pain. Peer-reviewed journal articles were found using database searches in Academic Search Premier, Blackwell Synergy, CINAHL, MEDLINE with CSA, OVID, and PsychInfo. Additionally, online sources, review articles and expert panel discussions were selected. The reference lists of the articles were also used to identify additional sources. Search parameters were limited from January 1990 to current journal articles. Setting search parameters for 1990 and onward gave a broad overview of how pain research has evolved. Studies were included if pain management in a skilled nursing setting was discussed. The articles chosen were evaluated for quality to be included in the literature review. The articles must have met the following criteria:

- A clearly stated purpose and objective
- Pertinent and comprehensive sources cited in literature reviews
- A clear description of theoretical frameworks and/or a provision of background information
- Clearly defined and identifiable variables
- Research designs that allowed a research question to be answered or a hypothesis tested
- Methods was clearly stated and appropriate to the type of study conducted
- Research design and methods described
- Evidence supported with appropriate statistical analysis or qualitative methods

• Findings evaluated for reliability and validity issues

Search Terms and Definitions

Terms used to conduct the literature review were *pain, assessment, dementia* and *cognitive impairment.* "Pain" is the state of physical suffering or discomfort. The terms "discomfort" or "physical suffering" are used interchangeably throughout the literature review to describe pain. "Assessment" is the use of a systematic method to evaluate and monitor pain. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV)^{68(p133)} defines "dementia" as "characterized by the development of multiple cognitive deficits (including memory impairment) that are due to the direct physiological effects of a general medical condition, to the persisting effects of a substance, or to multiple etiologies…". "Cognitive impairment" is an indication of a change in cognitive function caused by disease or trauma—damaging the thought process, ability to learn and remember, react to emotions, and/or capacity to verbalize in later stages of the disease process. Cognitive impairment defines related difficulties in how individuals distinguish, encode, store, retrieve and use information.⁶⁹ Certain medical conditions increase the probability of experiencing or having a progressive onset of cognitive decline. Most research studies examining cognitive decline center on dementia and Alzheimer's disease.

<u>Results</u>

The articles were categorized into pain traits/behaviors, assessment strategies, the efficacy of current pain tools, challenges and barriers to pain assessment, and evidence-based care guidelines. The search query yielded over 800 relevant abstracts. One-hundred and seven articles were kept for scientific relevancy to pain issues in the elderly residing in long-term care.

A total of 35 instruments (Table 2.1) with uni-dimensional and multidimensional domains are included in the review.

Table 2.1. Pain Tools Used to Assess Pain in the Elderly

Name of tool	Description	Self-reporting or observational tool?	Cited as effective tool to assess pain in severely CI?
Abbey Pain Scale ⁵	Six item scale: Vocalization, facial expression, change in body language, behavior change, physiological change, and physical changes	Observational	Yes
Assessment of Discomfort in Dementia (ADD) ^{37, 70, 71}	Does not measure pain, but establishes a protocol to reduce the under- detection/under-treatment of pain. Combines assessment and intervention strategies. Not tested on the experimental level. Protocol is structured in five steps that include a physical assessment, review of history, categorizing painful conditions, affective assessment and implementation of non-pharmacological measures ³⁷	Combination methods and protocol	Yes
Checklist of Nonverbal Pain Indicators (CNPI) ^{7, 70, 72, 73}	Identifies a pattern of behavior that reflects physical, emotional, psychosocial, intellectual, cultural or spiritual distress. Can be used to monitor the effectiveness of interventions. Six Pain Behavior categories: Revised from the Alabama Pain Behavior Scale. Includes five nonverbal behavioral indicators: nonverbal vocalizations (moans, groans, grunts, and cries), grimacing, bracing, restlessness, rubbing the affected area.	Observational	Yes
Color Pain Analogue Scale (CS) ⁷⁴	Horizontal scale. Colored bar, the darker the pain the more intense the color.	Self-reporting	No
Colored Analogue Scale (CAS) or Colored Visual Analogue Scale (CVAS): Assessment of Pain Intensity or Pain Affect ^{40, 75-78}	Non-verbal scale that the patient points to pain level on vertical pain scale. Original CAS was modified and used to assess the intensity of suffering ⁷⁶ . Degrees of pain coded by color. Vertical scale with severest pain on top. No pain is listed at the bottom and maximum pain is at the top.	Self-reporting	No
Comfort Checklist ^{70, 79}	Five domains of assessment: vocalization, motor signs, behavioral indicators, facial expressions, and misc. symptoms	Observational	Yes
Discomfort Scale for Dementia of the Alzheimer's Type (DS-DAT) ^{6,} ^{70, 80, 81}	Nine behavioral indicators of pain. Observational score of 0-3. Pain behaviors are noisy breathing, negative vocalizations, content facial expression, sad facial expression, frightened facial expression, relaxed body language, tense body language and fidgeting. Based on the frequency and intensity of the behavioral symptoms. Rater waits 15 minutes, repositions patient and re-assesses. Time consuming. DS-DAT requires extensive training, and experience of others too time intensive to be used in clinical settings, making DS-DAT too complicated and difficult for routine use.	Observational	Yes
Doloplus-2 ^{67, 82-84}	Pain assessment in the cognitively-impaired (CI) and rates somatic, psychomotor and psychosocial behaviors as indicators of pain. Five somatic items (somatic complaints, protective body posture adopted at rest, protection of sore areas, facial expression and gaze, and sleep pattern), two psychomotor	Observational	Yes

Name of tool	Description	Self-reporting or observational tool?	Cited as effective tool to assess pain in severely CI?
	items (based on observation of washing and/or dressing and mobility), and three psychosocial items (communication, social interaction, and behavior).		
Faces Pain Scale (Wong-Baker) ^{61,} 67, 75, 76, 78, 85-87	Self-reporting Tool: Line drawings of faces. One neutral face and 6 faces that represent increasing degrees of pain. Consists of a line drawing of seven faces which express increasing pain (no pain = 0, maximum pain = 6). Patient chooses face which best demonstrates the individual's degree of pain.	Self-reporting	No
Facial Affective Scale (FAS) ⁷⁵	Aimed at assessing the affective components of pain. Line drawings of nine faces, ranging in expression from very happy (no pain) to very painful (most severe pain). The original faces were 2 cm high, so they were enlarged up to 4 cm to aid in the visualization of each face. On the back of the faces, numerical values are printed and rage from 0.04 (very happy: no pain) to 0.97 (very painful: most severe pain).	Self-reporting	No
Facial Grimace Scale ⁷	Caregiver chooses face that represents patient's pain stated from six faces.	Observational	Yes
Horizontal Visual Analogue (HVAS) ⁶⁷	Uni-dimensional, self-assessment pain scale, consists of a 10-cm line anchored by two extremes of pain: no pain and extreme pain. Patients use a vertical sliding marker.	Self- reporting	No
Long Term Care Pain Assessment Tool: Verbal Description ^{88,89} (Janssen Pharmaceutical and Research Foundation, 2000)	Rates pain on 1-7 scale, 1=not at all and 7=most severe	Observational	Yes
McGill Pain Questionnaire (MPQ) 87, 90	Used to determine pain severity. Only two parts used for Scherder's ⁹⁰ study, the Pain Intensity Visual Analogue Scale 1 and Pain Affect.	Self-reporting	No
Mobilization-Observation- Behavior-Intensity-Dementia Pain Scale (MOBID) ⁹¹	Developed for use in severe cognitive impairment this tool evaluates pain behaviors during standardized active guided movements to infer pain intensity.	Observational	Yes
Multi-dimensional Pain Inventory, Dutch Language Version ⁹⁰	7-point rating scale of affective distress.	Self-reporting	No
Non-Communicative Patient's Pain Assessment Instrument (NOPPAIN) ^{30, 92}	Six pain related behaviors are graphically depicted (pain words, pain noises, pain faces, rubbing, bracing and restlessness. Two dimensions of pain evaluated—presence of pain and pain intensity.	Both	Yes
Nottingham Health Profile ⁹⁰	2-point scale meant to measure quality of life. Includes 8 pain questions used to measure aspects of whether the patient experiences pain while ambulating.	Both	For moderately impaired
Number of Words Chosen- Affective (NWC-A) of the McGill Pain Questionnaire ⁷⁶	Affective pain scale consisting of five items, each of which contains three affective adjectives. Items are arranged increasing intensity, which allows participants to indicate the nature of the pain (worry, depression).	Observational	No
Numerical Rating Scale (NRS) ^{39,}	Self-assessment rating pain a scale of 0-10. One of the most difficult tools to	Self-reporting	No

Name of tool	Description	Self-reporting or observational tool?	Cited as effective tool to assess pain in severely CI?
^{61, 74, 85} *Note also referred to as the Verbal Rating Scale (VRS)	use due to the nuances of the degrees of pain. Pain scale of 0 to 10 rating; rated by Delphi study ⁶¹ as being one the best of three. Most commonly used pain scale by nurses. Question whether this rated by the Delphi panel as being best because it has it is accurate or has a long history of use.		
Observed Pain Behaviors Scale ^{6,} 70,72	Seven domains: verbal response, facial expression, body language, psychological change, behavioral change, feedback from others and conscious state.	Observational	Yes
Pain Assessment Checklist for Seniors With Limited Ability to Communicate (PACSLAC) ⁹³	Subscales of the PACSLAC (Social/Personality/Mood Indicators, Facial Expressions, Activity/Body Movement, and Physiological Indicators/Eating/Sleeping Changes/Vocal Behaviors). No published findings for testing with population.	Observational	Yes
Pain Assessment for the Dementing Elderly (PADE) ^{70, 94}	Contains 24 items and is divided into three domains. Part I, Physical (observable facial expression, breathing pattern, and posture), Part II, Global Assessment (allowing the care provider the chance to rate overall pain of the resident they are caring for), and Part III, Functional, activities of daily living (ADL's) such as dressing,	Observational	Yes
Pain Assessment in Advanced Dementia (PAINAD) ^{11, 70, 95, 96}	Takes elements from a 0-to-10 visual analogue scale; the Face, Legs, Activity, Cry, Consolability Scale; and the Discomfort Scale for Dementia of the Alzheimer type, and wording from literature describing and defining behaviors. Five items: breathing, negative vocalizations, facial expression, body language, and consolability. Each element of the scale is scored, and the possible total scores of 0 (no pain) to 10 (severe pain) are comparable to the traditional 0-to- 10 pain scale.	Observational	Yes
Pain Assessment in the Communicatively Impaired (PACI) ^{85,97}	Seven items: three measure specific facial movements or expressions, two measure body movement, and two measure sounds and words associated with pain.	Observational	Yes
Pain Assessment in Noncommunicative Elderly Persons (PAINE) ⁹⁸	Uses a comprehensive list of pain symptoms based on systematic questioning of direct caregivers. Validity suggests the tool could be useful in dementia patients.	Observational	Yes
Philadelphia Geriatric Center–Pain Intensity Scale (PGC– PIS) ³⁹	Self-Reporting Scale patient reports a range of pain (Range 1=no pain to 5= extreme pain).	Self-reporting	No
Pittsburgh Agitation Scale (PAS) ⁸⁸	Used to measure agitation, but there is a moderate correlation between agitated state and pain. PAS measure four distinct kinds of agitation: aberrant vocalizations, motor agitation, aggressiveness and resisting care	Observational	Yes
Present Pain Intensity Scale (PPI)-	Self-reported, 6-point, word-number scale used to measure pain intensity at the	Self-reporting	No

Name of tool	Description	Self-reporting or observational tool?	Cited as effective tool to assess pain in severely CI?
subscale of McGill ^{85,86}	moment and ranges from 0 (no pain) to 5 (excruciating pain).		
Proxy Pain Questionnaire (PPQ) ^{70,} 99	Relies on report of caregiver that knows the patient well to determine changes indicative of pain. Asks three questions about the presence (i.e., "Within the last week has the resident experienced pain?"), frequency (i.e., "How often does the resident experience pain?"), and intensity (i.e., "When this resident has pain, how would you describe the extent of the pain?"). The first item is answered with a yes or no, and the remaining items are rated on a 13-point horizontal Likert-type scale (Never, occasionally, moderately often, often, and always for frequency; mild, moderate, and severe for intensity).	Observational	Yes
Verbal Descriptor Scale ⁶¹	Patient is asked if they are experiencing mild, moderate or severe pain.	Self-reporting	No
Verbal Rating Scale (VRS) 74, 87	Rates pain from none, mild, moderate, to severe. Vertical picture with a continuum scale. None on the top and severe on the bottom. In Wynne, Ling and Remsburg ⁸⁷ report as 1-10 scale, where patient rates pain to a numerical value.	Self-reporting	No
Verbal Rating Scale (VRS), 6- Point ⁶⁷	Consists of a list of adjectives, which describe different levels of pain. Patients were asked to point to the adjective that best describes one's current pain.	Self-reporting	No
Vertical Visual Analogue Scale (VVAS) ⁶⁷	Similar to the HVAS scale but is presented vertically, and the line is replaced by a red triangle with its summit facing downward (no pain= 0) and its base at the top (maximum pain =10)	Self-reporting	No
Visual Analogue Scale (VAS) and Mechanical Visual Analogue Scale (MVAS) ^{74, 87, 90}	Operationally is a horizontal or vertical line, 100 mm in length with word descriptors at each end. The patient marks on a line the point that represents the level of pain that is being experienced. The VAS score is determined by measuring in millimeters from the left hand end of the line to the point that the patient marks. MVAS is a plastic version of the VAS with a slider pointer that moves to the correct level of pain ⁷⁴ .	Self-reporting	No

Pain Traits

Most causes of pain in the elderly are attributed to osteoarthritis, osteoporosis, peripheral neuropathies, recent fracture, or cancer.¹⁰⁰ Pain is a subjective experience, difficult for outside observers to measure. While the intensity of pain experienced from individual to individual is poorly understood ¹⁰¹, the mechanism of how pain is felt, is not. Pain is the communication of peripheral nociceptive fibers to the parietal somatosensory cortex for interpretation in a return circuit, causing a withdrawal reflex from the painful stimulus.⁵² Generally, residents who are cognitively intact retract from a painful stimulus and give a clear indication of pain with verbal statements. Initial research speculated that cognitively-impaired individuals felt pain to a lesser degree.¹⁰² The ability to feel pain does not alter with age or the progression of diseases or symptoms, like dementia; however, pain expectancy, perception and willingness to report it does vary.^{103, 104}

Altered pain sensory occurs in dementia; however, this does not mean a lack of pain sensory.^{30, 52, 76-78, 90, 101, 105} Research provides no suggestion that patients with dementia physiologically experience pain less than other geriatric patients. Conversely, this group of patients may fail to anticipate sensations as painful, have poor recall of pain, and are not be able to verbally communicate to caregivers.⁷³ While sensory-discriminative parts of pain are preserved even in advanced states of Alzheimer's disease, the cognitive and affective functions related to expectancy and autonomic activity are severely affected.¹⁰¹ Due to impaired memory, the severe CI individual has no recall to anticipate pain and thus does not have an increased reaction or anticipatory withdrawal to avoid a painful stimulus.

Many behaviors are manifested when a resident experiences pain. Particular verbal, facial and behavioral actions are thought to indicate an individual is experiencing pain.^{106, 107}

Actions like rigidity, guarding, bracing, stopping, rubbing, shifting, grimacing, sighing/nonverbal vocalizations, and verbal complaint are typical behavioral cues.¹⁰⁸ Additional behaviors like rapid blinking, facial expressions, physical aggressiveness, agitation, crying, moaning, becoming withdrawn/quiet, guarding, noisy breathing, negative vocalizations and fidgeting are also identified in the research.^{80, 109} Unfortunately, one set of signs or behaviors do not strongly indicate pain in all residents. Noting deviations from "normal" behaviors for residents can be key to initially detecting an underlying problem.¹¹⁰

Pain assessment

Great variability exists in reported pain from nursing home to nursing home.⁵⁰ Residents in rural, for-profit and low occupancy facilities have less documented pain. It is not known if pain is better managed in these types of facilities, or if it is simply underreported.

A lack of knowledge about pain assessment and management contributes to poor assessment and treatment.^{7, 70, 111} Clinicians report difficulty distinguishing between behaviors of pain, anxiety, and agitation.^{110, 112-114} Solely using self-report of pain is difficult, because of the fluctuating changes in mental status.⁶⁹ Pain assessment depends mainly on one's capability to express the magnitude of pain to request some type of intervention.²⁵ Misreading symptoms may cause caregivers to assume a resident has a behavioral "problem," or is agitated and belligerent. The result of misreading behaviors leads to the incorrect prescribing of medications, increased agitation and disorientation, or the risk for delirium.⁶⁹ Residents may be unknowingly allowed to suffer if alternative methods of pain assessment are not used beyond self-reports.^{2, 6, 22, 107, 112, 115}

A multidisciplinary and multimodal approach is necessary to make effective assessments and manage pain.¹¹⁶ It is recommended that pain assessment for CI adults use a combination of physiological and behavioral cues.^{109, 117} First identifying potentially painful chronic conditions

and other sources of pain could lessen missing behaviors of pain, instead of attributing escalating behaviors to another cause.¹⁰⁶ Assessments should be completed after non-pharmacologic and pharmacologic comfort measures are taken and then documented. Being aware of pain behaviors during assessments and reassessments while weighing the effectiveness of interventions is important to gauge the benefit of actions taken.¹⁰⁸

Effectiveness of Pain Instruments

A pain tool does not exist to quantify and differentiate pain behaviors from mental health problems. Research has been conducted on pain behaviors in cognitively-impaired individuals^{17, 27, 62, 91, 118, 119}, but the need exists to develop a standardized behavioral tool to measure pain in this population. A comparison of organizational protocols against leading pain tools emphasizes the opportunity to develop pain tools that integrate a multidimensional assessment (Table 2.2). While recommendations from the American Geriatric Society (AGS) and the American Society for Pain Management Nursing (ASPMN) incorporate, observational, self-reported and other gold standard measures, knowledge about pain behaviors would be advanced by using multivariate statistical methods (e.g., structural equation modeling) and larger samples to increase the power and generalizability of the study findings.

Table 2.2. Recommended Standards for Pain Instrument Dimensions to Consider for Use with Cognitively-impaired Residents

	Observational Tool	Self- Report	Verbal Behavioral Cues	Physical Behavioral Cues	Facial Behavioral Cues	Psycho- affective	Ease of Use, requirements of specialized training considered	Mobility as Precipitating Event or Noted Decline in Mobility Globally
American Geriatrics Society Panel on Persistent Pain in Older Adults ^{120, 121}								
American Society for Pain Management Nursing (ASPMN) ¹²²								
MDS-RAI Impaired Cognitions Pain Tool (Pilot Tool)								
Pain Scale (PS), MDS- RAI 2.0 derived ¹²³								
Mobilization- Observation-Behavior- Intensity-Dementia Pain Scale (MOBID)* ⁹¹								
Non-Communicative Patient's Pain Assessment Instrument (NOPPAIN) ^{30, 92}								
Assessment of Discomfort in Dementia (ADD)** ^{37, 71}								

Grayed areas are the recommended parameters. *Limited use for those residents bed-bound

**Protocol includes an intervention

Instruments (Tables 2.1 and 2.2) to assess pain ideally should include body language, facial expressions, changes in behaviors, physical states or physiology, ability to console (i.e., behavior persistence), the occurrence of negative vocalizations, and labored breathing as signals for pain.¹²⁴ A successful standardized tool must be valid, reliable, brief and manageable for use in the nursing home setting.¹²⁵ Tsai and Chang¹²⁶ recommend using multiple forms of assessing pain (reported and observational) to provide a timely intervention and treatment. When using an observational pain tool, knowing the resident's baseline behaviors is vital to assessing behavioral changes.⁶¹ Current studies recommend that clinicians use a standardized tool; however a gold standard does not exist to assess pain in those unable to communicate.^{92, 127} (See Table 2.2 for list of available pain tools) General problems with existing instruments to assess pain include the following:¹²⁷

- Pain is a subjective experience; how can pain be accurately measured, when the occurrence of pain is an individual event and expression?
- The variability in pain signals makes it difficult to establish uniform measures.
- Because a gold standard to assess pain does not exist for residents unable to communicate, it is difficult to establish the validity of measures to detect pain in this population.
- Inappropriate medication use may mask pain behaviors, or behaviors may be mislabeled as pain cues, when in fact are related to medication side effects.
- It is difficult to discern pain behaviors from other sources of distress.
- Studies of pain tools often lack the sample size and replication of findings for generalizability across care settings.

Key concepts for using pain assessment tools are to ensure that the tool is understandable for the resident and the healthcare provider. For the resident, the use of pictures, text size, matching the tool with the resident's cognitive level, and considering the resident's ability to communicate verbally are helpful in choosing a pain tool.

Proper education for clinicians regarding pain tools can include video training to increase understanding of how to use the tool, and the importance of giving healthcare providers the time to assess and document findings appropriately.⁶⁴ When using self-report tools, it is also important for the assessor to allow the resident adequate time to answer and complete the exercises. For residents that can not verbalize pain, observational tools should be used.²⁵ Facial expressions are a valid measure for demented and healthy residents, and can serve as an alternate tool to measure pain.^{26, 128} Research on Facial Action Coding System (FACS) of facial expressions has emerged as an important instrument, regardless of the level of cognitive impairment. The primary goal is the discovery of barriers and the facilitation of measures to recognize pain more accurately.

Challenges and Barriers to Pain Management

In the literature, five categories of barriers exist hindering the effective management and treatment of pain— resident characteristics, cultural influences, inability to understand/interpret pain behaviors, lack of clinician training, and misconceptions of analgesic use. Residents may present a barrier through their inability to report pain from impaired cognition, hearing, or sight; a lack of dexterity; reluctance to complain; uncertainties about treatment; reluctance to bother staff; and/or the nurse's personality.^{74, 129} Barriers influencing the experience and report of pain are cognitive status, mood state, perception of control, expectations, and social and cultural conditioning.¹³⁰ A lack of education exists about the cultural aspects of pain presentation—

cultural factors like race, religion, educational background, sex or socio-economic status.⁶²

Responses to pain are influenced by environmental or socio-cultural factors and may be more pronounced in cognitively intact residents.⁶² A significant limitation to optimal pain control measures is often related to family or prescriber resistance to follow treatment recommendations.¹³¹ Health care provider bias and cultural beliefs are barriers to the recognition and management of pain.¹¹⁷ Differences in language may cause an inability to understand resident needs and contribute to under-reporting of pain assessment, or cause difficulty using rating scales.⁶¹

There is a lack of communication among professionals, especially in care planning—all healthcare professionals must be involved in treatment. Limited contact with physicians or the nurse practitioner causes less interventions for chronic pain to be made.¹ Nursing home employees often have a lack of knowledge into several aspects of pain care for the elderly, even though they report satisfaction with the way pain is assessed and treated.¹³² Education and inservices presenting formalized procedures for assessing and treating pain greatly improve outcomes in the nursing home setting.¹³³ Educational level influences beliefs and knowledge about pain. Having advanced education and training helps clinicians to dissuade myths about appropriate pain control and what symptoms to look for to identify it. An increased awareness of what pain is may facilitate and improve the assessment and management of pain in residents.^{40,} ¹³² The clinician is better prepared to assess a myriad of symptoms with an increased knowledge of pain and how interventions affect resident quality of life.

Symptoms of pain, like agitation, may be incorrectly treated with anti-psychotic medications instead of analgesics.^{19, 134-137} Achieving sufficient pain management is problematic due to the risk of side effects, medication interactions, co-morbid diseases, and prescriber issues,

such as reluctance to prescribe opioids and inadequate training into analgesic management.^{104, 138} Barriers to analgesic treatment are failure to assess or report pain, fear of drug addiction, concern about risks of falling (opioid), fear of gastro-intestinal concerns (i.e., with non-steroidal antiinflammatory drugs [NSAIDs]), and failure to use appropriate pharmacologic and nonpharmacologic interventions.^{9, 10, 61, 64, 65, 104} Communication with family members including medication information can help in correcting misunderstandings about analgesics and rationales for pain treatment.

Best Practices for Pain Management

The American Geriatrics Society and American Society for Pain Management Nursing (ASPMN) do not endorse specific tools for assessment of pain in the cognitively-impaired patient.^{121, 122, 139} An expert based consensus statement makes the following recommendations for assessing pain older adults:¹⁴⁰ 1) physical exam 2) medication history review 3) assessment of pain using self-reports 4) specialized tools for patients with dementia 5) functional status assessment 6) emotional assessment and 7) focused documentation describing nociceptive and neuropathic pain (i.e., location, onset, duration, previous effective interventions, and etiology if possible).

Documentation should include a risk analysis for NSAID use, and show measures to prevent constipation (i.e., hydration, ambulation, and diet) in patients using opioids. Pain should be treated prophylactically (especially in residents with documented history of chronic diseases like osteoarthritis, osteoporosis, cancer, or history of fractures), and finally there should be a reassessment of pain control measures. As needed acetaminophen, if used regularly for two weeks, should become a regularly scheduled medication.

Participants following a pain protocol may reach a state of pain management and relief.¹³¹ The American Geriatrics Society ¹²⁰ suggest the following quality indicators:

1) Screen for persistent pain with qualitative and quantitative assessments, especially in the cognitively-impaired with a standardized pain scale, behavioral assessment or proxy report.

2) At a minimum, screen annually for pain.

3) Pain screening should occur at the same time as cancer care visits.

4) Treat severe pain expediently—severe pain scores of 5 or greater on a 1-10 scale, or similar observational measures signify a need to adjust pain treatments to improve pain control.

5) New complaints of moderate to severe pain should be recorded in the medical record with an intervention and follow-up assessment of pain within 4 hours.

6) Educate new residents who have persistent pain, and document within 6 months of resident education to re-review the information given into the causes of symptoms and how to use medications or therapies.

7) Take steps to prevent constipation with opioid use (e.g., stool softener/laxative, increased fiber, documentation of potential constipation and decisions about interventions).

8) Reassess pain control with opioids for efficacy and side effects within 1 month.

Recommendations

A multidisciplinary and multimodal assessment approach is necessary to make effective assessments and to manage pain.¹¹⁷ Cognitively-impaired individuals should receive holistic assessments based on their abilities and background to make decisions about care needs.¹³³

Appropriate pain management is achieved through an individualized care plan that is ongoing, well documented and accurately detects pain.¹¹ A comprehensive assessment should include identification of relevant underlying conditions influencing pain, the perception of pain and management.¹⁴⁰ A quality indicator for assessing pain are screens for chronic pain with new residents visits and at regularly scheduled intervals.^{140, 141} Assessments should be judiciously documented with an extensive history and physical. Behavioral observations should occur as one part of a comprehensive exam.¹⁰⁹ Pharmacologic and non-pharmacologic interventions can reduce behavioral symptoms, and both could be attempted to relieve discomfort.¹³⁵ Pain-control strategies beyond medication are supportive verbal communication, music therapy, therapeutic massage, soothing/supportive touch, cold or heat therapy, and physical exercise or movement.^{71, 142} Of note, residents spent more time engaged in social activities when they received acetaminophen as opposed to a placebo.¹⁴³ Social engagement is an essential aspect of a healthy mental status and should be a part of every resident's care planning, despite cognitive limitations.¹³³

Relevance to Clinical Practice and Further Research

Examining pain assessment and treatment plays a vital role in understanding the intricacy of pain in the cognitively-impaired.² In an environment where nurses are at a shortage and skill in caring for the elderly is often lacking, taking the time to understand pain in this population is difficult. Further research of pain behaviors could enable affirmation of current knowledge, and provide insight into resource allocation for training and setting pain protocols as a top health priority. The Minimum Data Set-Resident Assessment Instrument (MDS-RAI) is a potential source to evaluate ongoing pain control initiatives and serve as a method to grade facility performance.

From this information, clinicians can initiate evidence-based protocols, synthesize underinvestigated aspects of pain highlighting care delivery systems that are successful or fail in recommended guidelines.⁶¹ Systematic methods of pain assessment are vital to establish best care practices.¹⁴⁴ Using the MDS-RAI as a tool, this resident survey can be used as a cost- and time-effective way to study residents at the unit and aggregate level, because the resident survey is federally mandated, familiar, and readily used across nursing home settings. The development of a MDS-RAI originated tool could be a serve as a valid measure of pain for residents that are cognitively-impaired.

Evidence is lacking to show a link between pain and specific behaviors exclusive to pain.¹²⁷ Further research is needed to define behaviors distinguishing between pain, fear, anger, embarrassment or mental disorders ¹⁴⁵ to reduce polypharmacy, or misuse of antipsychotics. Additional research of clinical sites using these tools could also integrate clinician perspectives of ease of use, and time to administer the assessment.

Conclusion

Chronic pain is prevalent in long-term care. Pain in cognitively-impaired residents is under-assessed and under-treated. Severely cognitively-impaired residents are at the high risk for inaccurate pain assessment, unnecessary treatment with psychotropics, and not receiving analgesic intervention. Failing to intervene can significantly affect the resident's quality of life.^{95, 146} Resources must be allocated to educate healthcare providers and support staff, about issues of resident care, appropriate means to assess, monitor and manage pain for this population, and the consequences of failing to ensure pain management.

A significant gap in the research exists in defining the links between pain tools and behaviors, accuracy of pain detection, decisions into healthcare provider's choice of pain tool,

and the allocation of resources needed to appropriately assess and document findings. Specific care factors causing inadequate pain treatment should be more thoroughly examined to develop resident-centered care solutions. Despite a large number of tools to assess pain, a standardized behavioral tool does not exist for broad use.¹⁴⁷ Efforts should be made to develop a behavioral tool with universal application across cognitive levels. A need exists for reflective discussions with health professionals, describing how to perform systematic assessments of verbal and non-verbal expressions of pain.¹²⁹ Finding solutions to inadequate care requires an evaluation of existing protocols for case-mix and resident acuity, root causes of insufficient care, and alternative forms of long-term housing, like the Green House® projects designed to provide more homelike care, as an alternative to current institutional, long-term care settings.¹⁴⁸

CHAPTER 3: A PILOT STUDY OF PAIN MEASUREMENT MODELS USING THE MDS-RAI 2.0

Introduction

Pain affects from 49 to 83% of 1.8 million residents living in long-term care facilities.^{2-4, 50} The outcome of pain and long-term suffering influences psychological, physiological and social aspects of an individual's life. Chronic pain is associated with anxiety and depressive symptoms¹⁴⁹ and can have a serious adverse affect on quality of life, resulting in an inability to sleep, clinical depression, weight loss, disturbances in gait, immune suppression, decreased socialization, and increased morbidity. It also contributes to burgeoning healthcare costs.^{22, 52, 149}

Behavioral and psychosocial factors play an important role in understanding the experience, continuation and exacerbation of pain.¹⁵⁰ Individuals display many different behavioral cues making it difficult for the clinician to comprehend the patient's needs. Specific verbal, behavioral and facial expressions are documented in the research as being representative of manifestations of pain.^{106, 107}

Pain is an individual, subjective experience. The complexity of assessing and determining patient pain increases with cognitive decline. Cognitive decline progressively hampers the individual's ability to anticipate and verbalize pain, but pain is still felt.¹⁰¹ Decades of research indicate pain is poorly assessed and managed in long-term care, especially for those with moderate to severe cognitive impairment.^{6-9, 12, 14}

Looking at underlying common characteristics of pain could clarify our understanding of how to measure and identify pain more accurately. Basing detection of pain only on self-reports

from the resident, fails to take into account other indicators that an individual could be expressing for pain.

Research to date lacks a large-scale analysis of pain in long-term care that evaluates a multi-dimensional construct of pain. The aims of this pilot study are to:

1) Determine the magnitude of the relationship between pain behaviors and a hypothesized measurement model.

2) Compare theoretical models to existing pain scales.

3) Examine the construct validity of a pain measurement model.

Research Question: Can a theoretically derived model of pain aid in detecting pain across all cognitive levels?

Multiple smaller scale studies have evaluated specific pain tools, recommending additional research using larger samples to increase the generalizability across long-term care settings and to include a more comprehensive analysis of residents most at risk, the severely cognitively-impaired.^{48, 92, 98, 151, 152} Data from existing nationwide assessment instruments, like the Minimum Data Set (MDS), are an excellent source for evaluating resident pain and other quality initiatives.¹⁵³ The goal of evaluating the dimensions and theoretical constructs of pain is to clarify the validity of measures and the reliability of existing quality indicators from the MDS to be able to accurately detect pain across all cognitive levels.

Significance

Nursing homes are under great scrutiny for adherence to regulations, quality improvement actions and public reporting. Stakeholders and researchers have raised concerns about the accuracy, usefulness, and timeliness of reports to describe care in skilled nursing settings.^{154, 155} The Joint Commission (TJC) calls for the close monitoring of pain management

in healthcare settings and evaluates the appropriateness of interventions.^{57, 58} The American Health Quality Association (AHQA) reports on healthcare entities that strive to improve pain management through quality initiatives, and the Centers for Medicare and Medicaid Services (CMS) encourage ongoing quality improvement (QI) in skilled care settings through resident assessment surveys.⁵⁹ Multiple entities are working towards improving care for the elderly, but large-scale research is needed to better understand pain behaviors and ensure pain treatment is effective and ongoing in this population.

Pain has a significant impact on quality of life and resident outcomes. Higher levels of comorbidities are reported with severe pain, along with increased depressive symptoms, reduced activity and significant physical effect.¹⁵⁶ Chronic pain is attributed to diseases like osteoarthritis, cancer, facture, and neuropathies—arthritis being the most common.¹⁴⁹

The study of pain, especially among those residents that are noncommunicative, could significantly improve quality of life and the quality of care in nursing homes.¹⁵⁷ Residents with advanced cognitive decline are at the highest risk for under-treatment because of an inability to self-report and verbalize pain. Incorrectly assessing pain leads to a higher incidence of inappropriate medication use, medication side effects and residents remaining in discomfort. These outcomes fail to correctly apportion healthcare resources, provide optimal treatment, or resolve the target issue of pain. Using evaluation tools to include a broader context of resident symptoms might help recognize patterns and methods to improve care.

Evaluating aggregate resident care in points in time can highlight successes or failures, and identify opportunities to improve treatments and outcomes. The integration and mechanisms of information technology (IT)/information systems (IS) are helpful tools to combine healthcare delivery networks to improve resident outcomes. Analysis of data sets can reveal statistical

relationships between symptoms, diagnoses, treatments and outcomes.¹⁵⁸ Using existing data lessens difficulties in recruiting and retaining those with increasing inability to assent or comprehend informed consent, offering important insights into resident care.

Background

Chronic pain in the elderly is most often felt in the feet, legs, back and major joints.^{149, 159} Other types of pain, like headache or visceral aches are less reported in the elderly. It is estimated at least 1 in 4 older individuals suffers with chronic musculoskeletal pain.¹⁴⁹ Pain is an expression of underlying body damage, or peripheral nociceptive stimulation.^{160, 161}

Pain is often communicated via behaviors.^{160, 162} Cohen-Mansfield and Creedon ¹⁵⁷ define pain behaviors as "observable nonverbal behaviors" to indicate pain to others. Broader definitions include all forms of behaviors displayed by an individual thought to reflect the existence of nociception, including facial expressions, speech, posturing, patterns of medication use, seeking healthcare intervention, or changes in socialization.¹⁶¹ Current studies suggest four clusters of pain behaviors—altered ambulation (gait) or posture, negative affect, facial/audible expressions, and avoidance of activities.¹⁶³ A research study of nurses' perceptions of pain found that key behavioral indicators of pain were changes in behaviors, repetitive movements, repetitive vocalizations, and physical symptoms.¹⁵⁷ Patients with severe dementia do not experience less pain intensity, less painful sites, or have a lower incidence of pain causing diseases, but pain often goes un-assessed and untreated in this population.¹⁵¹

The responsiveness of caregivers to intervene is a primary quality of care concern, especially for those institutionalized who rely upon others to interpret and meet their individual needs. Difficult to an understanding of pain, is how to differentiate between pain behaviors and the expected behaviors from a progression of a disease, such as memory impairment or the

inability to communicate needs. Unique domains are used to explain concepts of pain, to broaden how pain is recognized, especially in the cognitively-impaired resident.

Cognition

Cognition describes how individuals differentiate, encode, store, retrieve and use information.⁶⁹ The resident's ability to reason, remember and think describes cognitive status. Cognitive status influences a patient's ability and how he/she communicates with others. A distinction in increasing cognitive decline is how behaviors are communicated. In dementia, wandering may involve an interruption in the individual's ability to follow sequential mental tasks to reach a destination or goal.²³ The cognitively-impaired resident has increased difficulty to stay on task and remain attentive to reach the goal. Cognitive impairment in conjunction with pain is a significant factor in explaining why certain verbal or nonverbal behaviors occur, and how the clinician could incorrectly interpret cues. Residents with severe cognitive impairment, as with dementia, are at a high risk to suffer from pain, because of an inability to verbally report it.¹⁵¹

Affect

Affect and cognition are thought to be inextricably intertwined; however some see emotion completely independent of cognition.¹⁶⁴ Beyond culture-bound affectations, the elderly resident with severe cognitive impairment might have a flattened affect, or have limited verbal capacity with an increased moodiness and crying. Affective domains include emotions and feelings. In evaluating resident mood, depression may present as having generalized aches and pains without a source of injury or disease, while chronic untreated pain may cause depression.¹⁶⁵ This makes discernment of pain especially difficult with residents with

depression. Across cultures, the existence of multiple pain conditions is associated with anxiety and mood disorders.¹⁶⁶ Patient mood is an important concept of the pain construct in modeling whether depressed mood is an indicator of pain, or a consequence of long-term untreated pain. Turk, Wack, and Kerns' ¹⁶³ seminal work demonstrated dimensions of pain behaviors including a negative affect and facial expressions of distress consistent with a pain behavior construct. Multiple studies have found significant associations between pain and grimacing.^{167, 168} Research into Facial Action Coding Systems (FACS) has been used to confirm the existence of pain in different levels of cognitive impairment.^{26, 167} Findings indicate facial expressions to noxious stimulation is significantly increased in patients with dementia in comparison to cognitively intact patients.¹²⁸ Research of facial expressions indicates basic primordial expressions occur across cultures, gender and age along with learned "socially acceptable" emotions and expressions of mood. If the patient reverts to lower cognitive functioning making facial expressions instinctive and not a culturally bound expected reaction, universal expressions of pain could exist. Considering a severe decline in cognition, this might explain facial grimacing as a universal expression of pain.

Behavioral

A significant determinant of pain behaviors is the severity of pain.¹⁶⁹ Behaviors like verbal complaints/negative vocalizations, sighing, moaning, agitation, crying, grimacing, rapid blinking, shifting/fidgeting, rubbing, resistance, bracing, guarding and rigidity are common indicators of pain from the literature.^{80, 108, 138} Aggressive behaviors in cognitively-impaired residents are also indicated as a sign of pain.¹⁷⁰ Behavioral science indicates pain behaviors are subject to the same changes and influences to alter actions, as other types of behaviors.¹⁶⁵ Much of the research into pain describes learned behaviors and operant conditioning, as a factor for

continued behaviors of pain.^{150, 161} This assumption might hold true for cognitively intact residents, but is inadequate in explaining repetitive behaviors in the cognitively-impaired resident—if pain needs are not being met, what would be the drive for continuing the behavior?

Behaviors that are not followed by positive consequences but have neutral or adverse responses should diminish and end unwanted behaviors, thus describing the process of operant conditioning. The behavior should be deterred if these actions are not eliciting the desired response. Alternative behaviors would be attempted. The mechanism of operant conditioning does not explain repetitive behaviors—why pain behaviors would not be eliminated if pain needs were being ignored. This behavioral perspective makes it difficult to attribute behaviors to progression of a disease and those of pain. Essential, in an understanding of pain in the elderly, is not the isolation of certain affective characteristics, but those variables that correlate to actual behaviors, i.e., what is the outcome (consequence) of the behaviors?

Disruptive behaviors common in dementia may lead to negative consequences like continued untreated pain and the use of physical or chemical restraints to control the behavior.⁴¹ Because one set of signs or behaviors do not uniformly detect pain at all cognitive levels, examining the association of behaviors by cognitive groups would be valuable in advancing research in this field. Turk, Wack and Kerns¹⁶³ characterize common problems in attempting to accurately assess pain behaviors as:

1) Insufficient attention to the attributes of the construct

2) Precision and consistency in the characteristics of the methods of assessment (Are the measures comprehensive and reliable?)

Inferred Pain

Pain can be inferred from existing diseases (i.e., osteoarthritis, osteoporosis, neuropathies, cancer) that are known to cause pain, and existing pain sites. Having multiple sites of pain cause more severe and disabling effects than having a single-site of pain.¹⁷¹ Pain assessment tools most commonly ask residents to rate pain and/or report the frequency and intensity. This aspect of pain assessment is essential, because even residents with cognitive impairment should be engaged with eye contact and inquiries into their level of comfort and not discounted as a reliable source.^{172, 173} Additionally for cognitively-impaired residents, direct observation of behaviors is the strongest evidence for ensuring pain is appropriately assessed and intervened upon.⁸⁴ Inferred pain can be another valuable clue to examine and better capture pain. When clinicians use reported pain as the only assessment tool, as a one-dimensional measure, assessments often fall short of accurately detecting pain.

Nationally Required Nursing Home Quality Initiative

The Minimum Data Set- Resident Assessment Instrument 2.0 (MDS-RAI) comes from the Nursing Home Quality Initiative (NHQI) and provides information about quality of care in nursing homes to consumers.¹⁷⁴ An assessment must be completed on all Medicare residents within 7 days of admission to the nursing facility. Current quality measures do not establish guidelines or standards of care, but serve as a valid and reliable means to evaluate key quality measures. Requirements for the completion of certain sections (i.e., Section U, Medications) vary by state, but key items are included uniformly as quality indicators. Pain¹⁷⁵ is included as a quality measure, but not a Resident Assessment Protocol (RAP) triggering condition for care planning. Health policy considerations are a vital component to weigh the viability of specific

quality indicator assessment tools, like the MDS 2.0 and upcoming 3.0 versions, for the provision of quality care to the elderly residing in long-term care.¹⁵⁴

Theoretical Framework

The theoretical foundation for this research incorporates the concept of need-driven behaviors and consequences of need-driven, dementia-compromised behaviors (C-NDB) to frame a person-centered approach to care.^{23, 24, 35, 41, 176, 177} (see Table 3.1 for definitions) Needdriven, dementia compromised behaviors (NDB) are actions displayed to communicate an underlying need.²³ Optimally, the immediate identification of primary need driven behaviors would result in an action and resolution to decrease disruptive behaviors. Need-driven behaviors produce behavioral symptoms and explain how certain interventions could mitigate disruptive behaviors.¹⁷

The concept of dementia-compromised behaviors aids in explaining why continued behaviors are not lessened through the mechanisms of operant conditioning. Pain is one aspect of the framework. The framework is helpful in identifying the primary problem (pain) and developing antecedent and resulting consequences of unmet needs. The initial portion of the theoretical framework is used in this pilot study to identify pain. The remaining structure of the framework is integral to evaluate other aspects of the model like cognitive status, and outcomes of untreated pain like depression, social isolation, comorbidities, effective/non-effective interventions, and the cost-effectiveness of actions taken.²⁸

The construct of pain is thought to be multidimensional.^{162, 163} How NDBs are expressed, is specific to the individual and dependent upon proximal and background factors. Proximal factors are defined as "current situational issues or events" ^{36(p135)}; they varying greatly and are dependent upon personal and environmental cues like staffing level, or pain with movement.

Background factors involve cognitive, psychosocial, neurological, and general health causes.

These factors tend to be more constant. Need-driven behaviors aid in explaining why individuals display certain behaviors, especially those with cognitive impairment from dementia.²³ Need-driven behaviors provide a foundational framework for this pilot study to draw theoretical links between unique indicators obtained from the research, a state of the science, and clinical practice.

Term	Definition
Need-driven behaviors	Expressions of unmet needs or goals.
Need-driven dementia compromised behaviors (NDB)	The most meaningful response a dementia-compromised person can give with the limitations of the disease process; disruptive behaviors
	could be the only and base mechanisms of communication; reflect
	the interaction of background and proximal factors.
Consequences of Need-Driven	Explains the consequences of behavioral symptoms of individuals
Dementia-Compromised Behavior (C-	with dementia; needs are expressed behaviorally and unmet needs
NDB)	influences additional behavioral cues.
Antecedent	A preceding cause.
Consequence	Events/actions that results from inaction of the need or failing to
	respond appropriately to the primary need.
Proximal factor	More changing aspect of a person's physical status or social/physical environment. Proximal factors are more likely to precipitate NDBs; i.e. emotions, light level, noise, staff stability.
Background factor	Neurological, cognitive, general health or psychosocial factors that
	produce NDBs; i.e. regional brain involvement, memory/language
	skills, functional ability, affective state, behavioral response to
	stress.
Primary need	Immediate need.
Secondary need	Needs that may arise from primary needs not being met.

Methods

Design and Sample

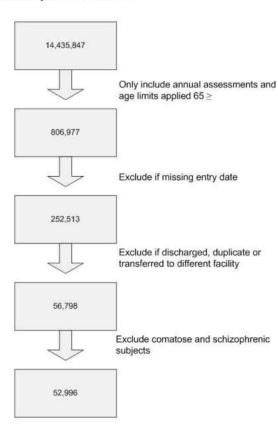
A cohort study was conducted in a secondary analysis of data from the Minimum Data

Set-Resident Assessment Instrument (MDS-RAI). A cross-sectional analysis was used to

determine pain prevalence. The first-year records of a longitudinal data collection were used for

the pilot study. A combined 14,435,847 subject observations was reduced to 806,977 (Figure

3.1) by using annual assessments and applying inclusion criteria of an age limit of 65 and older. Unconfirmed entry dates into the system were also excluded resulting in 252,513 subjects. Residents discharged, duplications and transfers occurring over a three-year span were dropped reducing the total to 56,798. Individuals coded as being comatose were excluded, because the behavioral sections of B through F in the MDS are omitted per instrument instructions. The behavioral indicators evaluated in this research are contained in this section. Schizophrenic residents were excluded to gain a starting point of cognitive levels, reducing the probability of fluctuating mental states due to psychosis. Data cleaning rules yield a final sample of 52,996 residents to evaluate trends in pain behaviors and associations between cognitive, affective, behavioral, and inferred pain dimensions.



Total Subject Assessments

Figure 3.1. Sample Method

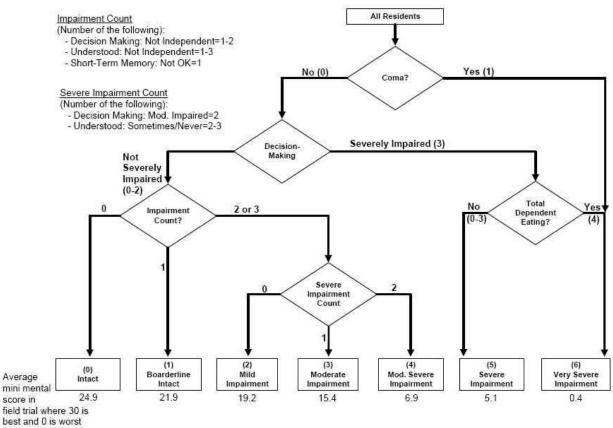
Instruments

The MDS is the most commonly used resident assessment document in nursing home facilities. The MDS is not a comprehensive assessment, but a preliminary screening tool to help identify potential problems, strengths and preferences for care. The MDS is a core set of items, definitions, and response categories composed of two parts: the Minimum Data Set (MDS) and the Resident Assessment Protocols (RAPs). The Resident Assessment Protocols provide a section of the MDS-RAI providing problem-oriented frameworks for additional assessment.¹⁷⁸ Key items that are problem-specific trigger assessment needs for specific conditions. The RAP items provide a critical link to care planning. The MDS-RAI 2.0 version has 18 RAPs covering the majority of areas addressed by a typical skilled nursing care facility in the care planning process. The RAPs help staff to look for causal or confounding factors that may be reversible. Goals are set to improve deficits where possible, or maintain and prevent avoidable decline.

The MDS has demonstrated good reliability and validity.¹⁷⁹⁻¹⁸¹ MDS items have excellent interrater and test-retest reliability in key areas of cognition and activities of daily living (ADL) with an average weighted kappa of 0.80. MDS-RAI items met a standard for superb reliability (i.e., intra-class correlation of 0.7 or higher) in key categories of functional status, such as cognition, activities of daily living (ADLs), continence, and diagnoses.¹⁸²

The Cognitive Performance Scale (CPS)^{183, 184} (Figure 3.2) was used to assess resident cognitive status. The CPS instrument is a MDS-RAI item scale derived from sections B, C and G of the resident assessment form. Seven levels of cognitive functioning can be determined ranging from a score of zero (intact) to six (severely cognitively-impaired). The scores are obtained from five MDS items: one communication item (ability to make self-understood), three cognitive items (short-term memory, if comatose, and decision-making), and one ADL item

(eating). The CPS measure correlates highly ($r \ge 0.70$) with the frequently used Folstein Mini-Mental Status Examination (MMSE)¹⁸⁵, a tool frequently used to systematically assess mental status.¹⁸⁶ Validation testing of the CPS scoring against the MMSE shows a sensitivity of 0.94, and a specificity of 0.94. MMSE scores range from 0 to 30. A score of 0 to 9 indicates severe impairment, 10-18 is moderate, 19-24 is mild, and scores greater than 24 indicate the individual's cognitive status is intact. The MMSE scores are converted CPS scores. A CPS score of 5 or 6 correlates with severe impairment, 3 to 4 for moderate impairment, 2 for mild impairment, and 0 to 1 as borderline intact to intact. The CPS scores are converted into average MMSE values, i.e., 3 is a mean MMSE of 15.4 (moderate impairment) and a CPS score of 4 or 5 is a mean MMSE of 5-6 (severe cognitive impairment).¹⁸⁷



CPS SCORING RULES

Figure 3.2. Cognitive Performance Scale ¹⁸³

The Pain Scale (PS) originating from Fries and colleagues uses two items from the MDS instrument: Item J2a for pain frequency and item J2b, pain intensity. If pain frequency is marked as no pain, subsequent pain intensity and pain sites are not scored. This Pain Scale ¹²³ was validated against a standardized pain instrument, the Visual Analogue Scale (VAS) and has shown validity in detecting pain in intact to moderately cognitively-impaired residents. The PS was not performed with a validation sample for severely cognitively-impaired residents, because residents were unable to perform the VAS. The limitation of using this tool in the significantly cognitively-impaired was also indicated in Fries instrument validation study, indicating the percentage of residents reporting no pain increased with increasing cognitive impairment.¹²³ The potential to use the PS in addition to other indicators was the impetus for testing a theoretical construct to improve pain detection in those with severe cognitive impairment, because pain frequency and intensity alone might not fully capture the pain spectrum in those with limited capacity to verbalize pain.

Data Collection

Data from 2001, 2002 and 2003 were collected from the annual assessment of deidentified residents residing in Medicare-certified nursing homes from across the United States (http://www.resdac.umn.edu/MDS/data_available.asp). A proposed panel model was evaluated for model fit through a series of steps using MDS-RAI data. The goal was to identify the dimensions (indicators) of the measurement instrument, clarify the order of the measurement levels, and examine the integrity of the measurement instruments. The pilot study was conducted to compare statistical models of pain, while grouping residents by cognitive status. The pilot model contains affective, behavioral and inferred pain traits grouped by cognitive status (See Figure 3.3). The model was compared to Fries existing pain instrument for utility. The Pain Scale (PS) is widely used as a secondarily derived tool using MDS data.

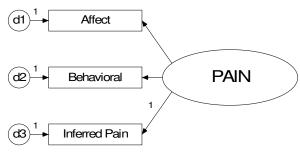


Figure 3.3. Latent Construct Pain

Statistical Analysis

Descriptive statistics and factor analyses were run with SPSS 14.0. Advanced multivariate techniques were used to build a measurement model and test the model fit with structural equation modeling. A measurement model of pain was hypothesized based on current research and literature of the domains and dimensions of pain in the elderly. Ordinal level correlations were run with Spearman's rho. A latent model of pain was built with AMOS 6.0 to determine how well 12 indicators from the MDS-RAI represent the latent construct of pain. Equality constraints were applied to compare four cognitive levels—intact, mild, moderate, and severely cognitively-impaired residents. Construct validity was evaluated by the extent to which the measurement of pain accurately represents the construct and assumes theoretical basis.

A critical step in building the model was hypothesizing associations based on conceptual relationships, not simply on the data available. Content validity or logical validity was evaluated in the model to determine if indicators represent all dimensions of the construct of pain. Fries ¹²³ Pain Scale (PS) contains only two indicators—pain frequency (J2a) and pain intensity (J2b) in an ordinal scale. These two indicators yield an under-identified model and cannot run as a stand-alone model in AMOS. These items were highly correlated (r=.977, p=0.01, one-tailed);

indicating one of these items could be dropped, because they closely measure the same aspect of the inferred pain dimension. These core indicators of pain are included in the hypothesized model for testing to define the dimension of inferred pain.

Confirmatory analysis was conducted to review factor loadings. Confirmatory factor analysis (CFA) was used to reduce the factors and confirm factor groupings—inferred pain, affect and behaviors. The measurement model was evaluated for validity and goodness of fit statistics to improve the model to ensure the final prototype is parsimonious. Indicators with a probability of 0.01 were included, non-significant items were not included in the model. The specification of free and fixed elements represents the initial hypothesis that presumes indirect or direct effects among latent variables.¹⁸⁸ The assessment of power in structural equation modeling is complex, because there are substantially more parameters beyond a straight forward procedure like the t-test or ANOVA, containing only a few parameters.¹⁸⁸ The sample size was considerable (n=52,996), so power analysis was not critical to determining appropriate sample size prior to the study to ensure statistical significance of the findings.

Results

Selected MDS items were collected on 52,996 residents. Overall, 80% of the sample was women and the average age was 84±8.1 years (see Table 3.2). Of the medical conditions selected, arthritis was the most prevalent (34.2%) with diabetes effecting around 20.9% (see Table 3.3). The most common pain site was the joints (14.9%).

(n=52,996)		Mean ±S.D.	Range
		<u>N (percent)</u>	
Age		83.7 ±8.1	65-112
Gender	Male	10,798 (20.4%)	
	Female	42,198 (79.6%)	
Cognitive Status	Mean CPS Score	2.9±1.9	0-6
	Mean MMSE	14.4±8.0	0.4-24.5
	Intact	7,428 (14.0%)	
	Mild	13,928 (26.3%)	
	Moderate	15,216 (28.7%)	
	Severe	16,424 (31.0%)	
Marital Status	Never married	12.7%	
	Married	15.5%	
	Widowed	62.3%	
	Separated	2.2%	
	Divorced	7.3%	
Ethnicity	American	0.3%	
	Indian/Alaskan Native		
	Asian/Pacific Islander	1.2%	
	Black, not of Hispanic		
	origin		
	Hispanic	11.4%	
	White, not of Hispanic	2 00/	
	origin	2.9%	
-		84.2%	
Language	English	94.6%	
	Spanish	2.4%	
	French	0.2%	
	Other	2.8%	
Education Level	No Schooling	3.0%	
	8 th grade/less	30.8%	
	9-11 grade	14.2%	
	High school	33.2%	
	Technical or trade	4.2%	
	school	7.00/	
	Some college	7.2%	
	Bachelor's degree	4.2%	
	Graduate degree	1.8%	
	Not coded/missing	1.5%	

Table 3.4 contains an index of behaviors, which with additional models could clarify antecedents and consequences of pain. The PS items (see Table 3.5) indicated 68.8% of residents reported no pain, while only 12.8% experienced pain daily. Pain frequency and intensity declined as the residents' cognitive status declined, indicating only 18.2% of severely

impaired were experiencing pain, while 47.7% of the intact group experienced pain less than

daily or daily.

 Table 3.3. Diseases/Events with Potential Pain Symptoms

Disease	Number from Total (n=52, 996)	Percent of Total
Diabetes	11,063	20.9%
Peripheral Vascular Disease	6,128	11.6%
*Arthritis	18,110	34.2%
Complaint of Joint Pain	7,703	14.5%
*Hip Fracture	2,113	4%
Multiple Sclerosis	440	.8%
Emphysema/COPD	6,423	12.1%
*Cancer	2,844	5.4%
Renal Failure	1,327	2.5%
*Pneumonia	472	.9%
Respiratory Infection	1,213	2.3%
Septicemia	28	.1%
TB	19	.0004%
*Urinary Tract Infection (UTI)	2,737	5.2%
Wound Infection	285	.5%

*Key Diagnoses Used for Pain Diagnosis Scoring

Table 3.4. Behavioral Index

COGNITIVE STATUS		Intact (n=7,428)	Mild (n=13,928)	Moderate (n= 15,216)	Severe (n=16,424)
CHANGE IN	Improved	101 (1.4%)	348 (2.5%)	645 (4.2%)	821 (5%)
BEHAVIORAL SYMPTOMS	Deteriorated	110 (1.5%)	357 (2.6%)	792 (5.2%)	792 (4.8%)
	PAIN BEHAVIOR				
Affect/		751 (10.1%)	1,840 (13.2%)	2,839 (18.6%)	2,033 (12.4%)
Nonverbal Cues	(E1D) Persistent Anger				
	(E1K) Insomnia	197 (2.6%)	378 (2.7%)	595 (3.9%)	560 (3.4%)
	(E1L) Sad Facial Expressions	173 (10.0%)	2,197 (15.8%)	3,558 (23.4%)	3,647 (22.2%)
	(E1M) Crying	245 (3.3%)	715 (5.2%)	1,158 (7.6%)	1,452 (8.9%)
	(E1O) Withdrawal	107 (1.4%)	394 (2.8%)	574 (3.8%)	659 (4.1%)
	(E1P) Reduced Social Interaction	196 (2.6%)	546 (3.9%)	744 (4.9%)	813 (4.9%)
	(E2) Persistence	1,742 (23.4%)	4,514 (32.4%)	6,895 (45.3%)	6,726 (40.9%)
Verbal Cues	(E1A) Negative Statements	181 (2.4%)	489 (3.6%)	711 (4.6%)	307 (1.9%)
	(E1B) Repetitive Questions	34 (0.4%)	426 (3.1%)	1,949 (12.8%)	1,085 (6.6%)
	(E1C) Repetitive Verbalizations	68 (0.9%)	355 (2.5%)	1,306 (8.6%)	1,631 (9.9%)
	(E1E) Self Deprecation	79 (1.1%)	277 (2.0%)	312 (2.1%)	115 (0.7%)
	(E1H) Health Complaints	776 (10.5%)	1,572 (11.3%)	1,386 (9.1%)	380 (2.3%)
	(E1I) Anxious Complaints	693 (9.3%)	1,853 (13.3%)	2,524 (16.6%)	960 (5.9%)
	(E4BA) Verbally Abusive Frequency	304 (4.1%)	943 (6.7%)	2,194 (14.4%)	1,915 (11.7%)
Physical Cues	(E4DA) Inappropriate Behavior Frequency; disruptive sounds, noisiness, screaming, self-abuse acts, sexual behavior or disrobing in public, smeared/threw feces, hoarding, rummaging through other's belongings	178 (2.5%)	857 (6.2%)	2,273 (14.9%)	3,344 (20.4%)
	(E4DB) Inappropriate Behavior Alterability	108 (1.5%)	505 (3.6%)	1,420 (9.3%)	2, 326 (14.2%)
	(B5D) Restlessness	65 (0.9%)	689 (4.9%)	3,023 (19.8%)	5,772 (35.1%)

COGNITIVE STATUS		Intact (n=7,428)	Mild (n=13,928)	Moderate (n= 15,216)	Severe (n=16,424)
	(E1N) Repetitive Physical Movements; pacing, hand wringing, restlessness, fidgeting, picking	100 (1.4%)	621 (4.4%)	2,158 (14.2%)	3.855 (23.5%)
	(E4AA) Wandering Frequency	5 (0.1%)	187 (1.4%)	1,874 (12.3%)	2,755 (16.8%)
	(E4AB) Wandering Alterability	2 (0.0%)	68 (0.5%)	900 (5.9%)	1,699 (10.3%)
	(E4CA) Physically Abusive Frequency	37 (0.5%)	223 (1.7%)	1,068 (7.1%)	2,094 (12.7%)
	(E4CB) Physically Abusive Alterability	23 (0.3%)	97 (0.7%)	617 (4.1%)	1,368 (8.3%)
	(E4EA) Resists Care Frequency	387 (5.1%)	1,417 (10.3%)	3,375 (22.2%)	4,934 (30.0%)
	(E4EB) Resists Care Alterability	287 (3.9%)	972 (7.0%)	2,244 (14.7%)	3,392 (20.7%)

		Total Population (n=52,996)	Intact (n=7,428)	Mild (n=13,928)	Moderate (n=15,216)	Severe (n=16,424)
Fries Pain Indicators						
Pain Frequency (J2a)	No pain	36,470 (68.8%)	3,887 (52.3%)	8,411 (60.4%)	10,737 (70.6%)	13,435 (81.8%)
	Pain less than daily	9,731 (18.4%)	1,869 (25.2%)	3,144 (22.6%)	2,796 (18.4%)	1,922 (11.7%)
	Pain daily	6,795 (12.8%)	1,672 (22.5%)	2,373 (17.0%)	1,683 (11.0%)	1,067 (6.5%)
	Pain totals	16,526 (31.2%)	3,541 (47.7%)	5,517 (39.6%)	4,479(29.4%)	2,989 (18.2%)
Pain Intensity (J2b)	Mild pain	8, 046 (15.2% of total ,or 49% within reported pain)	1,514 (20.4%/42.8%)	2,608 (18.7%/47.3%)	2,295 (15.1%/ 51.2%)	1,629 (9.9%/ 54.5%)
	Moderate pain	7,946 (15.0%/48%)	1,873 (25.2%/52.9%)	2,731 (19.6%/49.5%)	2,065 (13.6%/ 46.1%)	1,277 (7.8%/ 42.7%)
	Horrible/ Excruciat- ing	534 (1%/3%)	154 (2.1%/4.3%)	178(1.3%/3.2%)	119 (0.8%/ 2.7%)	83 (0.5%/2.8%)
	Total	16,526	3,541	5,517	4,479	2,989

Table 3.5. Fries Pain Scale (PS) ¹²³ Ratings

Initial and final models were built from the original pain model with the dimensions of affective, behavioral and inferred pain grouped by cognitive status. Careful consideration was given to what items to include in the initial model (see Figure 3.3 and Table 3.7, Definitions of Indicators) based on current empirical findings of reported pain symptoms and behaviors. All of the indicators in the measurement model were significant (p<.01) (see Table 3.8). Correlations are used to test for association not causality. The inferences made should have a logical connection to each other. It is important to examine both the degree of the relationship and the p-value. Researchers often disregard weak correlations, but a linear relationship may have meaning with current knowledge when examined in the context of other variables. The analysis assumes one-tailed direction, as pain increases, so do other behavioral symptoms of pain.

Cumulative scores of five potential pain-causing diseases (arthritis, hip fracture, cancer, pneumonia and urinary tract infection) were evaluated as an indicator for pain. While cumulative pain diagnoses were significant at the 0.01 level, the correlation was low, r=.182. In efforts to build a parsimonious model, the indicators of pain frequency, intensity and cumulative pain sites scores were kept and potential pain diagnoses scoring were not included in the preliminary model.

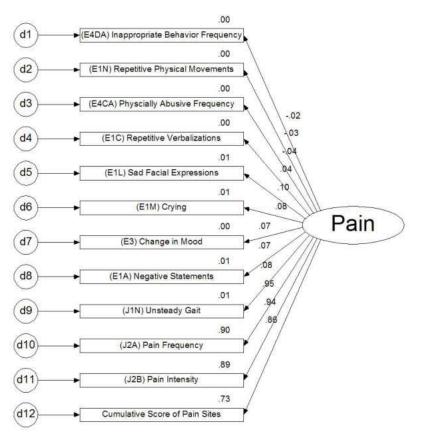


Figure 3.4. Preliminary Indicators in Model.

		Est.	S.E.	C.R.	Р	Label
Cum_Pain_Score_2001	< Pain	1.000				
J2B_PAIN_INTENSITY	< Pain	1.034	.003	311.057	***	k
J2A_PAIN_FREQUENCY	< Pain	.943	.003	313.011	***	j
J1N_UNSTEADY_GAIT	< Pain	.046	.003	15.931	***	i
E1A_NEG_STATE	< Pain	.019	.001	15.045	***	h
E3_MOOD_CHANGE	< Pain	.046	.003	16.511	***	g
E1M_CRYING	< Pain	.035	.002	21.770	***	f
E1L_WORRIED_FACE	< Pain	.085	.003	27.922	***	e
E1C_REPEAT_VERB	< Pain	.016	.001	11.887	***	d
E4CA_PHYS_ABUSIVE	< Pain	001	.001	-1.062	.288	с
E1N_REPEAT_MOVES	< Pain	.009	.002	5.090	***	b
E4DA_DIS_BEHAVIOR	< Pain	.008	.003	2.794	.005	а

 Table 3.6. Preliminary Model Factoring Loadings

***Significantly different from zero at the 0.001 level (two-tailed)

Table 3.7. Definitions of the Indicators

INDICATORS	
Variable	Description
Inferred/Reported Pain	
(J2A) Pain Frequency	Frequency resident complains or shows evidence of pain
(J2B) Pain Intensity	Intensity of pain described or displayed by the resident
Pain Sites Score	Cumulative pain site index, items J2a-J3j, K1c; higher
	scores indicates more pain sites
(J1N) Unsteady Gait	Problem present in last 7 days; Resident appears
	unbalanced, uncoordinated, jerking movements, careless
	movements, slow gait, shuffling steps or wide-based gait
	with halting steps.
Affect	
(E1L) Sad Facial Expressions	Sad, pained, worried facial expressions, i.e. furrowed
	brows
(E1M) Crying	Indicator of distress. Behavior is recorded by frequency in
	the last 30 days irrespective of the cause of the behavior
	(indicator)
(E3) Change in Mood	Refers to status of any symptoms described in section E
	(mood); snapshot of current observation period, not just a
	point in time.
(E1A) Negative Statements	Resident made negative statements, e.g. "Nothing matters,
	would rather be dead, what's the use, regrets having lived
	so long."
Behavioral	
(E1C) Repetitive Verbalizations	Calling out for help, repeated statements
(E4DA) Inappropriate Behavior	Disruptive sounds, noisiness, screaming, self-abuse acts,
Frequency	sexual behavior or disrobing in public, smeared/threw
	feces, hoarding, rummaging through other's belongings
(E1N) Repetitive Physical Movements	Pacing, hand wringing, restlessness, fidgeting, picking.
(E4CA) Physically Abusive Frequency	Others are hit, shoved, scratched, sexually abused
Cognition	
	Grouping variable of the comparative models; Cognitive
	performance algorithm scale
	0=intact
	1=mild
	2=moderate
	3=severe

Indicators	1	2	3	4	5	6	7	8	9	10	11	12
1. Sad Facial	1.0											
Expressions												
2. Crying	.339	1.0										
3. Change in	.167	.131	1.0									
Mood												
4. Negative	.199	.150	.115	1.0								
Statements												
5. Repetitive	.213	.154	.086	.153	1.0							
Verbalizations												
6.	.151	.114	.064	.086	.316	1.0						
Inappropriate												
Behavior												
7. Repetitive	.254	.145	.092	.059	.239	.292	1.0					
Physical												
Movements												
8. Physically	.109	.074	.045	.062	.124	.281	.188	1.0				
Abusive												
9. Unsteady	.054	.024	.036	.031	.014	.021	.057	.031	1.0			
gait												
10. Pain	.090	.073	.060	.067	.032	025	027	042	.075	1.0		
Frequency												
11. Pain	.095	.079	.063	.068	.035	026	026	042	.073	.977	1.0	
Intensity												
12. Cumulative	.095	.078	.061	.072	.035	024	025	042	.082	.965	.964	1.0
Pain Site Score												

Table 3.8. Correlation Matrix of the Indicators of Pain

Note: All correlation coefficients are significant at the .01 level (one-tailed)

Both models were recursive. The modification indices were examined for correlating measurement errors to reduce the chi-square and degrees of freedom in the original model from χ^2 =305889.3, df=249, p<.01; to χ^2 =4933.4, df=143, p<.01 in the corrected model (Figure 3.4).

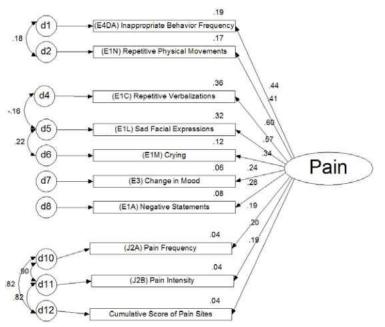


Figure 3.5. Final Model

Table 3.9. Final Model Factor Loadings

		Est.	S.E.	C.R.	Р	Label
Cum_Pain_Site_2001	< Pain	1.000				
J2B_PAIN_INTENSITY	< Pain	1.024	.030	34.198	***	i
J2A_PAIN_FREQUENCY	< Pain	.879	.026	33.856	***	h
E1A_NEG_STATE	< Pain	.373	.022	16.645	***	g
E3_MOOD_CHANGE	< Pain	.808	.051	15.860	***	f
E1M_CRYING	< Pain	.951	.056	17.117	***	e
E1L_WORRIED_FACE	< Pain	2.718	.152	17.913	***	d
E1C_REPEAT_VERB	< Pain	2.137	.117	18.289	***	с
E1N_REPEAT_MOVES	< Pain	2.216	.121	18.277	***	b
E4DA_DIS_BEHAVIOR	< Pain	2.961	.160	18.532	***	а

***Significantly different from zero at the 0.001 level (two-tailed)

The differences between the chi-square ($\Delta \chi^2$) and the degrees of freedom (df) of the two

models were compared to assess the model improvement from the initial model with twelve

indicators to the final model with ten indicators: $\Delta \chi^2 = \frac{\chi_0^2 - \chi_1^2}{df_0 - df_1}$

30589.3-4933.4/249-143= 25655.9/106=**242.04.** Comparing the original model to the final model shows a large gap and therefore increases the probability that the change model is improved. Behavioral item physically abusive (E4CA) was dropped due to weak correlations

and a non-significant factor loading (p=.288). Inferred pain component, unsteady gait (J1N), was also dropped due to weak correlations and to improve the model parsimony for the inferred dimension of pain. The final revised model allows measurement errors to be correlated with each other and better capture shared measurement errors of more correlated items. Chi-square values of the model were expected to be large, because of the sample size. Model fit statistics are found in Table 3.10 (See Table 3.11 for Definitions of Goodness of Fit Statistics).

Goodness of Fit	Stacked Original Model	Stacked Revised Model
Statistics	_	
χ^2	30589.3	4933.4
Degrees of freedom	249	143
(df)		
Р	.000	.000
Number of Free	63	77
parameters		
χ^2/df	122.849	34.45
RMR	.024	.011
GFI	.887	.981
TLI	.820	.965
AGFI	.859	.970
RMSEA	.048	.025
Hoelter (.05)	500	1850

Goodness of Fit Statistics	Terms and understanding statistical output
χ^2 (chi-square)	Best for models with sample sizes between 75-100; for n>100 chi-square is almost always significant since the magnitude is affected by the sample size; also affected by the size of correlations in the model, the larger the correlations the poorer the fit
Degrees of freedom (df)	The number of degrees of freedom and equals p-q (the # of sample moments subtract the # of parameters estimated)
Р	The probability is ideally non-significant; however, significant models can still yield valuable theoretical construct information
Number of Free parameters	Multiple times 5-10 to estimate required sample size for the study
χ^2/df	Use to compare models; this number should decrease from model to model; <5 is good, but must have p>.05; close to 1.0 means it is a correct model.
RMR	Root mean square residual is the square root of the average amount that the sample variances and covariances differ from their estimates, smaller values are better.
GFI (also GOF)	Slightly less than or equal (0-1) to 1 indicates a perfect fit; acceptable values are above 0.90; affected by sample size and can be large for poorly specified models.
TLI	The Tucker-Lewis coefficient should be between 0-1, values close to 1 indicate a very good fit.
AGFI (also AGOF)	Adjusted goodness of fit index, takes into account the df available for testing the model; AGFI is bound by 1, which indicates a perfect fit; however is not bound by 0.
RMSEA	Should be less than 0.05; score of less than 0.05 indicates a close fit of the model in relation to the df. Not definitive but the rule of thumb is a RMSEA of 0.01 is an exact fit, a score of 0.08 or less indicates a reasonable error of approximation. A model with an RMSEA of greater than 0.1 should not be used—indicates a poor fit.
Hoelter (.05)	The largest sample size for which one would accept the hypothesis that the model is correct; the index should only be calculated if the chi-square is statistically significant. How small one's sample size would have to be for chi-square to no longer be significant. Hoelter recommends values of at least 200, values ≤75 indicate a poor fit.

Table 3.11. Goodness of Fit Statistical Terms

The model fit was greatly improved from the initial to the final model. Reduced root mean square residuals (RMR) were achieved and the goodness of fit (GFI) further approached 1.0 with the adjustments made. The TLI values should be between zero and one—the adjusted model indicates a value of .965. Values close to 1.0 indicate a very good fit. Scores for RMSEA are ideally below 0.05 and the changes made reduced this value to 0.025.

In comparing, the model fit by cognitive status with a side-by-side comparison (Figure 3.4), notable variations in correlations occur within inferred pain domains, especially comparing intact/mild to moderate/severe cognitive states. The intact/mild groups and the moderate/severe groups show similar values for associations and correlated errors for inferred pain items (i.e., J2a

Pain Frequency, J2b Pain Intensity, and Cumulative Score of Pain Sites). This information is helpful in understanding the relationship of resident cognition and how additional dimensions (e.g., behavioral, affective and cognitive) add further detail to clarifying the pain construct. The overall model fit indicates utility across all cognitive levels. Pain scores could be converted to a standardized score, including all of the indicators to a converted t-score, the factorial scores could be retained using a weighted score, or pain indicators could simply be added for a cumulative score.

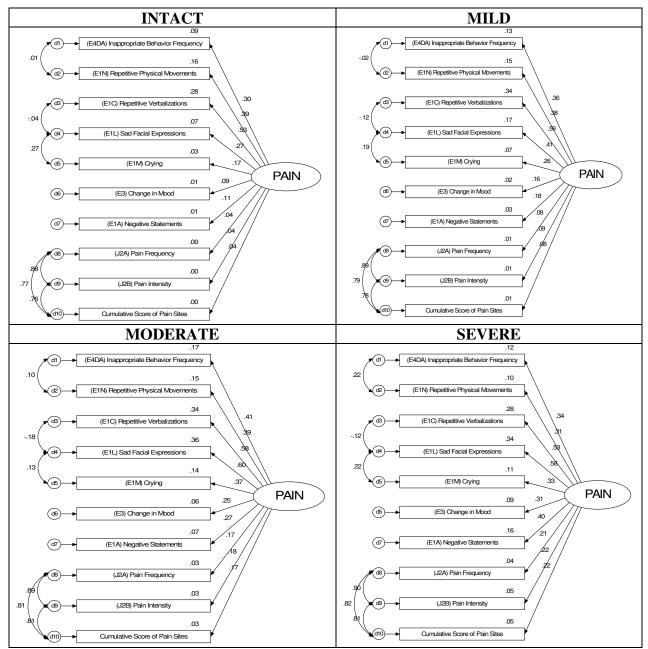


Figure 3.6. Measurement Models by Cognitive Status with Correlations and Shared Error.

Discussion

The findings from this pilot study support the pragmatic utility of additional measures to detect pain in the elderly, beyond self-reports of pain intensity and frequency. Research working towards further defining dimensions of pain in the elderly increases our ability to understand and

assess pain characteristics in this population. Findings of primary concern substantiate research to date ²⁷ on pain in those residents with severe cognitive impairment, along with the role behavioral indicators add to identify pain beyond self-report measures.

The PS items (Table 3.5) indicated the majority of the sample (68.8%) were not experiencing pain. When this total was broken down by cognitive status, as the cognitive state declined, pain frequency and intensity also declined. Forty-eight percent of the cognitively intact group was reported as experiencing pain, while only 18.2% of those with severe cognitive impairment were assessed as having pain. These findings support other research to date indicating pain is potentially under-reported in this population.^{27, 50, 151, 189-192}

Prior models of pain have included cognitive, affective and behavioral components.^{30, 92,} ^{149, 159, 193, 194} The latent construct of pain could include these three dimensions as a discrete measure in a model. Because this study was used as a stacked comparison, cognitive items were used as the grouping variable and not as a separate measure in the pain model. The goal was to gain an understanding of the overall all fit of the model by cognitive state. Future studies could examine this construct using cognition, affect and behavior as separate measures.

Self-reported measures of pain could be further validated with more assessments that are objective. From a theoretical perspective, the evaluation of the proposed models and indicators is not exhaustive of all the potential cues within the dimensions of cognition, affect, behavioral and inferred pain indicators that could explain the construct of pain. The research was limited to the available items from MDS. Important in the use of large data sets is having a clear clinical and evidentiary base to substantiate why certain indicators are used and not others.¹⁹⁵ Hypothesized indicators chosen from MDS were based on knowledge and research conducted to this point. Theoretical modeling can start a dialogue of other indicators useful and shown from

previous smaller-scale studies to indicate pain beyond self-reports from the resident.

Correlations between indicators can clarify the degree of association between the dimensions and unique relationships between behaviors. As our understanding of pain increases, clinicians are better equipped to measure quality initiatives in the assessment, treatment and prevention of pain.

Focusing interventions only on the severely cognitively-impaired, those at high-risk for untreated pain, fails to take in to account population-level factors, and would limit options to reduce the burden of chronic pain for all of those residing in long-term care.¹⁹⁶ A need exists for continued quality improvement and additional research to increase our understanding of pain behaviors and the effect of treatments on the elderly. The goal is improving pain control at all cognitive levels.¹⁵¹ Using existing data, we can target specific behaviors and evaluate outcomes to determine if uniformity of care is being applied across long-term care settings. In addition, when constructing federally required assessments, it is important to assess what standards are being applied in the use of key items as quality measures.

This pilot study adds insight into additional domains/dimensions that can be used to improve pain assessment, and re-evaluation efforts to detect pain and improve pain outcomes. Further evaluating concomitance between pain and cognitive status longitudinally would gain additional perspective of the long-term relationship between these two constructs. Future directions for research should include the persistence of behaviors. The MDS 2.0 contains alterability of selected behavioral items in section E4. Persistence of behaviors could indicate progression of the disease process, effectiveness of interventions to change behaviors, or an unknown factor in behavioral response to multiple stimuli.

Limitations of this study were the data distribution. The data were positively skewed. Normality and equal group distribution were not assumed. Mahanalobis distance was not used to eliminate outliers, because the majority (70%) of the population was initially reported as not experiencing pain and was not evenly distributed. Removing these cases would have removed a full spectrum of pain presentation of atypical symptoms of pain, the target of the study. Prior studies question the reliability of mood and behavioral sections from rater to rater when using MDS.^{182, 197} Additionally, the majority of residents needing skilled nursing care have some level of cognitive impairment, so intact groups were not proportionate to the mild, moderate and severe groups.

Conclusion

A comprehensive plan for pain management should evaluate staffing patterns, staff education, and examine differences in pain policies and procedures to ultimately use pain management as a primary quality indicator in long-term care settings.¹⁹⁸ Modeling theoretical constructs can serve as valuable tool to determine the fit between clinical knowledge, the healthcare context and individual needs. Additional research examining a covariance model of the relationship between pain and cognitive status over the long-term could reveal if concomitant relationships exist. Evaluating covariance models including antecedents and consequences of long-term suffering from unresolved pain would further support the significance of understanding indicators and accurately assessing, documenting and treating pain.

CHAPTER 4: A STUDY OF LONGITUDINAL DATA EXAMINING CONCOMITANCE OF PAIN AND COGNITION IN AN ELDERLY LONG-TERM CARE POPULATION

Introduction

Pain control is a primary concern across all care settings. Though a universal care concern, pain is frequently viewed in the elderly as a normal process of aging.¹⁹⁹ Estimates of 49 to 83% of 1.8 million residents in long-term care have acute or chronic pain, yet the recognition and treatment of pain still presents a challenge.^{2-4, 50, 200} Recognizing a spectrum of pain behaviors beyond traditional self-reports and increasing this knowledge with clinicians and support staff is a significant challenge in the provision of care to the elderly.

Predominantly, pain and cognitive decline often coexist in the elderly, with approximately 47% of residents in nursing homes having a diagnosis of dementia.³ Pain assessment and treatment is complex, because residents have varying degrees of cognitive function, complicating how their needs are communicated. When these symptoms do coexist, little is known about the interaction of pain and cognitive decline, beyond laboratory imaging of the brain from a patho-physiological perspective.^{201, 202} Empirical studies both support and refute poor neurocognitive performance in conjunction with increased pain intensity.^{194, 203-206} Evaluating longitudinal data to assess if a relationship occurs between pain and cognitive decline may assist in addressing these ambiguous findings.

The aim of this research was to examine if a concomitance exists between cognition and pain in the elderly residing in long-term care.

Research Questions:

In a sample of nursing home residents,

1) Is cognitive decline a predictor of increased pain?

2) Is increasing pain a predictor of cognitive decline?

Research evaluating the theoretical constructs of pain and contributing factors is lacking. Theoretical modeling using clinical data is a method to evaluate resident characteristics and symptoms for inter-relationships between variables. Modeling if chronic pain leads to worsening cognition, or declining cognition contributes to worsened pain, would test the theoretical constructs of this relationship. The significance and correlations of these variables creates a foundation for building additional models, with secondary needs and resident outcomes. Longterm unresolved pain may lead to secondary symptoms and comorbidities. Information of the relationship between pain and cognition adds to an understanding of how resident outcomes occur, and how quality initiatives can be approached—all fundamental to determine if resident care needs are being met.

Significance

Evaluating cognition in conjunction with pain helps to clarify if treating either symptom lessens the severity of the other, or if the symptoms are independent. Organic brain disorders cause a progressive process of cognitive decline.²⁰⁷ It is not possible for individuals to regain a normal level of functioning, the process is degenerative. Pain may potentiate symptoms of cognitive decline. Understanding if concomitance exists helps to understand if treatments could be targeted at symptoms to improve a resident's condition, or quality of life.

Understanding the relationship between cognition and pain establishes how these two variables could be included in a theoretical framework. This enables resident outcomes to be more accurately measured through symptoms and treatments, determining the most effective and cost-conscious actions. If pain and cognition were parallel and not an antecedent of the other, a symptom model would be inaccurate, making it difficult to determine where and what symptoms could be treated. Neglecting to include variables as predictors of the others yields an incomplete clinical picture and theoretical model, making it difficult to find and measure care solutions, because the root causes were not fully described. Understanding the clinical pathways and interrelationships of resident symptoms is essential to strategic planning and prioritizing resident care needs. Pain and cognition could be independent factors or directly influenced through the other.

Resource allocation in a struggling Medicare-funded system is a difficult process to navigate. A new National Institute of Health (NIH) nursing home rating system incorporates pain as a quality measure, previously neglected in long-term resident care assessments.^{174, 208} Staff assessments, resident nonverbal cues, verbal complaints, facial expressions and protective body movements were added as additional assessment items to more fully capture pain in this population.

The use of a federally mandated resident assessment surveys is a cost-effective, timeefficient tool to gain insight into resident care needs, and provides an opportunity to increase our understanding of resident symptom pathways and the effectiveness of interventions used. Using existing clinical data to test theoretical constructs adds valuable information to the validity of the models posited against real world, resident care data.

Background

Pain is an intricate sensory experience—involving physiological, pathological, social, cognitive, and emotional factors.^{209, 210} Sensory process is modulated by cognitive load.²¹¹⁻²¹⁴ Cognitive load helps to describe how hard it is for the individual to make sense of a stimulus. Cognitive decline is progressive and may manifest as symptoms of aphasia (language), apraxia

(perform directed acts), agnosia (recognize objects), and/or disturbances in global functioning (planning, organizing, sequencing, and abstract thoughts). Considerable issues exist in the detection of pain in residents with moderate to severe cognitive impairment. A lower incidence of pain is reported as cognition declines, largely due to measurement and communication issues.^{215, 216} Informal and formal caregivers have noted differences in pain behavioral cues depending on the resident's cognitive status, especially with the interpretation of body movements.²¹⁷

A case report presented by Ashpole and Katz²⁰⁹ described a patient with a life-long history of pain (somatoform pain disorder). The patient's refractory pain was unresolved causing daily verbal complaints of discomfort. After the onset of dementia, the patient's self-reports of pain sharply declined. The pain symptoms were posited to be presenting as an altered mood (e.g., depression or irritability) and cognitive decline.

Chronic pain is attributed to increased risk of depression in the elderly.^{156, 189, 218, 219} Depressive symptoms are linked to a decreased processing and motor function, but depression is not a conclusive result of memory impairment.²²⁰ Chronic pain results in changes to the resident's personality, social interactions, lifestyle, and functional status, impacting his/her quality of life.¹⁸⁹ Unresolved pain may result in a decline of the resident's quality of life causing delirium, depression, weight loss, social isolation, decreased activities of daily living, impaired gait, increased incidence of falls and comorbidities. Quality of life declines with chronic untreated pain, especially as the intensity of pain increases.¹⁸⁹ To date, the relationship between cognition and pain has been evaluated in case reports and patho-physiological studies, but not as a large-scale analysis of concomitance.

Theoretical framework

The concept of need-driven behaviors²³ and the framework extending this model to include the consequences of need-driven, dementia compromised behaviors ²⁴ (Figure 4.1) serves as the theoretical framework for this research study. The need-driven behavior, pain, is a co-existing symptom to cognitive state, a background factor. Proximal issues like a decline in physical state, and social and environmental causes, precipitate improvement or exacerbation of the original need, resolving the resident's pain.

The long-term consequence of unresolved need-driven behaviors gives rise to additional behavioral symptoms and secondary unmet needs. The primary relationship of cognition and pain are evaluated for this study. Future theoretical constructs including the complete model, would further evaluate the relationship of secondary needs (i.e., depression, weight loss, social isolation, higher falls risks, decreased ADLs, impaired gait), and how appropriate interventions mitigate the occurrence of secondary needs. Appropriate interventions to primary needs could improve resident quality of life, use healthcare resources more efficaciously, and reduce staff burden. The theoretical framework enables the clinician to translate a complex system of resident, caregiver, environment, and outcomes, as a measurable tool to improve care.

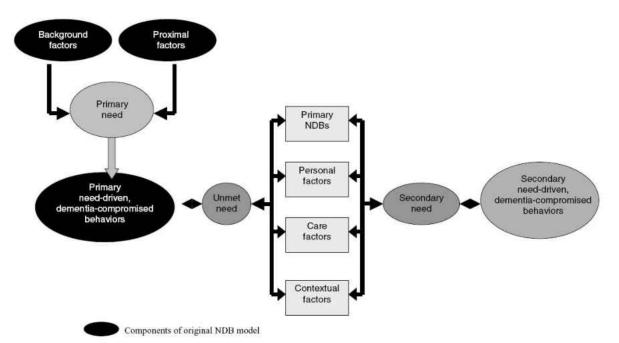


Figure 4.1. Reprinted with Permission, Kovach's et. al. ²⁴ Model of Consequences of Need-Driven, Dementia Compromised Behaviors

Methods

Design and Sample

A longitudinal cohort design was used. Data were collected from 2001, 2002 and 2003 on residents residing in Medicare receiving nursing homes across the United States. Minimum Data Set (MDS) 2.0 ¹⁷⁸ annual assessments were used as the data source, including all residents age 65 and older. Comatose residents were excluded from the sample, because key item sections (Sections B-F) are not scored. These items are required for the pain index instrument used in this study. Not filling out the cognitive, communications/hearing, mood and behavior, and psychosocial well-being sections of MDS adheres to the instructions given to assessors completing the resident assessment forms.

Data were extracted from a de-identified resident database containing the MDS items. The sample yielded 56,494 subjects (see Figure 4.2 for Sample Methods). The University of Central Florida Institutional Review Board (IRB) assigned an exempt status to the study. Data collection was retrospective and no interventions were tested.

Total Subject Assessments

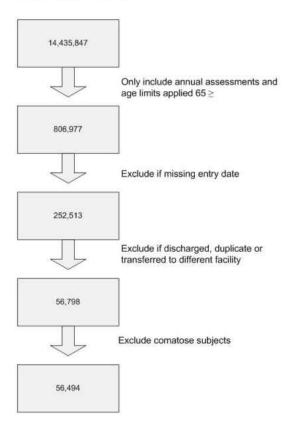


Figure 4.2. Sample Method

Instruments

The MDS is a nationally required assessment providing information on the quality of care provided in nursing homes.¹⁷⁴ Core items from the MDS instrument are used for care planning to trigger events or symptoms requiring intervention (e.g. pressure ulcers, delirium, cognitive loss, falls, and mood state). Pain is not a care-planning trigger from the Resident Assessment Protocol (RAP) however, it is a quality measure.¹⁷⁸ MDS items have demonstrated good to excellent validity and reliability¹⁷⁹⁻¹⁸¹ with interrater and test-retest reliability from 0.40 to 0.80 dependent on the item section.¹⁷⁹ A composite score was used to detect pain from core MDS

items (pain items analyzed are detailed in Table 4.1). The significance (p=.01) and validity of the measures used in the pain index were established in a previous pilot study.²¹⁶ Pain scores could range from 0 to 34. Score weighting is determined by the ordinal scoring used in the MDS instrument. The pain index includes Fries' Pain Scale¹²³ (PS) items (e.g. J2a for pain frequency and item J2b, pain intensity). The PS items highly correlated with a pain sites summary score.²¹⁶ Additional dimensions of affective and behavioral items are also included to aid in detecting pain across cognitive states (Figure 4.3).

Table 4.1.	Pain Score Items	5.
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INDICATORS	
Variable	Description
Inferred/Reported Pain	
(J2A) Pain Frequency	Frequency resident complains or shows evidence of pain
(J2B) Pain Intensity	Intensity of pain described or displayed by the resident
Pain Sites Score	Cumulative pain site index, items J2a-J3j, K1c; higher
	scores indicates more pain sites
Affect	
(E1L) Sad Facial Expressions	Sad, pained, worried facial expressions, i.e. furrowed
	brows
(E1M) Crying	Indicator of distress. Behavior is recorded by frequency in
	the last 30 days irrespective of the cause of the behavior
	(indicator)
(E3) Change in Mood	Refers to status of any symptoms described in section E
	(mood); snapshot of current observation period, not just a
	point in time.
Behavioral	
(E1A) Negative Statements	Resident made negative statements, e.g. "Nothing matters,
	would rather be dead, what's the use, regrets having lived
	so long."
(E1C) Repetitive Verbalizations	Calling out for help, repeated statements
(E4DA) Inappropriate Behavior	Disruptive sounds, noisiness, screaming, self-abuse acts,
Frequency	sexual behavior or disrobing in public, smeared/threw
	feces, hoarding, rummaging through other's belongings
(E1N) Repetitive Physical Movements	Pacing, hand wringing, restlessness, fidgeting, picking.
(E4CA) Physically Abusive Frequency	Others are hit, shoved, scratched, sexually abused

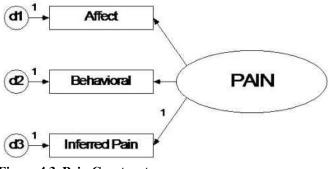


Figure 4.3. Pain Construct.

The Cognitive Performance Scale (CPS) was used to determine resident cognitive state. The CPS instrument uses key MDS items from section B, C and G of the resident assessment form.^{183, 184} The CPS measure correlates highly ($r \ge 0.70$) with the Folstein Mini-Mental Status Examination (MMSE).¹⁸⁵ The MDS derived CPS scores were converted to MMSE average totals. The averaged scores could range from 0.04 (severe impairment) to 24.9, an intact cognitive state. A CPS score of 6 converts to an average MMSE of 0.4; a 3 to 15.4; and 0 score to a MMSE of 24.9.¹⁸³ In validation testing of the CPS scores against the MMSE, a sensitivity of 0.94 and specificity of 0.94 were shown¹⁸⁵, indicating the utility of this instrument is viable in determining resident cognitive status from MDS derived items.

Statistical Analysis

Descriptive statistics, correlations and repeated measures ANOVAs were completed using SPSS 14.0. The SPSS statistical modeling program, AMOS 6.0, was used to build the covariance model of pain and cognitive state at three different time intervals for 2001, 2002 and 2003. Pain and cognition scores were hypothesized to be inversely related. Increasing pain score items indicated higher levels of pain. Cognitive decline was noted with a lower MMSE score. The analyses were one-tailed.

The covariance model was evaluated for goodness of fit statistics; however, the model was simplistic with only six discrete measures and five residual terms, so fit statistics would

indicate a just identified model. Due to the required large sample size to run structural equation modeling, assessment of statistical power is complex.^{188, 221} Sample size requirements generally are the number of free parameters (n=17) times five to 10, to estimate sample size. The sample total (n=56,494) far exceeds this rule.

Results

Select MDS items were colleted on 56,494 subjects with a mean age of 83 years. In total, 80% of the sample was female and 84% were Caucasian. The study demographics are in found Table 4.2. The most prevalent diagnosis was arthritis (33.7%) with 14.2% of the sample complaining of joint point at the first data collection (Table 4.3). Over the three year period, the percent of residents diagnosed with arthritis increased by 8% and recorded joint pain dropped to 11.3%.

 Table 4.2. Demographic Characteristics of Residents

		Mean ±S.D/	Range
(n=56,494)		Percent of Total	_
Age		83.3 ±8.2	65-112
Gender	Male	20.4%	
	Female	79.6%	
Marital Status	Never married	14.7%	
	Married	14.9%	
	Widowed	60.2%	
	Separated	2.3%	
	Divorced	7.9%	
Ethnicity	American Indian/Alaskan Native	0.3%	
	Asian/Pacific Islander	1.2%	
	Black, not of Hispanic origin	11.7%	
	Hispanic	2.9%	
	White, not of Hispanic origin	83.9%	
Language	English	94.6%	
	Spanish	2.4%	
	French	0.2%	
	Other	2.8%	
Education Level	No Schooling	3.0%	
	8 th grade/less	30.9%	
	9-11 grade	14.4%	
	High school	32.9%	
	Technical or trade school	4.1%	
	Some college	7.3%	
	Bachelor's degree	4.2%	
	Graduate degree	1.7%	
	Not coded/missing	1.5%	

Table 4.3. Diseases/Events with Potential Pain Symptoms

Disease	Number from Total (n=56, 494)	Percent of Total
Diabetes	11,885	21.0%
Peripheral Vascular Disease	6,459	11.4%
Arthritis	19,013	33.7%
Complaint of Joint Pain	8,018	14.2%
Hip Fracture	2,181	3.9%
Multiple Sclerosis	447	0.8%
Emphysema/COPD	7,021	12.4%
Cancer	3,031	5.4%
Renal Failure	1,382	2.4%
Pneumonia	498	0.9%
Respiratory Infection	1,277	2.3%
Septicemia	31	0.1%
Tuberculosis	20	0.0004%
Urinary Tract Infection (UTI)	2,865	5.1%
Wound Infection	295	0.5%

Cognitive state did not fluctuate over the three measures observed. Cognition declined slightly over the three-year period, as did pain (Table 4.4). The majority of the sample, 60 to 67%, was moderately to severely cognitively-impaired.

Cognitive Status	2001	2002	2003
CPS Mean Score	2.9±1.8	3.0±1.9	3.2±1.9
MMSE Mean Score	14.5±7.8	13.7±8.1	12.8±8.3
Intact	13.6%	12.2%	10.4%
Mild impairment	26.7%	24.4%	22.2%
Moderate impairment	29.4%	29%	28.4%
Severe impairment	30.3%	34.3%	39%
Pain Score	2.4±2.9	2.34±2.8	2.18±2.8
Mode	0	0	0
Range (Possible Range 0-34)	0-26	0-20	0-22
No reported pain symptoms	42%	43%	45%

Table 4.4. Longitudinal Chart of the Cognitive and Pain Scores

A one-way repeated measure ANOVA was calculated for cognition and pain. Each variable compared subject scores at three different time intervals: 2001, 2002, and 2003. A significant effect was found for cognition (F(2,112986) = 5949.23, p<.01) and pain (F(2, 112986) = 271.82, p<.01). Significant ANOVAs require a post hoc analysis. Follow-up protected *t* test with repeated measures was used, because of limitations of SPSS to run a post hoc analysis for within-subject factors.²²² A protected *t* test between each measure inflates the risk of Type I errors, so a significance level of 0.017 was used (0.05/3 measures) instead of 0.05. The follow-up protected *t* test revealed that cognition scores decreased significantly (p<.017) for the 2001 cogntion1 (m=14.5, sd=1.80) to 2002 cognition2 (m=13.7, sd=8.1) to 2003 cognition3 (m=12.8, sd=8.3) scores; and pain scores decreased significantly (p=.017) for pain1 (m=2.4, sd=2.9) to pain2 (m=2.34, sd2.8) to pain3 (m=2.18, sd=2.8).

Regression weights of 1 were assigned to each residual variable. A residual term was not attached to cognition1 (Figure 4.4), because there was no predictor for these variables. The covariance models indicate pain (1-3) and cognition (1-3) measurements were stable over time

with previous measures being a good predictor of subsequent measures. Higher stability was observed with the cognitive measure than with the measure of pain. The cross-legged effect of both cognitive and pain measure was not consistent. Little association was found between cognition and pain variables, regardless of the time interval. A concomitant relationship was significant (p<0.01), but the associations were weak ranging from absolute values of 0.03 to 0.08 (Table 4.5).

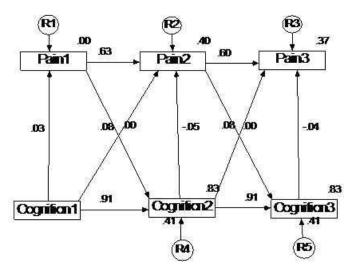


Figure 4.4. Covariance Model 1 of Three-Year Concomitance of Cognition and Pain

N=56,494	Mean	S.D.	1	2	3	4	5	6
1. Pain Score 2001	2.43	2.89	1.00					
2. MMSE 2001	14.51	7.88	.028**	1.00				
3. Pain Score 2002	2.34	2.85	.635**	.056**	1.00			
4. MMSE 2002	13.59	8.20	.022**	.912**	.041**	1.00		
5. Pain 2003	2.1	2.77	.492**	.073**	.606**	.065**	1.00	
6. MMSE 2003	12.63	8.36	.019**	.851**	.036**	.913**	.052**	1.00

Table 4.5. Correlations.

******Correlation is significant at the 0.01 level (one-tailed)

The root mean square residual (RMR) is the averaged squared amount by which the sample variances and covariances differ in their estimates.²²¹ A smaller RMR is preferred with a value of 0 indicating a perfect fit (see Table 4.6). The goodness of fit index (GFI), as it approaches 1 indicates a perfect fit. The optimal values outputted by the model for the GFI, TLI

and AGFI could be attributed to the simplicity of the model, even though all three were

approaching 1.0.

Goodness of Fit	Model 1	Model 2
Statistics		
χ^2	2524.9	2828.6
Degrees of freedom (df)	4	4
Р	.000	.000
Number of Free	17	17
parameters		
χ^2/df	631.224	707.158
RMR	.332	.205
GFI	.986	.984
TLI	.964	.959
AGFI	.924	.915
RMSEA	.106	.112
Hoelter (.01)	298	266

Table 4.6. Goodness of Fit Statistics of the Covariance Model

Discussion

The sample data do not confirm concomitance between pain and cognition in this longterm care population. The theoretical construct does not support either measure as a predictor of the other. These findings support Kovach's model of Consequences of Need-Driven, Dementia Compromised Behaviors (C-NDB). Cognition (background factor) and pain (proximal factor) exist as co-contributing aspects of how need-driven behaviors are manifested and communicated. Kovach's ²⁴ C-NDB model serves as template to understand how symptoms and environmental factors interact. This system contains environmental and contextual factors, affecting the resident and care outcomes. Failing to identify resident care needs is not in isolation of the resident, but is a complex system of clinician, support staff, environmental factors, and the resident.

MDS can be used as a reliable tool to track resident characteristics and outcomes over time. Reporting was consistent for cognition and pain over the three-year period—considerable fluctuations in recorded values of cognition and pain did not occur. Because pain assessments were recorded annually, differences in pain would be anticipated. The findings showed a gradual decline in recorded pain over the three-year period, as cognition also declined. This raises concern, because these findings may support previous research, indicating pain is under-reported and under-treated in residents with cognitive decline.²²³⁻²²⁵

Drops in pain scores at the third interval could also be attributed to residents having less pain, or residents having received appropriate interventions for their pain. Differences in pain would be expected with recent events like fracture, surgery, or falls. Partitioning this group of residents into a separate cohort could evaluate the consistency of pain reporting, and pain measures specific to these acute events. Until clinicians and support staff increase their awareness of affective, cognitive, and behavioral indicators of pain, the reliability of MDS for pain measures will be a concern.

Results suggest the importance of assessing memory function when managing residents that are physiologically distressed, because this information aids in determining the best methods to assess resident pain.^{92, 167, 218} Over the three-year period, declines in cognitive status occurred, consistent with the progression of organic brain disease. Acute declines in cognition may be indicative of a change in mental status not attributed to the progression of a pre-existing disease, but the onset of infection (i.e., urinary tract infection, pneumonia, or sepsis), or psychiatric illness.

Further research could look at specific diagnoses and the consistency of cognitive decline and pain measures over time. Additional variables like the use of multiple medications (e.g., polypharmacy), or certain classes of medications, (i.e., antipsychotics or hypnotics), could yield valuable information about attributable factors causing resident decline, and create an index of outcomes for pharmacoeconomic and clinical data to support resident care guidelines and health

policy reform. Supplemental theoretical modeling could evaluate latent growth models with predictors combining pain, cognition, age, gender, and facility characteristics gaining an understanding of pain and cognition in the elderly beyond this concomitance study. Additionally, research examining a growth curve model, plotting parallel points in time, would give valuable information into trends in data distribution and would clarify if the model were polynomial.

A limitation of this research was the data distribution. Normality and population distribution were not equal. The majority of the population assessed was not experiencing pain, and cognitive groups were not equal. While the population demographics are representative of nursing home residents, very distinct population demographics (i.e., gender, race, educational background, socio-economic factors) limit generalizability beyond this setting. Variability of the reliability measures from rater to rater of the MDS sections for mood and behavior have been reported.^{182, 197} The research was limited to the available items in MDS, and these items might not capture, define or describe all pain symptoms. Even with the additional dimensions to measure pain across cognitive states, there are still dimensions of pain yet to be defined or discovered.

Conclusion

This research sought to gain preliminary insight into the relationship between pain and cognition. Investigating if cognition is a predictor of pain in a concomitant relationship aided in defining how secondary patient outcomes might be mediated. Further research should be used to link cognition, resident ability to communicate, and levels of pain for significance with quality of life measures like depression, disturbances in gait, weight loss, decreased activity, declines in functional status, or social isolation. In the case of most organic brain diseases, there is not a

return to a normal level of cognitive functioning, but a progressive decline. Pain is a cycle that can be intervened upon, and symptoms can be lessened through medicinal and non-medicinal treatments improving resident comfort. With an understanding of the role of cognition in identifying how pain is communicated, we can improve pain detection and uniformity of measures to ameliorate symptoms. The significance of confirming, theoretical frameworks with advanced multivariate analysis is an opportunity to evaluate interactions of key variables. A global assessment of concomitance between pain and cognition offers a unique insight to have a better understanding of the relationship of pain and cognition in a general nursing home population.

CHAPTER 5: CONCLUSION

In a longitudinal study of cognition and pain in the elderly residents of long-term care facilities, it was found that measures of both pain and cognition decreased over a three-year period. Decreasing reports of pain from this study support previous research that pain may be underreported in those with impaired cognition. In the sample studied, neither pain nor cognition was a predictor of the other; however, it is important to gain information into how these variables co-exist and influence the occurrence of secondary needs and long-term patient outcomes.

Implications for Practice

Because pain was assessed and reported less frequently as cognition declined, it is important to identify and use other methods of assessing pain in this population, so pain does not go undetected causing suffering and exacerbation of additional secondary needs. Instead of treating resident's needs as a set of symptoms, we should anticipate the long-term consequence and effect on resident quality of life. For example, care planning might reveal a resident at risk for pain causing symptoms, and scores for the MDS-RAI would further substantiate pain through indicated pain behaviors. Initial screening would include a risk analysis for care deficits, take a prospective look at complications, and more closely monitor outcomes from interventions. We would gain immense benefit from having a better understanding of the mechanism with which resident state declines and how to increase resident quality of life in a cost-effective manner through more accurate measures of pain and targeted interventions.

Implications for Policy

At a minimum, the MDS-RAI 2.0 is recorded annually on all residents under Medicare coverage to evaluate the quality of care for reporting to consumers and providers. New

admissions and changes in resident status require additional assessments of residents to note changes in care needs. The MDS-RAI 2.0 does not use pain as a Resident Assessment Protocol (RAP) trigger to indicate a problem from clinically relevant data about resident health problems or functional status. Significant health policy concerns arise when pain, a fundamental care need, is not being used as a quality measure to evaluate care being provided in nursing homes across the United States. It is also argued that pain measures are a point in time from annual assessments, and if pain items were used as a quality measure, how could this data be accurate to gain an overall picture of resident care with only a 7-day review in an annual assessment. The upcoming MDS-RAI 3.0 is slated for release in October 2009, and integrates additional pain measures; however pain management should be a care priority in grading nursing home performance to give an accurate picture of care to consumers and providers. Health policy on pain management has a significant opportunity to improve care for this population, if the MDS-RAI is used as a quality measure, than the inclusiveness and accuracy of reporting should include pain as a health priority.

Implications for Research

The findings of this study add important details into the identification of additional dimensions of pain beyond self-report measures, like pain intensity and pain frequency. Identifying dimensions, such as affective, behavioral and cognitive factors work towards building a solution to improve the assessment, detection and treatment of pain in the elderly. Efforts defining additional dimensions of pain beyond the affective, behavioral and inferred dimensions discussed are an opportunity to further research on residents living in long-term care. Having an understanding of the antecedents of pain and cognitive decline enables clinicians to identify which variables can be intervened to enable the most efficacious outcomes. Future

research examining covariance models with added quality of life indicators and secondary needs, such as delirium, functional status, social engagement, depression, or falls, would contribute additional knowledge into patient outcomes, cost-effective measures, program planning for care priorities, and clarify administrative factors (i.e., unit culture, staffing, non-medicinal interventions) which improve or negatively effect patient care.

This was one of the first studies to look at the relationship of cognition and pain in longterm care residents using a large dataset. While cognition is not concomitant with pain, cognitive state is a key factor in how we approach measuring pain in the cognitively-impaired resident. Pain is a symptom that can be intervened upon and changed, while cognition can be used to determine the most appropriate method to assess pain in the elderly, improving the accuracy of detecting pain in this population.

APPENDIX A: UNIVERSITY OF CENTRAL FLORIDA IRB APPROVAL



University of Central Florida Institutional Review Board Office of Research & Commercialization 12201 Research Parkway, Suite 501 Orlando, Florida 32826-3246 Telephone: 407-823-2901, 407-882-2012 or 407-882-2276 www.research.ucf.edu/compliance/irb.html

Notice of Exempt Review Status

From: UCF Institutional Review Board FWA00000351, Exp. 6/24/11, IRB00001138

To: Allison H. Burfield

Date: August 07, 2008

IRB Number: SBE-08-05756

Study Title: Cohort Study of Pain Behaviors in the Elderly Residing in Skilled Nursing Care

Dear Researcher:

Your research protocol was reviewed by the IRB Chair on 8/7/2008. Per federal regulations, 45 CFR 46.101, your study has been determined to be **minimal risk for human subjects and exempt** from 45 CFR 46 federal regulations and further IRB review or renewal unless you later wish to add the use of identifiers or change the protocol procedures in a way that might increase risk to participants. Before making any changes to your study, call the IRB office to discuss the changes. A change which incorporates the use of identifiers may mean the study is no longer exempt, thus requiring the submission of a new application to change the classification to expedited if the risk is still minimal. Please submit the Termination/Final Report form when the study has been completed. All forms may be completed and submitted online at <u>https://iris.research.ucf.edu</u>.

The category for which exempt status has been determined for this protocol is as follows:

4. Research involving the collection or study of existing data, documents, records, pathological specimens or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. ("*Existing*" means already collected and/or stored before your study starts, not that collection will occur as part of routine care.)

The IRB has approved a request to **waive the consent process** as set forth in the federal regulations 45 CFR 46.116(d)(1-4).

All data, which may include signed consent form documents, must be retained in a locked file cabinet for a minimum of three years (six if HIPAA applies) past the completion of this research. Any links to the identification of participants should be maintained on a password-protected computer if electronic information is used. Additional requirements may be imposed by your funding agency, your department, or other entities. Access to data is limited to authorized individuals listed as key study personnel.

On behalf of Tracy Dietz, Ph.D., UCF IRB Chair, this letter is signed by:

Signature applied by Janice Turchin on 08/07/2008 11:16:41 AM EDT

Janui miturchi

IRB Coordinator

APPENDIX B: DATA USER AGREEMENT



Doctoral Program in Public Affairs

June 30, 2008

Allison Burfield Doctoral Student College of Nursing University of Central Florida Orlando, Florida

Dear Ms. Burfield:

It is my pleasure to serve on your dissertation committee at the College of Nursing. As a principal investigator for the nursing home care quality project, I will provide you with research files generated from the MDS and OSCAR files. For your information, the MDS files are available for 1999-2003 from the Health Informatics Research Lab. You are authorized to use the data files, without personal identifiers. In addition, our research staff will provide you with technical support if it is needed.

I look forward to working with you.

Sincerely,

mt. U Thomas T.H. Wan, Ph.D., MHS

Professor of Public Affairs, Health Services Administration and Medicine Director, Doctoral Program in Public Affairs Associate Dean for Research

College of Health and Public Affairs 3280 Progress Drive • Orlando, FL 32826-0544 • (407) 823-0170 • FAX: (407) 823-0744 An Equal Opportunity and Allimative Action Institution

APPENDIX C: DISSERTATION DEFENSE ANNOUNCEMENT

Announcing the Final Examination of Mrs. Allison H. Burfield for the degree of Doctor of Philosophy

Date: March 25, 2009
Time: 2:00 pm
Room: HPA I, Room 117
Dissertation Title: Cohort Study of Pain Behaviors in the Elderly Residing in Skilled Nursing Care

Aim/Objectives: The aim of this research was to examine if a concomitant relationship exists between cognition and pain in an elderly population residing in long-term care.

Background/Significance: Prior research has found that cognitive load mediates interpretation of a stimulus. In the presence of decreased cognitive capacity, the relationship between cognition and increasing pain is unknown in the elderly. Chronic and acute onset of pain contributes to a significant decline in resident quality of life affecting the residents' physical, mental, psychosocial, and spiritual well-being.

Methods: A longitudinal cohort design was used. A pilot study established core indicators used in the pain construct and instrument. Data were collected from the Minimum Data Set-Resident Assessment Instrument (MDS-RAI) for 2001, 2002 and 2003 annual assessments of nursing home residents. Key cognitive, mood, behavioral, and health condition items were used to determine resident cognition and the existence of pain. A covariance model was used to evaluate the relationship between cognition and pain at three intervals.

Results: The sample included 56,494 subjects from nursing homes across the United States, with an average age of 83 ± 8.2 years. ANOVA indicated a significant effect (p<.01) for pain and cognition with protected *t* test revealing scores decreased significantly over time with these two measures. Relative stability was found for pain and cognition over time. Greater stability was found in the cognitive measure than the pain measure. Cross-legged effects observed between cognition and pain measure was not consistent. A concomitant relationship was not found between cognition and pain. Although the relationship was significant at the 0.01 level, the correlations were low (r≤.08) indicating a weak association between cognition and pain. **Discussion/Implication:** Gaining an understanding of the concomitance between pain and cognition aids in building a more accurate model of the theoretical constructs, depicting interrelationships and additional factors from significant associations not just supposition. MDS is a reliable tool to follow resident characteristics and outcomes over time. Accurate measures of pain and cognition can give important information into how resident symptoms can be intervened to affect health outcomes.

Conclusion: While cognition is not concomitant with pain, cognitive state is a key factor in how we approach measuring pain in the cognitively-impaired resident. Cognition can be used to determine the most appropriate method to assess pain in the elderly, improving the accuracy of detecting pain in this population.

Outline of Studies: Major: Nursing Educational Career: A.D.N., 1995, Athens Technical College B.S.N., 2000, University of Central Florida M.S.N., 2006, University of Central Florida

Committee in Charge: Dr. Mary Lou Sole Dr. Thomas T.H. Wan Dr. Steven Talbert Dr. Diane Andrews

Approved for distribution by Mary Lou Sole, Committee Chair, on March 4, 2009.

The public is welcome to attend.

APPENDIX D: COPYRIGHT PERMISSION FOR KOVACH'S C-NDB

PAGE 02/03

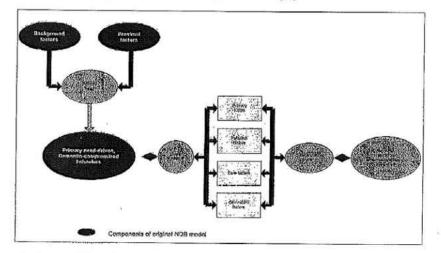
Mrs. Allison H. Burfield, MSN, RN, Doctoral Candidate 12532 Castlemain Trail Orlando, FL 32828

March 2, 2009

Attn: Ms. Lina Kopicaite Journals Rights & Permissions Controller Blackwell Publishing 9600 Garsington Road Oxford OX4 2DQ United Kingdom

Dear Ms. Kopicaite:

Per our email, I am completing my doctoral dissertation at the University of Central Florida entitled "A Cohort Study of Pain Behaviors in the Elderly Residing in Skilled Nursing Care". I would like your permission to reprint in my dissertation an excerpt from the following, Kovach, C. R., Noonan, P. E., Schlidt, A. M., & Wells, T. (2005). A model of consequences of need-driven, dementia-compromised behavior. *Journal of Nursing Scholarship*, *37*(2), 134-140, the figure found on page 135:



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If these arrangements meet with your approval, please sign this letter where indicated and fax (407.384.9632) or email the letter to allichb6@bellsouth.net. Thank you for your attention in this matter.

Sincerely,

allisi & Burguid

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Allison H. Burfield 12532 Castlemain Trail Orlando, FL 32828

02 March 2009

Dear Ms. Burfield,

Thank you for your request. Please consider this written permission to use material from "Need-Driven Dementia-Compromised Behaviors: An Alternative View of Disruptive Behavior" in your dissertation. Proper attribution to the original source should be included. This permission does not include any 3rd party material found within the work. Please contact us for any future usage or publication of your dissertation.

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APPENDIX F: MINIMUM DATA SET- RESIDENT ASSESSMENT INSTRUMENT 2.0

Numeric Identifier

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

BASIC ASSESSMENT TRACKING FORM

1.	RESIDENT NAME		 Signatures of Persons who Completed a Portion of the Accompanying Assessment of Tracking Form
		a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)	I certify that the accompanying information accurately reflects resident assessment or tracking
2	GENDER®	1.Male 2.Female	information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with
3.	BIRTHDATE	Month Dey Year	applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that recidents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued partici- pation in the government-funded health care programs is conditioned on the accuracy and truthther.
4.		1. American Indian/Alaskan Native 4. Hispanic 2. Asian/Pacific Islander 5. White, not of 3. Black, not of Hispanic origin Hispanic origin	ness of this information, and that I may be personally subject to or may subject my organization to substantial criminal civil, and/or administrative penalties for submitting failes information. I also certify that I am authorized to submit this information by this facility on its behalf.
5.	SOCIAL	a. Social Security Number	Signature and Title Sections Date
	AND		a.
	NUMBERSO	b. Medicare number (or comparable railroad in surance number)	b.
	[C in 1" box if non med. no.]		
6.	FACILITY	a. State No.	с.
	PROVIDER		d.
	0.0965.0		e.
		b, Federal No.	1.
7.	MEDICAID NO. ["+" if		9
	pending, "N" if not a		h
	Adaptic ald		
	recipient 0 REASONS	[NoteOther codes do not apply to this form]	b 2
8.	FOR	a. Primary reason for assessment	J.
	ASSESS- MENT	 Admission assessment (required by day 14) 	k.
	00000000	2 Annuel assessment 3. Significant change in status assessment	L.
		Significant correction of prior full assessment Ouarterly review assessment Significant correction of prior quarterly assessment NONE OF ABOVE	
		b. Codes for assessments required for Medicare PPS or the State 1. Medicare 5 day assessment 2. Medicare 30 day assessment 3. Medicare 60 day assessment 4. Medicare 90 day assessment 5. Medicare readmission/return assessment 6. Coher state required assessment 7. Medicare 14 day 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.)

 Θ = Key items for computerized resident tracking

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

Resident_

Numeric Identifier

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

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1.	DATE OF ENTRY	Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital_etc_in_such cases, use prio admission date
		Month Day Year
2	ADMITTED FROM (AT ENTRY)	Private home/apt, with no home health services Private home/apt, with home health services Services Seard and care/assisted living/group home Acute care hospital Acute care hospital Reviabilitation hospital Rother
3.	LIVED ALONE (PRIOR TO ENTRY)	0.No 1.Yes 2.in other facility
4.	2IP CODE OF PRIOR PRIMARY RESIDENCE	
5.	RESIDEN- TIAL HISTORY 5 YEARS PRIOR TO ENTRY	(Check all settings resident lived in during 5 years prior to date of entry given in item AB1 above) Prior stay at this nursing home Stay in other nursing home Other residential facility—board and care home, assisted living, group c. MH/psychiatric setting MR/DD setting NONE OF ABOVE
6.	LIFETIME OCCUPA- TION(S) [Put */" between two occupations]	
7.	EDUCATION (Highest Level Completed)	1. No schooling 5. Technical or trade school 2.8th gradeAess 6. Some college 3.9-11 grades 7. Bachelor's degree 4. High school 8. Graduate degree
8.	LANGUAGE	(Code for correct response) a. Primary Language 0. English 1. Spanish 2. French 3. Other 5. If other, specify
9.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem? 0. No 1. Yes
10.	CONDITIONS RELATED TO MR/DD STATUS	(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely) Not applicable—no MR/DD (Skip to AB11) R/DD with organic condition Down's syndrome Autism Epilepsy Other organic condition related to MR/DD MR/DD with no organic condition
11.	DATE BACK- GROUND INFORMA- TION COMPLETED	Month Day Year

CUSTOMARY ROUTINE	st box only
CYCLE OF DAILY EVENTS	
(In year prior to DATE OF ENTRY Stays up late at night (e.g., after 9 pm)	
to this nursing Naps regularly during day (at least 1 hour)	
last in Goes out 1+ days a week	ł
now being Stays busy with hobbies, reading, or fixed daily routine	
another Spends most of time alone or watching TV	
nursing home) Moves independently indoors (with appliances, if used)	
Use of tobacco products at least daily	L
NONE OF ABOVE	
EATING PATTERNS	
Distinct food preferences	L.
Eats between meals all or most days	
Use of alcoholic beverage(s) at least weekly	
NONE OF ABOVE	
ADL PATTERNS	
In bedclothes much of day	
Wakens to toilet all or most nights	ļ
Has irregular bowel movement pattern	
Showers for bathing	
Bathing in PM	
NONE OF ABOVE	
INVOLVEMENT 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	

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:

a. Signature of RN Assessment Coordinator		Date
I certify that the accompanying information accurate information for this resident and that I collected or co- dates specified. To the best of my knowledge, this in applicable Medicare and Medicaid requirements. I u basis for ensuing that residents receive appropriate from federal funds. I further understand that payment pation in the government-funded health care program nees of this information, and that I may be personally substantial criminal, civil, and/or administrative perso- certify that I am authorized to submit this information	rdinated collection of this inform formation was collected in accor- nderstand that this information i and quality care, and as a basis of such federal funds and conti is is conditioned on the accuracy subject to or may subject my org littles for submitting false inform	nation on the ordance with is used as a for payment nued partici- and truthful- ganization to
Signature and Title	Sections	Date
b.		
C.		
a.		
e.		
f.		
g.		

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

Resident					meric Identifier_	2012/02			
	FOR		MINIMUM DATA SI HOME RESIDENT				INC		
	FOR	NURSING	FULL ASS			CARE SCREEN	IING		
		(State	us in last 7 days, un			indicated)			
ECTION A.	IDENTIFICATIO		KGROUND INFORM			Check all that resident v	vas normally able to re	call during	-
1. RESIDENT					RECALL	last7 days) Current season a		and the second	
NAME	a. (First)	b. (Middle Initial)	c.(Last) d	L (Jr/Sr)	10000000000	Location of own room	That he/she is in	a nursing home	d.
ROOM			ar family .			Staffnames/faces c.	and a second design of the sec	VE are recalled	
NUMBER				4	SKILLS FOR	(Made decisions regardir	ng tasks of daily life)		
ASSESS-	a. Last day of MDS of	servation period			DAILY DECISION-	0. INDEPENDENT-dec 1. MODIFIED INDEPEN			
REFERENCE		<u> </u>			MAKING	only 2. MODERATELY IMPAIL			
DATE	Month	Day	Year			required			
	b. Original (0) or corre	cted copy of form	(enter number of correction)	5	INDICATORS	3. SEVERELY IMPAIRED (Code for behavior in the	last 7 days.) [Note: Ac	curate assessmen	at .
L DATE OF REENTRY			nporary discharge to a hosp nt or admission if less than	pital in	OF DELIRIUM-	requires conversations of resident's behavior o	with staff and family w wer this time}.	no have direct kno	nwiedg
REER INCO	has so days (of and	e mat daaren ante		so days)	PERIODIC DISOR-	0. Behavior not present			
					DERED	 Behavior present, not of 2. Behavior present, over 	of recent on set last 7 days appears diff	erent from resident's	usual
	Month	Day	Year		THINKING/ AWARENESS	functioning (e.g., new c	onset or worsening)	-Styleness second acti	100000
STATUS	1.Never married 2.Married	3. Widowed 4. Separated	5. Divorced			a. EASILY DISTRACTED sidetracked)	(e.g., difficulty paying	attention; gets	L
MEDICAL						b. PERIODS OF ALTERI	ED PERCEPTION OR	AWARENESS OF	
RECORD NO.						present; believes he/sh	e.g., moves lips or talks te is somewhere else; co	to someone not onfuses night and	
CURRENT	(Billing Office to indica	ta; check all tha	t apply in last 30 days)			day)		20 1200 - 200 - 201	
PAYMENT	Medicaid per diem	a. VA per	dem	t.			al, irrelevant, or rambling	(e.g., speech is from subject to	
FORN.H. STAY	Medicare per diem	Selfor	family pays for full per diem			subject; loses train of th			
28625442	Medicare ancillary		aid resident liability or Medica	re		d. PERIODS OF RESTL clothing, napkins, etc; f	ESSNESS(e.g., fidge requent position change	ting or picking at ski as; repetitive physica	n.
	part A Medicare ancilary	c co-pay Private	ment a insurance per diem (includin	n.		movements or calling of	out)		
	part B	d co-pay	ment)	* <u>L</u>		e. PERIODS OF LETHA difficult to arouse; little		iss; staring into spac	.0;
REASONS	CHAMPUS per diem a. Primary reason for a 1. Admission asse	10.	perdiem	J.		f. MENTAL FUNCTION DAY-(e.g., sometime sometimes present, so	s better, sometimes wor	URSE OF THE se; behaviors	
ASSESS-	2 Annual assessn		and the second	6	CHANGE IN	Resident's cognitive statu	s, skills, or abilities have	changed as	
Note-If this	Significant correl	ction of prior full a	issessment		STATUS	compared to status of 90 than 90 days) 0. No change	and the second second		
is a discharg	e 6. Discharged-re	turn not anticipated	ed		11 00000000	0. No change	1. Improved	2. Deteriorated	
or reentry assessment	 B. Discharged prio 	r to completing in	itial assessment	SE	CTION C.	COMMUNICATION	HEARING PAT	TERNS	
only a limited subset of	10. Significant corre	ction of prior qua	rterly assessment	1	HEARING	(With hearing appliance,			
MDS items need be	0. NONE OF ABC		or Medicare PPS or the Sta			0. HEARS ADEQUATELY 1. MINIMAL DIFFICULTY	when not in quiet setting	19	
completed	1. Medicare 5 day	assessment	or medicare PPS of the sta	ie i		2. HEARS IN SPECIAL 3 tonal quality and speak	k distinctly		-
	2 Medicare 30 da 3. Medicare 60 da	y assessment				3. HIGHLY MPAIREDIab	sence of useful hearing	ė.	
	4. Medicare 90 da 5. Medicare readn	y assessment hission/return ass	assment	2	CATION	(Check all that apply du Hearing aid, present and			a
	6. Other state requ 7. Medicare 14 day	iired assessment v assessment			DEVICES/ TECH-	Hearing aid, present and			b,
ļ	8. Other Medicare	requiredassess			NIQUES	Other receptive comm.te	chniques used (e.g., lip r	reading)	c.
RESPONSI- BILITY/	(Check all that apply		le power attorney/financial	d 3	MODES OF	NONE OF ABOVE (Check all used by resid	ent to make needs kn ov	with	d,
LEGAL	Legal guardian Other legal oversight		member responsible	e	EXPRESSION	Speech	Signs/gesture		d,
	Durable power of		t responsible for self	ť.		CARLES AND	a. Communicati	on board	
	attorney/health care		E OF ABOVE	9		Writing messages to express or clarify needs	b. Other		
ADVANCED DIRECTIVES		apply)	nentation in the medical			American sign language or Braille	NONE OF AL	BOVE	-
	Living will	a. Feedin	ng restrictions	t. 4	MAKING	(Expressing information of	14		14
	Do not resuscitate Do not hospitalize	b. Medic	ation restrictions	g.	SELF UNDER-	0. UNDERSTOOD	200 45-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0	unede av faskiser	
	Organ donation	c. Other	treatment restrictions	h	STOOD	thoughts	20D-difficulty finding w		
	Autopsy request	e. NONE	E OF ABOVE	1.		2. SOMETIMES UNDER requests		ed to making concre	te
				5	SPEECH	3. RAR ELY/NEVER UNL Code for speech in the l			-
ECTION B.	COGNITIVE PA	TTERNS			CLARITY	0. CLEAR SPEECH-dis	stinct, intelligible words		
	(Persistent vegetative	stata/no discarni	ble consciousness)			1. UNCLEAR SPEECH- 2. NO SPEECH-absen		k.	
	0. No (Recall of what was les	1.Yes ()	f yes, skip to Section G)	6	ABILITYTO	(Understanding verbal int		ever able)	
MEMORY			pears to recall after 5 minutes		STAND	0. UNDERSTANDS 1. USUALLY UNDERSTA	WDS-may miss some	part/intent of	
	0. Memory OK	1. Memory pro	blem		OTHERS	message 2. SOMETIMES UNDER			
	b. Long-term memory 0. Memory OK	OK—seems/app 1.Memory pro	pears to recall long past blem			direct communication 3. RARELY/NEVER UNI	Charles and the second second	and the second second second	
		in the pro-	ann.	7	CHANGEIN	Resident's ability to expre	ess, understand, or hear	information has	
					COMMUNI- CATION/	changed as compared to assessment if less than 9	0 days)		
				L	HEARING	0. No change	1. Improved	2. Deteriorated	

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

SECTION D. VISION PATTERNS

1.	VISION	(Ability to see in adequate light and with glasses if used)	
	2 "Sec. 2" (1)	O.ADEQUATE—sees fine detail, including regular print in newspaperubooks I. MPAIRED—sees targe print, but not regular print in newspapers/ books 2. MODERATELY IMPAIRED—limited vision; not able to see newspaper headlings, but can identify objects 3. HIGHLY IMPAIRED—object identification in question, but eyes appear to follow objects 4. SEVERELY MRAIRED—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, burnps into people and objects, misjudges placement of chair when seating self) Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes NONE OF ABOVE	a b,
_			c.
3.	VISUAL	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1.	INDICATORS OF DEPRES- SION, ANXIETY,	0. Indicator not exhibited in last 30 1. Indicator of this type exhibited of	in last 30 days, intespective of the 0 days up to five days a week daily or almost daily (6, 7 days a week)
	SAD MOOD	VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be	h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions
		dead: What's the use; Regrets having lived so long; Let me die*	I. Repetitive anxious complaints/concerns (non- health related) e.g., persistently seeks attention/
		b. Repetitive questions—e.g., "Where do I go; What do I do?"	reassurance regarding schedules, meats, laundry, clothing, relationship issues
		c. Repetitive verbalizations e.g., calling out for help, ("God help me")	SLEEP-CYCLE ISSUES j. Unpleasant mood in morning
		d. Persistent anger with self or otherse g, easily	k. Insomnia/change in usual sleep pattern
		annoyed, anger at placement in nursing home; anger at care received	SAD, APATHETIC, ANXIOUS APPEARANCE
		e. Selfdeprecation-e.g.,*/ am nothing: I am of no use	L Sad, pained, worried facial expressions—e.g., furrowed brows
		to anyone"	m. Crying, tearfulness
		 Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, 	n. Repetitive physical movements—e.g., pacing, handwinging, restlessness, fidgeting, picking
		being with others	LOSS OF INTEREST
		g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack	 Withdrawai from activities of interest—e.g., no interest in long standing activities or being with firmily/friends
		Here a Here Catholic	p. Reduced social interaction
2	MOOD PERSIS- TENCE	One or more indicators of depre not easily altered by attempts to the resident over last 7 days 0. No mood 1. Indicators pr indicators easily altered	esent, 2 Indicators present,
3.	CHANGE IN MOOD	Resident's mood status has chang days ago (or since last assessme 0. No change 1. Improv	nt if less than 90 days)
4.	BEHAVIORAL SYMPTOMS	(A) Behavioral symptom freque 0. Behavior not exhibited in last 1. Behavior of this type occurre	ncy in last 7 days 7 days d 1 to 3 days in last 7 days d 4 to 6 days, but less than daily
		(B) Behavioral symptom alterable 0. Behavior not present OR beh 1. Behavior was not easily alter	navior was easily altered ed (A) (I
		a. WANDERING (moved with no oblivious to needs or safety)	
		 b. VERBALLY ABUSIVE BEHAVI were threatened, screamed at, c. PHYSICALLY ABUSIVE BEHAVIOL 	cursed at)
		were hit, shoved, scratched, se	
		d. SOCIALLY INAPPROPRIATE/ SYMPTOMS (made disruptive self-abusive acts, sexual behav smeared/threw food/feces, hoat belongings)	sounds, noisiness, screaming,
		e. RESISTS CARE (resisted takin assistance, or eating)	ng medications/ injections, ADL

5.		Resident's behavior status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated		
B	CTION F. PS	SYCHOSOCIAL WELL-BEING		
1.	SENSE OF	At ease interacting with others	a.	-
	INVOLVE-	At ease doing planned or structured activities	b.	-
	MENT	At ease doing self-initiated activities Establishes own goals	c	-
			d	-
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)		
		Accepts invitations into most group activities	f.	
_		NONE OF ABOVE	9	8
2	RELATION-	Covert/open conflict with or repeated criticism of staff Unhappy with roommate	a .	-
	SHIPS	Unhappy with residents other than roommate	b. c.	-
		Openly expresses conflict/anger with family/friends	d	-
		Absence of personal contact with family/friends	e.	
		Recent loss of close family member/friend	e.	-
		Does not adjust easily to change in routines	g	0
		NONE OF ABOVE	h	
3.	PASTROLES		2	
		Expresses sadness/anger/empty feeling over lost roles/status	b.	
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community		
		NONE OF ABOVE	d	2
		HYSICAL FUNCTIONING AND STRUCTURAL PROE		
		(DENT—No help or oversight —OR— Help/oversight provided only 1 of the second s	1 - 1	arne
2	1. SUPERVI last7 days 1 or 2 time 2. LIMITED/ guided ma emide, here weight - Full sta 4. TOTAL DE 8. ACTIVITY (B) ADL SUPF (C) ADL SUPF OVER ALL performan 0. No setup o 1. Setup helj 2. One perso 3. Two+ pers	17 days SION—Oversight, encouragement or cueing provided 3 or more times, —OR—Supervision (3 or more times) plus physical assistance provis es during last 7 days ASSISTANCE—Resident highly involved in activity: received physical 1 insurvering of limbs or other nonweight bearing assistance 3 or more time help provided only 1 or 2 times during last 7 days VE ASSISTANCE—While resident performed part of activity, over last bearing support fliperformance during part (but not all) of last 7 days EPENDENCE—Full staff performance of activity during entire 7 days PORT PROVIDED—(Code for MOS T SUPPORT PROVIDED)	duri ied o ielp mes	ng only in
a.	1. SUPERVI last7 days 1 or 2 time 2. LIMITED/ guided ma emide, here weight - Full sta 4. TOTAL DE 8. ACTIVITY (B) ADL SUPF (C) ADL SUPF OVER ALL performan 0. No setup o 1. Setup helj 2. One perso 3. Two+ pers	17 days SION—Oversight, encouragement or cueing provided 3 or more times, o-OR—Supervision (3 or more times) plus physical assistance provides during last 7 days ASSISTANCE—Resident highly involved in activity: received physical 1 insurvering of limbs or other nonweight bearing assistance 3 or more time help provided only 1 or 2 times during last 7 days VE ASSISTANCE—While resident performed part of activity, over last is of following type(s) provided 3 or more times: bearing support Berformance during part (but not all) of last 7 days PENDENCE—Full staff performance of activity during entire 7 days PORT PROVIDED—(Code for MOST SUPPORT PROVIDED LISHIFT) during last 7 days; code regardless of resident's self-ce classification) or physical help from staff in physical assist 8. ADL activity itself did not oris physical assist Nor polytical assist 8. ADL activity itself did not oris physical assist How resident moves to and from king position, turns side to side, and positions body while in bed	duri delp mes 7-da	in y Brock
	1. SUPERVI last7 days 1 or 2 time 2. LIMITED guided ma OR—Mon 3. EXTENS/ period, he —Weight — Full sta 4. TOTAL DE 8. ACTIVITY (B) ADL SUPP OVER ALL performan 0. No setupo 1. Setuphelp 2. One perso 3. Two-pers BED	17 days 19 da	duri delp mes 7-da	pport a si
b. c.	1. SUPERVI last7 days 1 or 2 time OR—Mon 3. EXTENSI period, he —Weight — Full sta 4. TOTAL DE 8. ACTIVITY (B) ADL SUPF OVER ALL performan 0. No setup o 1. Setup helj 2. One persp 3. Two+ pers BED MOBILITY TRANSFER WALK IN ROOM	17 days SION—Oversight, encouragement or cueing provided 3 or more times, -OR—Supervision (3 or more times) plus physical assistance provis es during last 7 days ASSISTANCE—Resident highly involved in activity: received physical 1 insurvering of limbs or other nonweight bearing assistance 3 or more time help provided only 1 or 2 times during last 7 days VE ASSISTANCE—While resident performance and factivity, over last bearing support flow from the performance of activity during entire 7 days PORT PROVIDED—(Code for MOST SUPPORT PROVIDED	duri delp mes 7-da	pport a si
b. c.	1. SUPERVI last7 days 1 or 2 time OR—Mon 3. EXTENS/ period, he —Weight — Full sta 4. TOTAL DE 8. ACTIVITY (B) ADL SUP; OVER ALL performan 0. No setup of 1. Setup helj 2. One perso 3. Two-pers BED MOBILITY TRANSFER WALK IN CORRIDOR	17 days SION—Oversight, encouragement or cueing provided 3 or more times, —OR—Supervision (3 or more times) plus physical assistance provises during last 7 days ASSISTANCE—Resident highly involved in activity: received physical a sistance 3 or more times) plus physical assistance 3 or more time help provided only 1 or 2 times during last 7 days VE ASSISTANCE—While resident performed part of activity, over last bearing support fleeformance during part (but not all) of last 7 days PENDENCE—Full staff performance of activity during entire 7 days PDDNOT OCCUR during entire 7 days ORT PROVIDED—(Code for MOS TSUPPORT PROVIDED LSHIFTS during last 7 days; code regardless of resident's self- ce classification) physical assist	duri delp mes 7-da	pport a si
b. c. d.	1. SUPERVI last7 days 1 or 2 time QR—Mon 3. EXTENSI period, he —Weight — Full sta 4. TOTAL DE 8. ACTIVITY (B) ADL SUP; OVER ALL OVER ALL OVER ALL OVER ALL OVER ALL Statp help S. One perso 3. Two-perso 3. Two-perso 3. Two-perso BED MOBILITY TRANSFER WALK IN CORRIDOR CORRIDOR CORRIDOR CORRIDOR	17 days SION—Oversight, encouragement or cueing provided 3 or more times, -OR—Supervision (3 or more times) plus physical assistance provis es during last 7 days ASSISTANCE—Resident highly involved in activity: received physical 1 insurvering of limbs or other norweight bearing assistance 3 or more time help provided only 1 or 2 times during last 7 days VE ASSISTANCE—While resident performance and factivity, over last bearing support flow resident during part (but not all) of last 7 days EPENDENCE—Full staff performance of activity during entire 7 days PORT PROVIDED—(Code for MOS T SUPPORT PROVIDED) LSHIFT 3 during last 7 days; code regardless of residents self- ca classification) up physical assist Not occur during entire 7 days How resident moves to and from hing position, turns side to side, and positions body while in bed How resident moves between locations in his/her room How resident walks between locations in his/her room and acjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	duri delp mes 7-da	in y Brock
b. c.	1. SUPERVI last7 days 1 or 2 time 2. LIMITED oR—Mon 3. EXTENSI period, he —Weight — Full sta 4. TOTAL DE 8. ACTIVITY (B) ADL SUP; OVER ALL OVER ALL OVER ALL Performan 0. No setup of 1. Setup helj OVER ALL OVER ALL OVER ALL OVER ALL CORDELITY TRANSFER WALK IN CORRIDOR CORRIDOR CORRIDOR CORRIDOR	17 days 17 days 18/0N—Oversight, encouragement or cueing provided 3 or more times, -OR—Supervision (3 or more times) plus physical assistance provide a during last 7 days ASSISTANCE—Resident highly involved in activity: received physical a sistance 3 or more times) plus physical assistance 3 or more time help provided only 1 or 2 times during last 7 days VE ASSISTANCE—While resident performance of activity, over last be following type(s) provided 3 or more times. bearing support If performance during part (but not all) of last 7 days VE DID NOT OCCUR during entire 7 days 2007 DPC/IDED—(Code for MOST SUPPORT PROVIDED L SHIFTS during last 7 days; code regardless of resident's self- certassification) If physical assist Interview and from lying position, turns side to side, and positions body while in bad How resident moves between locations in his/her room How resident walks between locations in his/her room and acjacent corridor on sume foor. If in wheekhair, self-sufficiency	duri delp mes 7-da	in y Brock
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b. c. d. f.	1. SUPERVI Isst7 days 1 or 2 time 2. LIMITED, guided ma OR-Mon 3. EXTENS/ period, he - Weight- - Full sta 4. TOTAL DE 8. ACTIVITY (B) ADL SUPF OVER ALL performan 0. No setupo c 1. Setup help 2. One perso 3. Two+pers BED MOBILITY TRANSFER WALK IN ROOM WALK IN CORRIDOR LOCOMO- TION OFF UNIT DRESSING EATING	17 days SION—Oversight, encouragement or cueing provided 3 or more times, -OR—Supervision (3 or more times) plus physical assistance provide addining last 7 days ASSISTANCE—Resident highly involved in activity: received physical 1 insurvering of limbs or other nonweight bearing assistance 3 or more time in help provided only 1 or 2 times during last 7 days VE ASSISTANCE—While resident performance and factority, over last bearing support flipefromance during part (but not all) of last 7 days EPENDENCE—Full staff performance of activity during entire 7 days PORT PROVIDED—(Code for MOST SUPPORT PROVIDED) SHIFT 3 during last 7 days, code regardless of resident's self- control staff control of the staff performance of activity itself did not ons physical assist N. ADL activity itself did not ons physical assist N. A	duri delp mes 7-da	in y Brock

BATHING How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) Code for most dependent in self-performance and support. (A) BATHING SELF-PERFORMANCE codes appear below (A) (B) Support (A) (B) Code for most dependent in self-performance and support. (A) (B) (B) (A) (B)	mt
transfers in/out of tub/shower (EXCLUDE washing of back and hair.) Code for most dependent in self-performance and support. (A) BATHING SELF-PERFORMANCE codes appear below (A) (B) External (condom) catheter	
(A) BATHING SELF-PERFORMANCE codes appear below (A) (B) External (condom) catheter	t.
External (condorn) catheter	9
0. Independent—No help provided External condumy carreter c. Enemas/inigation	h.
1. Supervision—Oversight help only Indiveding catheter d. Ostomy present	4
2. Physical help limited to transfer only Intermittent catheter e. NONE OF ABOVE	4
	o status of
4 Total dependence URINARY 90 days ago (or since last assessment if less than 90 days	
A chickly itself did not occur during entire 7 days CONTI- NENCE O.No change I.Improved 2.Deter	patero
(Bathing support codes are as defined in Item 1, code B above)	
3. TESTFOR (Code for ability during test in the Tast 7 days) SECTION I. DISEASE DIAGNOSES	
BALANCE 0. Maintained position as required in test. 1. Unsteady, but able to rebalance self without physical support mood and behavior status, medical treatments, nursing monitoring, or risk of de	ognitive status
(see training 2 Partial physical support during test: inactive diagnoses)	ten. (Do not est
manual) or stands (sits) but does not follow directions for test 1. DISEASES. (If none apply, CHECK the NONE OF ABOVE box)	
3. Not able to attempt test without physical help a. Balance while standing Hemiplegia/Hemiple	resis y
MULTIPLITIONAL Multiple sciences	W.
b. Balance while sitting—position, trunk control 4. FUNCTIONAL (Code for imitations during last 7 days that interfered with daily functions or Diabetes mellitus a. Paraplegia	x.
LIMITATION placed resident at risk of injuna	V.
IN RANGE OF (A) RANGE OF MOTION (B) VOLUNTARY MOVEMENT Hypothypothypothypothypothypothypothypoth	z
1. Limitation on one side 1. Partial loss HEARTCRCULATION Secure asorder	
(see training 2. Limitation on both sides 2. Full loss (A) (B) Arterioscierotic heart disease Transient ischemic a	ftack (TIA) bb.
manual) a. Neck (ASHD) d. Traumatic brain injur	
b. Arm—including shoulder or elbow Cardiac dysrhythmias e. PSYCHIATRIC/MO	
C. Hand—Including wrist or fingers Congestive heart failure t. Anxiety disorder	dd.
d. Leg-Including hip or knee Deep vein thrombosis g. Depression	ee.
e. Foxt—including ankle or toes Hypertension h. Manic depression (b	
F. Other limitation or loss Hypotension L disease)	Π.
5. MODES OF (Check all that apply during last 7 days) LOCOMO- Conclusion of the second	00
TION Carlevvaluer/cluch a. Wheelchair primary mode of d. Curler cardiovascular disease k. PULMONARY	
Astrina	hh.
Other person wheeled c. NONE OF ABOVE e. Arthritis I. Emphysema/COPD	й.
6. MODES OF (Check all that apply during last 7 days) TRANSFER TRAN TRAN TRANSFER TRANSFER TRANSFER TRANSFER TR	
Bedrast all or most of time a Littled mechanically d	11.
Bed rails used for bed mobility Transfer aid (e.g., slide board, Osteoporosis o. Diabetic retinopethy	kk.
or transfer b. trapeze, cane, walker, brace) e. Pathological bone fracture p. Glaucoma	1
Lifed manually NONE OF ABOVE	an mm.
7. TASK Some or all of ADL activities were broken into subtasks during last 7 SECIMENTAL days so that resident could perform than r Alleroies	
	nn.
A ANA Deside the forest of the	00.
FUNCTIONAL least some ADLs Center Cancer	pp.
REHABILITA- TION Direct care staff believe resident is capable of increased independence b. Dementia other than NONE OF ABOVE	lgq.
POTENTIAL In at least some ADLs D. Alchemer's disease u	IT.
Resident able to perform tasks/activity but is very slow c. 2. INFECTIONS (If none apply, CHECK the NONE OF ABOVE box)	
Difference in ADL Self-Performance or ADL Support, comparing more to aveniese to aveniese. Septicemia	9
(e.g., wernicien resistant a. Sexually transmitted	diseases h
e. Iuberculosis	L
9. CHANGE IN Resident's ADL self performance status has changed as compared Urinary tract infection	n in last 30
FUNCTION days)	J
0. No change 1. Improved 2. Deteriorated Viral hepatitis	k.
	1
	[m.
1. CONTINENCE SELF-CONTROL CATEGORIES 3. OTHER CURRENT'S CURRENT CURRENT	1 1.1
OR MORE D	1 1 1.1
0. CONTINENT - Complete control (includes use of indwelling unnary catheter or ostomy device that does not leak unite or stod)	11111
AND ICD-9	
ROWEL ass than weakly	
2. OCCASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not daily; BOWEL, once a week SECTION J. HEALTH CONDITIONS	
A DOOD TAL UCASE AND A DOOD TAL UCASE AND A DOOD TAL AND AND A DOOD TAL AND A DOOD TAL AND A DOOD TAL AND AN	me frame is
conditions indicated	
INDICATORS OF FLUID CA22nessiverago	f.
14. NCONTINENT—Hed in adequate control BLADDER, multiple daily episodes: BOWEL all (or almost all of the time	9
a. BOWEL Control of bowel movement, with appliance or bowel continence more pounds within a 7 day Hallucinations	n
CONTI- programs, if employed Halucinations	4
b. BLADDER Control of urinary bladder function (if dribbles, volume insufficient to Inability to lie flat due to Recurrent lung a spin	
CONT- tool through underpants, with appliances, volume insuncements of the standard standar	89005 IN
NENCE programs, if employed Dehydrated, output exceeds Shorthass of breath	-
BOWEL Bowel elimination pattern Diarrhea c. linput c. Syncope (fainting)	m.
PATTERN increment every time days Fecal impaction	
Constitution NONE OF ABOVE Constitution and Advantage of Above	0
IS. I IS. OTHER OTHER NONE OF ABOVE	0
MDS 2.0 September, 2000 e.	

2. PAIN	(Code the highest level of pa	ain pre	esent in the last 7 days)
Symptoms	 a. FREQUENCY with which resident complains or shows evidence of pain 0. No pain (<i>skip to J4</i>) 1. Pain less than daily 2. Pain daily 		 b. INTENSITY of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating
3. PAIN SITE	(If pain present, check all site	es that	apply in last 7 days)
	Back pain	a.	Incisional pain
	Bone pain	b.	Joint pain (other than hip)
	Chest pain while doing usual activities	c.	Soft tissue pain (e.g., lesion, muscle)
	Headache	d.	Stomach pain
	Hip pain	e.	Other
4. ACCIDENTS	(Check all that apply)		
	Fell in past 30 days	a.	Hip fracture in last 180 days
	Fell in past 31-180 days	b.	Other fracture in last 180 days
			NONE OF ABOVE
5. STABILITY OF	patterns unstable—(fluctuatin	sident' g, pre	s cognitive, ADL, mood or behavior carious, or deteriorating)
CONDITIONS	Resident experiencing an acu chronic problem	te epi	sode or a flare-up of a recurrent or
	End-stage disease, 6 or fewer	mont	hs to live
	NONE OF ABOVE		

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL	Chewingproblem					a.
	PROBLEMS	Swallowing problem					b.
		Mouth pain					c.
		NONE OF ABOVE					d.
2.	HEIGHT AND WEIGHT	Record (a.) height in inches recent measure in last 30 day standard facility practice—e.g. off, and in nightclothes	s; meas , in a.m.	ure weig	htcon	sistently in accor	dwith
3.	WEIGHT	a.Weight loss—5 % or more 180 days 0.No 1.Yes	5				
		b.Weight gain—5 % or more 180 days 0.No 1.Yes					
4.	NUTRI- TIONAL	Complains about the taste of many foods	а.			er more of food ost meals	c.
	PROBLEMS	Regular or repetitive complaints of hunger	b.	NONE	OF AE	BOVE	d.
5.	NUTRI-	(Check all that apply in las	t7 days	s)			
	TIONAL APPROACH-	Parenteral/IV	a.	Dietary	supple	ement between	f.
	ES	Feedingtube	b.	Dista	and a	to billion of bould sum	
		Mechanically altered diet	c.	utensil,		tabilized built-up	g.
		Syringe (oral feeding) Therapeutic diet	d.	On a pl		weight change	
		inerely ende	e.	NONE		OVE	h.
	PARENTERAL OR ENTERAL INTAKE	(Skip to Section L if neither : a. Code the proportion of total parenteral or tube feedings i 0. None 1. 1% to 25% 2. 28% to 50% b. Code the average fluid inta	t calorie in the la 4	the rest of the re	cked) sident re 575% 100% or tube	eceived through e in last 7 days	ι.
		0. None 1. 1 to 500 cc/day 2.501 to 1000 cc/day	4	3. 1001 to 1. 1501 to 5. 2001 o	2000	cc/day	

SECTION L. ORAL/DENTAL STATUS

1.	STATUS AND	Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
	DISEASE	Has dentures or removable bridge	Ь.
		Some/all natural teeth lost—does not have or does not use dentures (or partial plates)	c.
		Broken, loose, or carious teeth	d.
		Inflamed gums (gingiva); swollen or bleeding gums; oral abcesses; ulcers or rashes	e.
		Daily cleaning of teeth/dentures or daily mouth care—by resident or staff	f.
		NONE OF ABOVE	a

	Numeric Ident	ifier	
SEC	CTION M. S	KIN CONDITION	
1.	ULCERS (Due to any cause)	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "O" (zero). Code all that apply during last 7 days. Code 9 = 9 or more.) [Requires full body exam.]	Number at Stage
		a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
		c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	
2.	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)	
		 Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue 	
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
3.	HISTORY OF	Resident had an ulcer that was resolved or cured in LAST 90 DAYS	
	RESOLVED ULCERS	0.No 1.Yes	
4.	OTHER SKIN	(Check all that apply during last 7 days)	
	PROBLEMS	Abrasions, bruises	a
	OR LESIONS PRESENT	Burns (second or third degree)	b.
		Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)	c.
		Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster	d.
		Skin desensitized to pain or pressure	e.
		Skin tears or cuts (other than surgery)	f.
		Surgical wounds	g.
		NONE OF ABOVE	h.
5.	SKIN	(Check all that apply during last 7 days)	
	TREAT-	Pressure relieving device(s) for chair	a
	MENTS	Pressure relieving device(s) for bed	b.
		Turning/repositioning program	c.
		Nutrition or hydration intervention to manage skin problems	d.
		Ulcer care	e.
		Surgical wound care	f.
		Application of dressings (with or without topical medications) other than to feet	g.
		Application of ointments/medications (other than to feet)	h.
		Other preventative or protective skin care (other than to feet)	i.
		NONE OF ABOVE	j.
6.	FOOT	(Check all that apply during last 7 days)	
	PROBLEMS AND CARE	Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems	a
		Infection of the foot—e.g., cellulitis, purulent drainage	b.
		Open lesions on the foot	с.
		Nails/calluses trimmed during last 90 days	d.
		Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)	e.
		Application of dressings (with or without topical medications)	f.
		NONE OF ABOVE	
			l Я-

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	(Check appropriate the Resident awake all or n per time period) in the: Morning	me perin nost ofti a.	ods over last 7 days) me (i.e., naps no more than one hour Evening	c.
		Afternoon	b.	NONE OF ABOVE	d.
(lf r	esident is co	matose, skip to Se	ction C		
2.	TIME INVOLVED IN	(When awake and not 0. Most—more than 2/3 1. Some—from 1/3 to 2	oftime		
3.	PREFERRED	(Check all settings in Own room Day/activity room Inside NH/off unit			d.
4.	GENERAL ACTIVITY PREFER- ENCES (adapted to resident's current abilities)	(Check all PREFERE) available to resident) Cards/other games Crafts/arts Exercise/sports Music Reading/writing Spiritual/religious activities	ACES w a. b. c. d. e. f.	hether or not activity is currently Trips/shopping Walking/wheeling outdoors Watching TV Gardening or plants Talking or conversing Helping others NONE OF ABOVE	g. h. j. k. I. m.

i.	PREFERS CHANGE IN		Slight chan	ige 2.Maj	orchange	,
	ROUTINE	 Type of activities in which Extent of resident involver 				-
E	CTION O. M	EDICATIONS		19 Ardery		
	NUMBER OF MEDICA- TIONS	(Record the number of dil enter "0" if none used)	Terent ma	dications used in th	e last 7 i	Jays,
2.	NEW MEDICA- TIONS	(Resident currently receivin last 90 days) 0.No 1.N		ions that were initia	ted during	g the
3.	INJECTIONS	(Record the number of DA the last 7 days; enter "0" if			eived du	ing
4.	DAYS	(Record the number of DA used. Nate—enter*1* for lo				
	THE	a. Antipsychotic		d. Hypnotic		
	MEDICATION	b. Antianxiety		e. Diuretic		
		c. Antidepressant		G. Dilliers		
E	CTION P. SP	PECIAL TREATMENTS	SANDF	ROCEDURES	5	
1.	SPECIAL	a. SPECIAL CARE-Check				ing
	TREAT- MENTS,	the last 14 days		- 997/360 		× _
	PROCE- DURES, AND	TREATMENTS		Ventilator or respi	rator	L
	PROGRAMS	Chemotherapy	a	PROGRAMS		
		Dialysis	b,	Alcohol/drug treat	ment	
		IV medication	c.	program	Sarotan.	m.
		Intake/output	d.	Alzheimer's/demi care unit	entia spe	cial n.
		Monitoring acute medical		Hospice care		0.
		condition	e.	Pediatric unit		p.
		Ostomy care	1.	Respite care		9
		Oxygentherapy	9	Training in skills re	uncired to	
		Radiation	h.	return to the com	munity (e	.g.
		Suctioning	i	taking medication work, shopping, tr	s house	tion 1
		Tracheostomy care	1	ADLs)	anspons	LIGHT,
		Transfusions	k	NONE OF ABON	Έ	5.
		 b.THERAPIES - Record t bllowing therapies was the last 7 calendar day [Note—count only pos (A) = # of days administe (B) = total # of minutes p 	administe ys (Enter l st admiss red for 15	ared (for at least 1 0 if none or less th ion therapies] minutes or more	5 minute Ian 15 m	seach orthe sa day) in in. daily) MIN (B)
		a. Speech - language path	ology and	audiology service	s	TIT
		b. Occupational therapy				
		10.5			\vdash	+++
		c. Physical therapy			\vdash	+++-
		d. Respiratory therapy				
		e. Psychological therapy (b	y any lice	nsed mental		
		health professional) (Check all interventions o	r stratogic	e used in last 7 d	-	
2.	INTERVEN-	matter where received)	r su ateyn	es useu intrast / u	ays-no	
	PROGRAMS	Special behavior symptom	evaluation	program		
	FOR MOOD, BEHAVIOR,	Evaluation by a licensed me		10 9 T 19 M	0 days	a.
	COGNITIVE	Group therapy	in the second			b,
	LOSS	Resident-specific deliberate	changes	in the environment	to addre:	and and a second se
		mood/behavior patterns—e		ng cureau in which	to rumm	age d.
		Reorientation-e.g., cueing	ģ			0.
	1 mile and 1 miles and	NONE OF ABOVE	(3.614)	1		t.
3.	NURSING REHABILITA- TION/ RESTOR- ATIVE CARE	more than or equal to 15 (Enter 0 if none or less that	practices w minutes an 15 min.	vas provided to ti per day in the la daily.)	rehabiliti he resid st 7 day:	ent for
	stress writing	 a. Range of motion (passive b. Range of motion (active) 	′ –	f. Walking	ante-or	-
				g. Dressing or gro	oming	
				No. And States	15 21 1 1 Series	
		c. Splint or brace assistance		h. Eating or swalle	owing	
				No. And States	owing	are
		c. Splint or brace assistance TRAINING AND SKILL		h. Eating or swalle	owing osthesis c	are

4.	DEVICES AND RESTRAINTS	(Use the following codes for last 7 days .) 0. Not used 1. Used less than daily 2. Used daily		
		Bed rails		
		a. — Full bed rails on all open sides of bed b. — Other types of side rails used (e.g., half rail, one side)		
		 Conertypes or side rais used (e.g., nair rai, one side) C. Trunk restraint 		
		d. Limb restraint	ŀ	
		e. Chair prevents rising	ľ	
5.	HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no hospital admissions)		
6,	ROOM (ER)	Record number of times resident visited ER without an overnight stay In tast 90 days (or since last assessment if less than 90 days). (Enter 0 if no ER visits)		
7.	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 Olfnone)		
8.	PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change, (Enter 0 if none)		
9,	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission)?		
		0. No 1. Yes		
E	CTION Q. DI	SCHARGE POTENTIAL AND OVERALL STATUS		
1.	DISCHARGE	a. Resident expresses/indicates preference to return to the community	ſ	
	STENTIAL	0 No 1 Yes	ł	

		0.140	1.185	
		b. Resident has a su	pport person who is positive towards discharge	
		0.No	1.Yes	_
			e of a short duration— discharge projected within clude expected discharge due to death) 2. Within 31-90 days	
		1. Within 30 days	3. Discharge status uncertain	
2	OVERALL CHANGE IN CARE NEEDS	compared to status	If sufficiency has changed significantly as of 90 days ago (or since last assessment if less	
		0. Nochange 1. Im su	proved—receives fewer 2. Deteriorated—receives oports, needs less more support trictive level of care	

SECTION R. ASSESSMENT INFORMATION

Numeric Identifier

1.	TION IN	a. Resident: b. Family:	0.No 0.No	1.Yes 1.Yes	2. No family	+
	ASSESS- MENT	c. Significant other:	0.No	1.Yes	2. None	
					MENT:	
		1890. N. 1778. NAMES NO. (NAMES N				
				201202010201	Mersola Inc.	
1.5	ignature of RN	Assessment Coordina	tor (sign on a	201202010201		
b.D		ment Coordinator	tor (sign on a	201202010201	-]

	SPECIAL TREAT- MENTS AND PROCE-	a. RECREA recreation last 7 da	n theraj	oy adm	inistere				DA	YS	fay) ir Mit	N			
	DURES	(A) = # of d (B) = total	ays adr # of mir	niniste nutes p	red for provided	15 minu 1 in last	tes or r 7 days	nore	(A	0	(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													
		when at	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?													
2.	WALKING WHEN MOST SELF SUFFICIENT		s 0,1,2, 0 ntreceis	ved phy	ID at lea sical the	ist one srapy in	of the fe	ollowi pait tra	<i>ng ar</i> ining	ne (P.1.)					
		 Resident received physical therapy involving gait training (P1.b.c) Physical therapy was ordered for the resident involving gait training (T.1.b) Resident tree eved nursing rehabilitation for walking (P3.f) 													
		Resident received nursing renabilitation for waining (r-s.i) 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 (POR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)													
		a. Furth	est dista												
		episod	ie.	ance w	alked w	ithout si	tting do	wn du	ringth	nis					
		0.150		an ce w	alked w	3.1	tting do 0-25 fee ess thar	•		1is					
		0.150	+ føet 149 føet 50 føet			3. 1 4. L	0-25 fee ess thar ring this	t 10 fe episo	et	nis					
		0. 150 1. 51- 2. 26- b. Time 0. 1-2	+ føet 149 føet 50 føet	without		3.1 4.L Iown du 3.1 4.1	0-25 fee essthar	t 10 fe episo nutes nutes	et	nis					
		0. 150 1. 51- 2. 26- b. Time 0. 1-2	+ feet 149 feet 50 feet walked minutes minutes) minute	without	sitting d	3.1 4.L lown du 3.1 4.1 5.3	0-25 fee ess thar ing this 1-15 mir 5-30 mir 1+ minu	t n 10 fe episo nutes nutes tes	et de.	nis					
		0. 150 1. 51- 2. 284 b. Time 0. 1-2 1. 3-4 2. 5-10 c. Self-P 0. NC 1. SU	+ fact 149 feet 50 feet walked minutes 0 minutes 0 minute erforma eEPEND PERVIS	without s ance in ENT—	sitting o walkin No help	3, 1 4, L lown du 3, 1 4, 1 5, 3 g during or over	0-25 fee ess thar ing this 1-15 mir 5-30 mir 5-30 mir 5-30 mir 5-30 mir 5-30 mir 1+ minu 1+ minu 1+ minu 1+ sepi	t episo nutes nutes tes sode.	et de.						
		0. 150 1. 51- 2. 264 b. Time 0. 1-2 1. 3-4 2. 5-10 c. Setf-P 0. I/C 1. SU/ prov 2. Lim rec	+ faot 149 feet 50 feet walked minutes minutes 0 minute erforma	without s ance in ENT	sitting o walkin No help Xersigh WCE—I elp in gu	3. 1 4. L 3. 1 4. 1 5. 3 g during or over it, encou	0-25 fee ess thar ring this 1-15 min 5-30 min 5-	t 10 fe episo nutes tes sode. int or i	et de. :uein	9 walki	ng; ther				
		0. 1500 1. 51- 2. 28-4 b. Time 0. 1-2 1. 3-4 2. 5-10 c. Self-F 0. NC 1. SU proc. 2. LIM rec. non 3. EX	+ feet 149 feet 50 feet walked minutes minutes 0 minutes 0 minutes	without ance in ENT- ON	sitting o walkin No help Oversigh WCE—I a ssistar STANC	3. 1 4. L 3. 1 5. 3 g during or over t, enco. Residen ided ma ide E—Res	0-25 fee ess than ing this 1-15 min 5-30 min 5-30 min 1-1 minu this epi sight inagement this highly sneuver	t 10 fe nutes nutes tes sode. involv ing of	et de. cuein ed in limbs	9 walki s or of	ng; ther				
		0. 150 1. 51- 2. 28-1 b. Time 0. 1-2 1. 3-4 2. 5-11 c. Self-F 0. N/C 1. SU prov 2. L/M record non 3. EX bee d. Walkin regard	+ faet 143 feet 50 feet walked minutes minutes minute erforma PERV/S rided <i>TED At</i> sived phy weight b <i>TENSIM</i> ring assi ng suppless of	s ance in ENT ION(SSISTA sical h earing E ASS sical content sical content ort pro-	sitting o walkin No help Xversigt STANC while w svided a 's self-p	3. 1 4. Li 3. 1 4. 1 5. 3 g during or over t, encos ar over t, encos ar over t, encos ar over t, encos ar over t, encos ter t, encos ter ter t, encos ter t, enco	0-25 fee ess thar ing this 1-15 mir 5-30 mir 1- minu this epi sight rageme t highly an euver ident re- dent re-	t 10 fe episo nutes tes sode. intori involv ing of seivec this ep	et de. cuein ed in s limbs	9 walki sorol jht	ther				
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		0. 150 1. 51- 2. 28-4 b. Time 4 0. 1-2 1. 3-4 2. 5-10 c. Self-P 0. NLC 1. SUL 1. Set 1. Set 2. One	+ faot 149 feet 50 feet minutes 0 minutes 0 minutes 0 minute erforma erefor	without s ance in ENT CON(SSISTA sistance of pro- sistance of pro- sistance of pro- physic physic s physic	walking of walking of walking of walking of walking of walking was a satisfar a satisfar while was while was while was walking a satisfar a sat	3, 1 4, L lown du 3, 1 4, 1 5, 3 g during c or over t, encou ce E—Res alking associat erforma staf	0-25 fee ess thar 1-16 mit 5-30 mit this epi this epi thi	t 110 fe episo nutes tes tes sode. involv involv involv involv insifical	et de. cuein ed in limbs liweig isock ion).	9 walki sorol jht a (coo	de				
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Numeric Identifier

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Resident

MINIMUM DATA SET (MDS) - VERSION 2.0

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

SECTION W. SUPPLEMENTAL MDS ITEMS

 1.
 National Provider ID
 Enter for all assessments and tracking forms, if available, including form is between July 1 and September 30, skip to W3.

 2.
 Influenza Vaccine
 a. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)?

 0.
 No (If No, go to item W2b) 1. Yes (If Yes, go to item W2b)

 b.
 If Influenza vaccine not received, state reason: 1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible

 3.
 Pneumococcal Vaccine
 a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b)

 b.
 If Influenza vaccine 3. Not eligible 2. Offered and declined 3. Not offered 3. Not offered 3. Not offered 3. Not offered

MDS 2.0 May, 2005

A1.	RESIDENT		E1.	INDICAT
	0.5597.655 () U	a. (First) b. (Middle Initial) C. (Last) d. (Jr/Sr)		DEPR
A2.	ROOM			ANXIE SAD M (con
A3.	ASSESS- MENT REFERENCE DATE	a. Last day of MDS observation period		(con
A4a	DATE OF REENTRY	b. Original (0) or corrected copy of form (enter number of correction) 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)		
A6.	MEDICAL RECORD NO.	Month Day Year		
B1.	COMATOSE	(Parsistent vegetative state/ho discernible consciousness) 0.No 1.Yes (Skip to Section G)		
B2.	MEMORY	(Recall of what was learned or known) (Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes D. Memory OK 1. Memory problem b. Long-term memory OK—seems/appears to recall long past	E2.	MOO PERS TENC
B4.	COGNITIVE SKILLS FOR DALLY DECISION- MAKING	O.Memory OK	E4.	BEHAVIO SYMPT
B5.	INDICATORS OF DELIRIUM- PERIODIC DISOR- DERED THINKING/ AWARENESS	(Code for behavior in the last 7 days) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time]. 0. Behavior not present 1. Behavior present, over last 7 days appears different from resident's usual functioning (e.g. new onset or worsening) a. EASILY DISTRACTED—(e.g., difficulty paying attention: gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AVARENESS OF SURROUNDINGS—(e.g., move files or talks to someone not present; believes he/she is somewhere else; confuses night and day)		
		C. EPISODES OF DISORGANIZED SPEECH(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject: loses train of thought) C. PERIODS OF RESTLESSNESS(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes, repetitive physical movements or calificg out) e. PERIODS OF LETHARGY(e.g., sluggishness; staring into space; difficult to arouse; little body movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY(e.g., sometimes better, sometimes worse; behaviors	G1.	(A) ADL SH/ 0. IND durit 1. SUF last: 1 or 2. LIM guid OR-
С4.	MAKING SELF UNDER- STOOD	sometimes present, sometimes not) (Expressing intermation content—howaver able) 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty linding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests		3. EXT peria — W — F 4. TOT 8. ACT
C6.	ABILITY TO UNDER-	3. RARELY/NEVER UNDERSTOOD (Understanding verbal information content—however able) 0. UNDERSTANDS	a	BEI
	STAND	1. USUALLY UNDERSTANDS—may miss some part/intent of message	D.	TRANS
		2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY/MEVER UNDERSTANDS	C.	WALK ROO
E1.	INDICATORS OF DEPRES-	0. Indicator not exhibited in last 30 days	d. e.	CORRI
	SION, ANXIETY, SAD MOOD	1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week) VERBAL EXPRESSIONS OF DISTRESS C. Repetitive worbalizations— OF DISTRESS C. Repetitive worbalizations— C.	L	LOCOL TIO
		a. Resident made negative statements—e.g., "Nothing matters; Would rather be d. Persistent anger with self or others—e.g. easily annoyed	g.	OFF U
		dead;What's the use; anger at placement in Regrets having fixed so nursing home; anger at care long; Let me die' received	h.	EATI
		b. Repetitive questions—e.g., "Where do I go: What do I do ?" e. Self deprecation—e.g.," I am nothing; I am of no use to anyone"		

MDS QUARTERLY ASSESSMENT FORM

Numeric Identifier SLEEP-CYCLE ISSUES TORS VERBAL EXPRESSIONS OF DISTRESS . Unpleasant mood in morning ESf. Expressions of what k. Insomnia/change in usual ŤΥ. appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others sleep pattern DOD SAD, APATHETIC, ANXIOUS APPEARANCE t) g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack Sad, pained, worried facial expressions—e.g., furrowed expres brows . Crying tearfulness . Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking h. Repetitive health Repetitive nearth complaints—e.g., persistently seeks medical attention, obsessive concern with body functions OSS OF INTEREST Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ p. Reduced social interaction reassurance regarding schedules, meals, laundry, clothing, relationship issu One or more indicators of depressed, sad or anxious mood were not easily aftered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood 1. Indicators present, 2. Indicators present, indicators easily aftered not easily aftered DISeasily altered ORAL (A) Behavioral symptom frequency in last 7 days OMS 0. Behavior not exhibited in last 7 days 1. Bohavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) Behavioral symptom alterability in last 7 days 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered 3. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety) (A) (B) b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at) c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abuse d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAV/IORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smear-dithrew bod/feces, hoarding, rummaged through others' belongings) RESISTS CARE (resisted taking medications/injections, ADL assistance, or eating) SELF-PERFORMANCE—(Code ky resident's PERFORMANCE OVER ALL FTS during last 7 days—Not including setup) EPENDENT—No help or oversight —OR— Help/oversight provided only 1 or 2 times ng last 7 days PERVISION—Oversight, encouragement or cueing provided 3 or more times during 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 2 times during last 7 days ITEDASSISTANCE—Resident highly involved in activity; received physical help in led maneuvering offinitis or other nonweight bearing assistance 3 or more times — —More help provided only 1 or 2 times during last 7 days TENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day od, help of billowing type(s) provided 3 or more times: wight-beams support uil staff performance during part (but not all) of last 7 days AL DEPENDENCE-Full staff performance of activity during entire 7 days TIVITY DID NOT OCCUR during entire 7 days (A) How resident moves to and from lying position, turns side to side, and positions body while in bed YTL How resident moves between surfaces-to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet) FER M How resident walks between locations in his/her room How resident walks in corridor on unit. NO. How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair NIT How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair MO-NIT ING How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral NG nutrition).

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A1.	RESIDENT		E1.	INDICAT
	085916=51	a. (First) b. (Middle Initial) C. (Last) d. (Jr/Sr)		DEPRE
A2.	ROOM			ANXIE SAD MC (cont
A3.	ASSESS- MENT REFERENCE DATE	a. Last day of MDS observation period		
A4a	DATE OF REENTRY	b. Original (0) or corrected copy of form (enter number of correction) 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)		
A6.	MEDICAL RECORD NO.	Month Day Year		
B1.	COMATOSE	(Persistant vegetative state/ho discernible consciousness) 0.No 1.Yes (Skip to Section G)		
B2.	MEMORY	(Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK—seems/appears to recall long past	E2.	MOOI PERSI TENC
B4.	COGNITIVE SKILLS FOR DAILY DECISION- MAKING	O. Memory OK         1. Memory problem     (Made decisions regarding tasks of daily life)     O. INDEPENDENT—decisions consistent/reasonable     1. MODIFIED INDEPENDENCE—some difficulty in new situations     only     MODERATELY IMPAIRED—decisions poor; cues/supervision     required	E4.	BEHAVIC SYMPTC
B5.	INDICATORS	required 3. SEVERELY MPA/RED—never/rarely made decisions (Code for bahavior in the last 7 days.) (Note: Accurate assessment		
	OF DELIRIUM- PERIODIC DISOR- DERED THINKING/ AWARENESS	requires conversations with staff and family who have direct knowledge of resident's behavior over this time]. O. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)		
		a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AVVARENESS OF SU RROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)		
		c. EPISODES OF DISORGANIZED SPEECH-(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)	G1.	(A) ADL SHIF
		d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; trequent position changes; repetitive physical movements or calling out)		0. INDE durin 1. SUP
		e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE		last7 1 or 2
	_	DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)		guide OR-
с4.	MAKING SELF UNDER- STOOD	(Expressing information content—however able) 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty Inding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete		3. EXT perio —W — Fi 4. TOT
C6.	ABILITYTO	requests 3. RARELYNEVER UNDERSTOOD (Understanding verbal information content—however able)	a	8. ACT
	UNDER- STAND OTHERS	0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part/intent of	b.	TRANS
		message 2.SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELYNEVER UNDERSTANDS	c.	WALK
E1.	INDICATORS	(Code for indicators observed in last 30 days, irrespective of the assumed cause)	d.	WALK
	DEPRES- SION, ANXIETY,	0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)	e.	LOCON
	SAD MOOD	VERBAL EXPRESSIONS c. Repetitive verbelizations	r.	LOCON
		a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; anger at placement in	g.	OFF UN
		Regrets having fixed so long; Let me de" received b, Repetitive questionse.g., e. Self deprecatione.g., */am	h.	EATIN
		"Where do I go; What do I nothing; I am of no use to anyone"	-	

MDS QUARTERLY ASSESSMENT FORM

#### Numeric Identifier SLEEP-CYCLE ISSUES ORS VERBAL EXPRESSIONS OF DISTRESS . Unpleasant mood in morning E8-1. Expressions of what k. Insomnia/change in usual appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others TY, sleep pattern SAD, APATHETIC, ANXIOUS APPEARANCE g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack Sad, pained, worried facial expressions—e.g., furrowed expres brows . Crying tearfulness . Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking h. Repetitive health Repetitive nearth complaints—e.g., persistently seeks medical attention, obsessive concern with body functions OSS OF INTEREST Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ p. Reduced social interaction reassurance regarding schedules, meals, laundry, clothing, relationship issu One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood 1. indicators present, 2. indicators present, indicators easily altered not easily altered S. indicators easily altered not easily altered ORAL (A) Behavioral symptom frequency in fast 7 days OMS 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) Behavioral symptom alterability in last 7 days 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered 3. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety) (A) (B) b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at) c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abus d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAV/IORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smear-dithrew bod/feces, hoarding, rummaged through others' belongings) RESISTS CARE (resisted taking medications/injections, ADL assistance, or eating) SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL FTS during last 7 days—Not including setup) PENDENT—No help or oversight —OR— Help/oversight provided only 1 or 2 times g last 7 days ERVISION—Oversight, encouragement or cueing provided 3 or more times during / days —OR— Supervision (3 or more times) plus physical assistance provided only 2 times during last 7 days TEDASSISTANCE—Resident highly involved in activity, received physical help in ed maneuvering of limbs or other nonweight bearing assistance 3 or more times — —More help provided only 1 or 2 times during last 7 days ENSIVE ASSISTANCE—While resident performed part of activity, over last 7-day d, help of following type(s) provided 3 or more times: leight-bearing support uil staff performance during part (but not all) of last 7 days AL DEPENDENCE-Full staff performance of activity during entire 7 days IVITY DID NOT OCCUR during entire 7 days (A) How resident moves to and from lying position, turns side to side, and positions body while in bed TY How resident moves between surfaces-to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet) FER IN VI How resident walks between locations in his/her room IN How resident walks in corridor on unit. 10-How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair ίт How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair 10-IT NG How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition). IG

i.	TOILET USE	How resident uses the toilet roo transfer on/offtoilet, cleanses, o catheter, adjusts clothes		
j.	PERSONAL	How resident maintains person brushing teeth, shaving, applyi and perineum (EXCLUDE bath	nal hygiene, including co ng makeup, washing/dry	mbing hair, /ing face, hands,
32.	BATHING	How resident takes full-body but transfers in/out of tub/shower ( <i>Code for most dependent in</i> (A) BATHING SELF PERFOR	ath/shower, sponge bath EXCLUDE washing of b self-performance.	ack and hair.)
		0. Independent—No help pro 1. Supervision—Oversight hi 2. Physical help limited to trai	elp only	(A)
		<ol> <li>Physical help in part of bat</li> <li>Total dependence</li> <li>Activity itself did not occur</li> </ol>	0.000	
34.	FUNCTIONAL LIMITATION IN RANGE OF MOTION	(Code for limitations during las placed residents at risk of injur, (A) RANGE OF MOTION 0. No limitation 1. Limitation on one side	Ŵ	RYMOVEMENT
		2. Limitation on both sides a.Neck b.Arm—including shoulder or c.Hand—including wrist or fing	2. Full loss	(A) (B
		d. Leg—Including hip or knee e. Foot—Including ankle or toe f. Other limitation or loss	6	
36.	MODES OF TRANSFER	(Check all that apply during la Bedfast all or most of time Bed rails used for bed mobility or transfer	ast 7 days)	OVE
H1.	(Code for resi	SELF-CONTROL CATEGOR dent's PERFORMANCE OVE	R ALL SHIFTS)	
	device that	T—Complete control [includes does not leak urine or stool]	use or moweanly unnery	
	1. USUALLY C	ONTINENT-BLADDER, inco is than weekly	ntinent episodes once a	01-02-0
	1. USUALLY C BOWEL, les 2. OCCASION BOWEL, on 3. FREQUEN	ONTINENT-BLADDER, inco is than weekly IALLY INCONTINENT-BLADD ce a week TLY INCONTINENT-BLADDE	DER, 2 or more times a R, tended to be incontin	week or less; week but not daily;
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b.	1. USUALD'C BOWEL, let 2. OCCASION BOWEL, on 3. FREQUEN control pres 4. INCONTINI BOWEL, all BOWEL, all BOWEL CONTI- NENCE BLADDER CONTI-	CONTINENT—BLADDER, inco is than weekly IALLY INCONTINENT—BLADI ce a weekl TLY INCONTINENT—BLADDE rul (e.g., on day shift); BOWEL, Control of bowel moyem Control of bowel moyem programs, if employed	DER, 2 or more times a v R, tended to be incontin 2-3 times a week BLADDER, multiple daily ith appliance or bowel or son (if dribbles, volume)	week or less; week but not delly; ent delly, but some repisodes; ontinence insufficient to or continence
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b. 12.	1. USUALEY C BOWEL, let 2. OCCASION BOWEL 01 3. FREQUEN control pres 4. NCONTIN- BOWEL 01 BOWEL 01 BOWEL CONTI- NENCE BLADDER CONTI- NENCE BLADDER CONTI- NENCE BLADDER CONTI- NENCE BLADDER CONTI- NENCE	ONTIVENT—BLADDER, inco is than weekly ALLY INCONTINENT—BLADD ce a week TV INCONTINENT—BLADD ent (e.g., on day shift); BOWEL, INT—Had in adequate control B (or almost all) of the time Control of the time Control of bowel movement, w programs, if employed Control of uniary bladder func- pack through underpants), with programs, if employed Fecal impaction Any scheduled toileting plan Bladder retraining program Extern al (condom) cath eter	DER, 2 or more times a v R, tended to be incontin 2-3 times a week BLADDER, multiple daily ith appliance or bowel or ton (if dribbles, volume in happliances (e.g., folley) d. NONE OF ABC a. Indwelling cathe	week or less; week but not delly; ent daily, but some repisodes; ontinence or continence DVE e. eter t t t L DVE
b. H2.	1. USUALEY C BOWEL, let 2. OCCASION BOWEL on 3. FREQUEN control pres 4. INCONTINI BOWEL, all BOWEL, all BOWEL, all BOWEL, all BOWEL, all BOWEL BLADDER CONTI- NENCE BLADDER CONTI- NENCE BLADDER CONTI- NENCE BLADDER CONTI- NENCE BLADDER CONTI- NENCE BLADDER CONTI- NENCE BLADDER CONTI- NENCE BLADDER CONTI- NENCE BLADDER CONTI- NENCE	ONTIVENT—BLADDER, inco is than weekly ALLY INCONTINENT—BLADI ce a week TLY INCONTINENT—BLADI ce a week TLY INCONTINENT—BLADDE TLY INCONTINENT—BLADDE (or almost all of the time Control of bowel movement, w programs, if employed Control of uninary bladder func seak through underpants), with programs, if employed Control of uninary bladder func seak through underpants), with programs, if employed Fecal impaction Any scheduled toileting plan Bladder retraining program External (condom) catheter	DER, 2 or more times a v R, tended to be incontin 2-3 times a week BLADDER, multiple daily ith appliance or bowel or son (if dribbles, volume in h appliances (e.g., folley) d. NONE OF ABC b. Ostomy presen c. NONE OF ABC UNIC OF ABC L NONE OF ABC C. NONE OF ABC C. NONE OF ABC C. NONE OF ABC	week or less; week but not delly; ent dally, but some repisodes; ontinence nsufficient to or continence DVE e. eter t t L DVE m. 90 days that have a m.
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b. 12. 13. 13.	1. USUAL DY C BOWEL, let BOWEL, let BOWEL and BOWEL AND PROBLEM CONDITIONS	ONTIVENT—BLADDER, inco is than weekly ALLY INCONTINENT—BLADD ce a week ITY INCONTINENT—BLADD ent (e.g., on day shift); BOWEL, ITY INCONTINENT—BLADDE ent (e.g., on day shift); BOWEL, ITY INCONTINENT—BLADDE (Control of the time Control of the time Control of bowel movement, w programs, if employed Fecal impaction Any scheduled toileting plan Bladder retraining program External (condom) catheter Urinary tractinification In last 30 days (Include only those diseases include only those diseases phydrated; output exceeds input	DER, 2 or more times a v R, tended to be incontin 2-3 times a week BLADDER, multiple daily ith appliance or bowel or iton (if bibles, volume in happliances (e.g., foley) d. NONE OF ABC a. Indeveling cathe b. Ostorny presen c. NONE OF ABC (dagno edin the last in tontoring, or isk of dati in last 7 days) Hallucinations NONE OF ABC	week or less; week but not deily; ent daily, but some repisodes; ontinence insufficient to or continence DVE e. ater d. L DVE m. 90 days that have a tood or behavior status; 1             DVE DVE p. DVE p.
b. H2. H3.	1. USUAL DY C BOWEL, let 2. OCCASION BOWEL on 3. FREQUEN control pres 4. INCONTINI BOWEL, all BOWEL, all BOWEL, all BOWEL, all BOWEL, all BOWEL, all BOWEL, all BOWEL E BLADDER CONTI- NENCE BLADDER CONTI- NENCE BLADDER CONTI- NENCE BLADDER CONTI- NENCE BLADDER CONTI- NENCE BLADDER CONTI- NENCE BLADDER CONTI- NENCE BLADDER CONTI- NENCE BLADDER CONTI- NENCE BLADDER CONTI- NENCE AND ICD-9 CODES PROBLEM	ONTIVENT—BLADDER, incos is than weekly ALLY INCONTINENT—BLADDE ce a week IVY INCONTINENT—BLADDE ent (e.g., on day shift); BOWEL, ENT—Had in adequate control E (or almost all) of the time Control of bowel movement, w programs, if employed Control of bowel movement, w programs, if employed Control of bowel movement, w programs, if employed Fecal impaction Extern al (condom) cath eter Urinary tractinitiction in last 30 days (Include only those diseases (Include only those diseases) Dehrydrated; output exceeds Input (Code the highest level of pain a. FREQUENCY with which resident complains or shows evidence of pain	DER, 2 or more times a v R, tended to be incontin 2-3 times a week BLADDER, multiple daily ith appliance or bowel or iton (if bibles, volume in happliances (e.g., foley) d. NONE OF ABC a. Indeveling cathe b. Ostorny presen c. NONE OF ABC (dagno edin the last in tontoring, or isk of dati in last 7 days) Hallucinations NONE OF ABC	week or less; week but not deily; ent daily, but some repisodes; ontinence or continence DVE e. e. otter d. t. DVE m. 90 days that have a socod or behavior status, 0 1 1 1 1 1 1 1 1 1 1 1 1 1
b. H2. H3. I3.	1. USUALEY C BOMEL, let BOMEL and BOWEL and BOWEL and BOWEL all BOWEL all BOWEL all BOWEL all BOWEL all BOWEL all BOWEL B BOWEL B BOWEL B BOWEL B BOWEL B BOWEL B BOWEL B BOWEL B BOWEL B BOWEL B AND ICD-9 CODES PROBLEM CONDITIONS PAIN	ONTIVENT—BLADDER, inco is than weekly ALLY INCONTINENT—BLADD ce a week I'LY INCONTINENT—BLADD ent (e.g., on day shift); BOWEL, I'LY INCONTINENT—BLADDE ent (Control of the time Control of the time Control of bowel movement, w programs, if employed Control of bowel movement, w programs, if employed Fecal impaction Any scheduled toileting plan Bladder retraining program External (condom) catheter Urinary tractinification in last 30 days Include only those difeesans medical treatments, nursing m a b C(Deck all problems present Dehydrated; output exceeds input (Code the highest level of pa a, FREQUENCY with which resident complains or	DER, 2 or more times a v R, tended to be incontin 2-3 times a week BLADDER, multiple daily ith appliance or bowel or ton (if dribbles, volume in happliances (e.g., foley) d. NONE OF ABC a. Indwelling cathle b. Ostomy presen c. NONE OF ABC (in Just 7 days) thatus cognitive status m c. NONE OF ABC (in Just 7 days) Halucinations b. IN TENSITY ( 1. Mild pain	week or less; week but not daily; ent daily, but some repisodes; ontinence or continence DVE e. ater t L DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE m. DVE M. DVE M. DVE DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE M. DVE DVE M. DVE M. DVE DVE DVE DVE DVE DVE DVE DVE DV

J5.	STABILITY	Conditionskliseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating)							
	CONDITIONS	Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem	b.						
		End-stage disease, 6 or fewer months to live	c						
		NONE OF ABOVE	d						
K3.		a.Weight loss—6 % or more in last 30 days; or 10 % or more in last	a.						
nj.	CHANGE	180 days O.No 1.Yes							
		b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days							
		0.No 1.Yes							
K5.	NUTRI-	Feeding tube	b.						
	TIONAL APPROACH- ES	On a planned weight change program NONE OF ABOVE	h.						
M1.	ULCERS		1.						
W14.	(Due to any	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during <b>last 7 days</b> . Code 9 = 9 or more.) <b>[Requires full body exam.]</b>	Number at Stage						
	cause)	a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.							
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.							
		c, Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.							
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.							
M2.	TYPE OF ULCER	(For each type of ulcar, code for the highest stage in the last 7 days scale in item M1—i.e., 0=none; stages 1, 2, 3, 4) a. Pressure ulcer—any lesion caused by pressure resulting in damage							
		of underlying tissue b. Stasis ulcer-open lesion caused by poor circulation in the lower	<u> </u>						
		extremites							
N1.	TIME	(Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:							
		Afternaan b. NONE OF ABOVE	e.						
11f -	neident is co	matose, skip to Section O)	Tre.						
N2.		(When awake and not receiving treatments or ADL care)							
112	TIME INVOLVED IN ACTIVITIES	0. Most-more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None							
01.	NUMBER OF MEDICA- TIONS	(Record the number of different medications used in the last 7 days enter "0" if none used)							
04.	DAYS	(Record the number of DAVS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly)							
	THE FOLLOWING MEDICATION	a. Antipsychotic d. Hypnotic b. Antianxiety e. Diuretic							
		c. Antidepressant							
P4.	DEVICES AND RESTRAINTS	Use the following codes for last 7 days: 0. Not used 1. Used less than daily 2. Used daily	Ì						
	04.444.0444.444.44	Bedrails							
		<ul> <li>a. — Full bed rails on all open sides of bed</li> <li>b. — Other types of side rails used (e.g., half rail, one side)</li> </ul>	-						
		c. Trunk restraint							
		d. Limb restraint							
		e. Chair prevents rising	_						
Q2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less							
	ALL HELDS	0. No change 1. Improved—receives lawer 2. Deteriorated—receives supports, needs less more support restrictive level of care							
R2.	SIGNATURE	OF PERSON COORDINATING THE ASSESSMENT:							
a .S	ignature of RN	Assessment Coordinator (sign on above line)							
	S	ment Coordinator							

Numeric	Identifier
THUI INDIA	Parentinet.

Resident

# MINIMUM DATA SET (MDS) - VERSION 2.0

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

### SECTION W. SUPPLEMENTAL MDS ITEMS

 1.
 National Provider ID
 Enter for all assessments and tracking forms, if available.

 1f the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.

 2.
 Influenza Vaccine

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

 0.
 No (If No, go to item W2b)

 1.
 Yes (If Yes, go to item W2b)

 1.
 Not in facility during this year's flu season 2.

 2.
 Influenza vaccine not received, state reason: 1.

 1.
 Not in facility during this year's flu season 2.

 2.
 Influenza vaccine not received, state reason: 1.

 3.
 Pneumococcal Vaccine

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

 0.
 No (If No, go to item W3b)

 1.
 Yes (If Yes, skip item W3b)

 b.
 If IPPV not received, state reason: 1.

 1.
 Yes (If Yes, skip item W3b)

 b.
 If IPPV not received, state reason: 1.

 1.
 Yes (If Yes, skip item W3b)

 b.
 If IPPV not received, state reason: 1.

 1.
 Yes (If Yes, skip item W3b)

MDS 2.0 May, 2005

A1.	(OP1	TERLY ASSESSMENT FORM FIONAL VERSION FOR RUG-III)	E1.	OF DEPRES-	OF DISTRESS	Repetitive health complaints—e.g., persistently seeks medical
A1.	NAME	a. (First) b. (Middle Initial) C. (Last) d. (Jr/Sr)		SION, ANXIETY, SAD MOOD	statements—e.g., "Nothing matters; Would rather be	attention, obsessive concern with body functions
A2.	ROOM				Regrets having lived so	Repetitive anxious complaints/concerns (non- health related) e.g., persistently seeks attention/
A3.	ASSESS- MENT REFERENCE	a. Last day of MDS observation period			"Where do I go; What do I	reassurance regarding schedules, meals, laundry, clothing, relationship issues
	DATE	Month Day Year b. Original (0) or corrected copy of form (enter number of correction)			e.g., calling out for help, ("God help me") j. (	EEP-CYCLE ISSUES Unpleasant mood in mornin
A4.	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)			d. Persistent anger with self or others—e.g., easily	Insomnia/change in usual sleep pattern ND, APATHETIC, AN XIOUS
		Month Day Year			placement in nursing home; anger at care received	APPEARANCE Sad, pained, worried facial expressions—e.g., furrowed
A6.	RECORD				am nothing; I am of no use to anyone" m.	Crying, tearfulness
B1.	NO. COMATOSE	(Persistent vegetative state/ho discernible consciousness) 0.No 1.Yes (Skip to Section G)			fears—e.g., fear of being	Repetitive physical movements—e.g., pacing, hand wringing, restessness
B2.	MEMORY	(Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem			g. Recurrent statements that	fidgeting, picking ISS OF INTEREST
		b. Long-term memory OKseems/appears to recall long past 0. Memory OK 1. Memory problem			to happen—e.g., believes in the or she is about to die,	With drawal from activities of nterest—e.g., no interest in ong standing activities or being with family/friends
B3.	MEMORY/ RECALL	(Check all that resident was normally able to recall during fast 7 days)	L		p.1	Reduced social interaction
	ABILITY	Current season a. Location of own room b. Staffnames/faces c. NONE OF ABOVE are recalled e.	E2.	MOOD PERSIS- TENCE	One or more indicators of depressed, sa not easily altered by attempts to "cheer the resident over last 7 days [0. No mood 1. indicators present, 2	up", console, or reassure indicators present,
B4.	COGNITIVE	(Made decisions regarding tasks of daily life)	FA	DELIANAODAL	indicators easily altered	not easily altered
	DAILY DECISION- MAKING	0. INDEPENDENT—decisions consistent/reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only . MODERATELY IMPAIRED—decisions poor; cues/supervision	E4.	SYMPTOMS	(A) Behavioral symptom frequency in la 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 d 2. Behavior of this type occurred 4 to 6 d 3. Behavior of this type occurred daily	days in last 7 days
86	INDICATORS	required 3. SEVERELY IMPA/RED—never/rarely made decisions (Code for behavior in the fast 7 days.) [Note: Accurate assessment			(B) Behavioral symptom alterability in la 0. Behavior not present OR behavior wa 1. Behavior was not easily altered	ist 7 days as easily altered (/
вэ.	OF DELIRIUM- PERIODIC	requires conversations with staff and family who have direct knowledge of resident's behavior over this time].			<ul> <li>a. WANDERING (moved with no rational p oblivious to needs or safety)</li> </ul>	and the second se
	DISOR- DERED THINKING/	0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)			b. VERBALLY ABUSIVE BEHAVIORAL S were threatened, screamed at, cursed a c, PHYSICALLY ABUSIVE BEHAVIORAL	at)
	AWARENESS	a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)			were hit, shoved, scratched, sexually ab d. SOCIALLY INAPPROPRIATE/DISRUP	used) TIVE BEHAVIORAL
		b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)			SYMPTOMS (made disruptive sounds, self-abusive acts, sexual behavior or dis smeared/threw food/faces, hoarding, run belongings)	vobing in public,
		c, EPISODES OF DISORGANIZED SPEECH-(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to	_		e. RESISTS CARE (resisted taking medic assistance, or eating)	0 V V
		subject; loses train of thought) d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)	G1.		F-PERFORMANCE—(Code for resident's I furing last 7 days—Not including setup) IDENT—No help or oversight —OR— Help	
		e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)		1. SUPERVI	ISION—Oversight, encouragement or cueir ISION—Oversight, encouragement or cueir ISION— Supervision (3 or more times) plut	ng provided 3 or more times s physical assistance provid
		f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)		2. LIMITED guided ma	es during last 7 days ASSISTANCE—Resident highly involved in aneuvering of limbs or other nonweight bear	ing assistance 3 or more tin
<b>G</b> .	MAKING SELF UNDER- STOOD	(Expressing internation content—dwaver able) 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty linding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELYMEVZER UNDERSTOOD		3. EXTENSI period, he —Weight — Full sta	e help provided only 1 or 2 times during last INE ASSISTANCE—While resident perform jo of following type(s) provided 3 or more tim bearing support iff performance during part (but not all) of last EPENDENCE—Full staff performance of ac	ed part of activity, over last nes: at 7 days
	the second se	(Understanding verbal information content—however able)			V DID NOT OCCUR during entire 7 days	S 10 (0)
C6,	ABILITY TO	1 The second		(B) ADI SUP	PORT PROVIDED-(Code for MOST SUF	PORTPROVIDED
C6.	ABILITY TO UNDER- STAND OTHERS	0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part/intent of message S. SUMETIMES UNDERSTANDS—research adequately to simple		OVER AL	L SHIFTS during last 7 days; code regard new classification)	ILESS of resident's self Lactivity itself did not cur during entire 7 days
	UNDER- STAND OTHERS	1. USUALLY UNDERSTANDS—may miss some part/intent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RAREL/INVEVER UNDERSTANDS		OVER AL performan 0. No setup o 1. Setup help	nce classification) or physical help from staff o only on physical assist 8. AD	dless of resident's self
	UNDER- STAND	1. USUALLY UNDERSTANDS—may miss some part/intent of mescage 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELYNEVER UNDERSTANDS	a	OVER AL performan 0. No setup o 1. Setup help 2. One perso	nce classification) or physical help from staff o only on physical assist 8. AD	diess of resident's self Lactivity itself did not sur during entire 7 days

_	Resident		and the second s		ifier	10	10	_
G1.		(A) (B)	H3.	APPLIANCES	Any scheduled toileting plan	8.	Indwelling catheter	T
c.	ROOM	How resident walks between locations in his/her room		PROGRAMS	Bladder retraining program		Ostomy present	L
d.	WALK IN CORRIDOR	How resident walks in corridor on unit			External (condom) catheter	6	NONE OF ABOVE	ľ
e.	LOCOMO- TION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	mo		status, medical treatments, no		current ADL status, cognitive sta onitoring, or risk of death. (Do not	
f.	LOCOMO-	How resident moves to and returns from off unit locations (e.g.,	11.	DISEASES	(If none apply, CHECK the I	NONE C	F ABOVE box	٦
1	TION OFF UNIT	areas set aside for dining, activities, or treatments). If facility has			MUSCULOSKELETAL		Multiple sclerosis	1
_	OFFUNIT	only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair			Hip fracture	m.	Quadriplegia	1
g.	DRESSING	How resident puts on, fastens, and takes off all items of street			NEUROLOGICAL		PSYCHIATRIC/MOOD	
Ĩ.		clothing, including donning/removing prosthesis			Aphasia	r.	Depression	ļ
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of			Cerebral palsy		Manic depressive (bipolar	ł
		nourishment by other means (e.g., tube feeding, total parenteral nutrition)			Cerebrovascular accident (stroke)	-	disease)	
i.	TOILETUSE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or			Hemiplegia/Hemiparesis	L.	NONE OF ABOVE	
		catheter, adjusts clothes	12.	INFECTIONS	(If none apply, CHECK the I	V.		+
I.	PERSONAL	How resident maintains personal hygiene, including combing hair,	1.2.	III EC HOILD			Septicemia	
1	HYGIENE	brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)			Antibiotic resistant infection (e.g., Methicillin resistant		Sexually transmitted diseases	1
_					staph)	-	Tuberculosis	
G2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.)			Clostndium difficile (c. diff.)	b.	1000 V 10000 V 1000	ał
		Code for most dependent in self-performance. (A) BATHING SELF PERFORMANCE codes appear below			Conjunctivitis	c.	Urinary tract infection in last 30 days	"
					HIV infection	d.	Viral hepatitis	I
		0. Independent—No help provided			Pneumonia		Wound infection	t
		1. Supervision—Oversight help only			Respiratory infection		NONE OF ABOVE	t
		2. Physical help limited to transfer only	13.	OTHER	(Include only those disease	s diagn	osed in the last 90 days that ha	avi
		<ol><li>Physical help in part of bathing activity</li></ol>	1.3.	OTHER	relationship to current ADL	status, c	ognitive status, mood or behavior	rs
		4. Total dependence		DIAGNOSES AND ICD-9	medical treatments, nursing r	nomitorii	ng, or risk of death)	
		<ol> <li>Activity itself did not occur during entire 7 days</li> </ol>		CODES	-		E E E E	
G3.	TESTFOR	(Code for ability during test in the last 7 days)		1.00000000000000	a			1
1	BALANCE	0. Maintained position as required in test	-		b.	A Lo Baral		•
	(see training	<ol> <li>Unsteady, but able to rebalance self without physical support</li> <li>Partial physical support during test;</li> </ol>	J1.	PROBLEM		it in last	7 days unless other time frame i	15
	manual)	or stands (sits) but does not follow directions for test		Conditional	INDICATORS OF FLUID		OTHER	
		3. Not able to attempt test without physical help			STATUS		Delusions	1
		a. Balance while standing			Weight gain or loss of 3 or		Edema	t
_		b. Balance while sitting—position, trunk control			more pounds within a 7 day		Fever	5
G4.	LIMITATION	(Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury)			period	8.	Hallucinations	ľ
	IN RANGE OF	(A) RANGE OF MOTION (B) VOLUNTARY MOVEMENT			Inability to lie flat due to		Internal bleeding	E
	MOTION	0. No limitation 0. No loss			shortness of breath	b.	Recurrentlung aspirations in	f
		1. Limitation on one side 1. Partial loss 2. Limitation on both sides 2. Full loss (A) (B)			Dehydrated; output exceeds		last 90 days	5
		a. Neck			input	c.	Shortness of breath	Į.
		b. Arm—Including shoulder or elbow			Insufficient fuid; did NOT		Unsteady gait	t
		c. Hand—Including wrist or fingers			consume all/almost all liquids provided during last 3 days		Vomiting	t
		d. Leg-Including hip or knee					NONE OF ABOVE	t
		e. Foot-Including ankle or toes	J2	PAIN	(Code the highest level of p	ainores		Ť
		f. Other limitation or loss	1º2	SYMPTOMS	in an			
G6.	MODES OF	(Check all that apply during last 7 days)			a. FREQUENCY with which resident complains or		b. INTENSITY of pain	1
<b>0</b> 0.	TRANSFER				shows evidence of pain	_	1. Mild pain	
		Bedfast all or most of time a. NONE OF ABOVE f.			0. No pain (skip to J4)		2. Moderate pain	
		Bed rails used for bed mobility or transfer b.			1. Pain less than daily		3. Times when pain is horrible	
G7.	TASK	Some or all of ADL activities were broken into subtasks during last 7			2. Pain daily		orexcrutiating	
1.1.1	SEGMENTA-	days so that resident could perform them	J4.	ACCIDENTS	(Check all that apply)		Hip fracture in last 180 days	1
H1.	TION	0, Ño 1, Yes E SELF-CONTROL CATEGORIES		0.00	Fell in past 30 days	a.	Other fracture in last 180 days	s l
		ident's PERFORMANCE OVER ALL SHIFTS)			Fell in past 31-180 days	b.	NONE OF ABOVE	t
	n Nacionale a subsection de la composición		J5.	STABILITY	Conditions/diseases make re	sident's	cognitive, ADL, mood or behavio	x I
	u. CONTINEN device that	IT—Complete control jincludes use of indwalling urinary catheter or ostomy does not leak urine or stool]		OF	status unstable—(fluctuating,	precario	ous, or deteriorating)	4
		CONTINENT-BLADDER, incontinent episodes once a week or less;		CONDITIONS	Resident experiencing an act chronic problem	rte episo	ode or a flare-up of a recurrent or	
		ss than weekly			End-stage disease, 6 or fewe	month	s to live	1
	2 0004500	VALLY INCONTINENT-BLADDER, 2 or more times a week but not daily;			NONE OF ABOVE	- materials		ľ
	BOWEL, or	the a week	K1.	ORAL	Chevingproblem			+
		TV BOOMTRIDET DI ADDED Lock de la la la la la la la	n.	PROBLEMS	Swallowingproblem			ľ
	control pres	TLY INCONTINENT—BLADDER, tended to be incontinent daily, but some sent (e.g., on day shift); BOWEL, 2-3 times a week			NONE OF ABOVE			ľ
		an de Telenen de la deservición de la compacta come en entre compacta de	K2.	HEIGHT	the second s	and (h	) weight in pounds. Base weigh	te
	4. INCONTIN	ENT-Had inadequate control BLADDER, multiple daily episodes; (or almost all) of the time	ne.	AND	recent measure in last 30 da	ys;mea	sure weight consistently in accord	d
a	BOWEL, an			WEIGHT	standard facility practice—e.g off and in nightclothes	in a.m	n after voiding, before meal, with s	sh
a	CONTI-	Control of bowel movement, with appliance or bowel continence programs, if employed			and and an ingenticionities		17.00	ſ
_	NENCE		КЗ.	MITTON	a Weight loss 5 % or mark	COLUMN TWO IS NOT	HT (h) b, WT (b) 30 days; or 10 % or more in last	h
b.	BLADDER CONTI- NENCE	Control of uninary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	K3.	WEIGHT	180 days 0.No 1.Ye		av days, or no stor more in last	
					and the second		00 days	1
H2.	BOWEL	Diamhea NONE OF ABOVE			in averging gam - o whot more	in idst.	30 days; or 10 % or more in last	1 J.
12.	ELIMINATION PATTERN	C			180 days 0 No. 1 Ye		30 days; or 10 % or more in last	

	Resident				Numeric Identifier								
K5.	NUTRI-	(Check all that apply in last	7 day	\$)		P1.		a. SPECIAL CARE—Check	reatmen	nts or programs recei	ved dur	ing	
	TIONAL	Parenteral/IV	a.	On a planned weight change		[ ]	TREAT- MENTS,	the last 14 days				<u> </u>	
	APPROACH- ES	F		program	h.	1	PROCE-	TREATMENTS		Ventilator or respira	tor		
		Feedingtube	D.	NONE OF ABOVE	i	1	DURES, AND PROGRAMS	Chemotherapy		PROGRAMS		L	
M1.	ULCERS	(Record the number of ulcers a	t each	ulcer stage—regardless of	ge	1	PROGRAMIS	Dialysis	a.	and a second			
	(Due to any	cause. If none present at a stag during last 7 days. Code 9 = 9	e, recc or mor	ord "0" (zero). Code all that apply e.) [Requires full body exam.]	Number at Stage	1		IV medication	b.	Alcohol/drugtreatn program	ient		
	cause)				at	1		Intake/output	<u>с.</u>	Alzheimer's/demer	tia sne	cial F	m
		<ul> <li>a. Stage 1. A persistent area of skin) that does not</li> </ul>		edness (without a break in the ear when pressure is relieved.		1			d.	care unit	au spe	Ŀ	n.
		b. Stage 2. A partial thickness				1		Monitoring acute medical condition	ė.	Hospice care		4	D.
		clinically as an abra	ision, b	blister, or shallow crater.		1		Ostomy care	f.	Pediatric unit		þ	p
		c. Stage 3. A full thickness of s	kin is lo	ost, exposing the subcutaneous		1		Oxygen therapy	a.	Respite care		4	q.
		tissues - presents a undermining adjace	sade	ep crater with or without		1		Radiation	h.	Training in skills rec return to the comm			
		d. Stage 4. A full thickness of s				1		Suctioning	i	taking medications	house		с. —
		exposing muscle or		subcutarieous tissue is lost,		1		Tracheostomy care	1	<ul> <li>work, shopping, tra ADLs)</li> </ul>	nsporta	ation,	
M2.	TYPE OF	(For each type of ulcer, code for	or the l	highest stage in the last 7 days		1		Transfusions	k	NONE OF ABOVE		,	
	ULCER	using scale in item M1—i.e.,				1		b. THERAPIES - Record th	e numbe	er of days and total	minute	s each	of
		<ul> <li>Pressure ulcer—any lesion of underlying tissue</li> </ul>	aused	by pressure resulting in damage		1		the following therapies w in the last 7 calendar da	as admi	nistered (for at least	15 mi	nutes a	a day)
		b. Stasis ulcer—open lesion ca	uradh	upper circulation in the lower		1		[Note-count only post	admiss	sion therapies]			
		extremities	usead	y poor circulation in the lower		1		(A) = # of days administere	d for 15	minutes or more	DAYS	MIN	
M4.	OTHER SKIN	(Check all that apply during la	st 7 da	iys)		1		(B) = total # of minutes pro			(A)	(B	<u> </u>
	PROBLEMS OR LESIONS	Abrasions, bruises			а.			a. Speech - language pathol	ogy and	audiology services	$\vdash$	+	++
	PRESENT	Burns (second or third degree)			b.	1		b. Occupational therapy			$\square$	$\square$	
		Open lesions other than ulcers,			c.	1		c. Physical therapy					
		And the state of t		g rash, heat rash, herpes zoster	d.	1		d. Respiratory therapy					
		Skin desensitized to pain or pre Skin tears or cuts (other than su			e.	1		e. Psychological therapy (by	any lice	insed mental		+	+
		Surgical wounds	igery)		a.			health professional)				_	
		NONE OF ABOVE			5	P3.	NURSING REHABILITA-	Record the NUMBER OF D restorative techniques or pri					
M5.	SKIN	(Check all that apply during la	ast 7 d	ays)	12	1	TION/	more than or equal to 15 n	ninutes	per day in the last	7 day	S	`
	TREAT- MENTS	Pressure relieving device(s) for	chair		a.	1	RESTOR- ATIVE CARE	(Enter 0 if none or less than a. Range of motion (passive)	15 min.	1			
	WEN 15	Pressure relieving device(s) for	bed		b.	1	ALL OF THE	b. Range of motion (active)	-	f. Walking		ŀ	_
		Turning/repositioning program			c.	1		c. Splint or brace assistance		g. Dressing or groo	-	ł	_
		Nutrition or hydration intervention	on to m	anage skin problems	d.	1		TRAINING AND SKILL		h. Eating or swallow			
		Ulcer care Surgical wound care			e.	1		PRACTICE IN:		i. Amputation/pros	thesis	are	_
			rwitho	ut topical medications) other than	f.	1		d. Bed mobility		j. Communication		- F	_
		to feet	witho	ut topical medications) other than	g			e. Transfer Use the following codes for	act 7 d	k. Other		_	
		Application of ointments/medic	ations	(other than to feet)	n	P4.	DEVICES AND RESTRAINTS		asi / u	ays.			
		Other preventative or protective	skin c	are (other than to feet)	L		RESTRAINTS	<ol> <li>Used less than daily</li> <li>Used daily</li> </ol>					
		NONE OF ABOVE		(= +=)	j.			Bed rails				_	
M6.	FOOT PROBLEMS	(Check all that apply during l						a. — Full bed rails on all ope	n sides	ofbed		_ <b>Г</b>	
	AND CARE	Resident has one or more foot bunions, hammer toes, overlap	problet ping to	ns—e.g., corns, callouses, es, pain, structural problems				b. — Other types of side rail	s used (	e.g., halfrail, one side	e)	t t	
		Infection of the foot-e.g., cellul	itis, pu	rulent drainage	h.			c. Trunk restraint				_ [	
		Open lesions on the foot			c.			d. Limb restraint					
		Nails/calluses trimmed during la	ast 90	days	d.			e. Chair prevents rising				$\rightarrow$	
		Received preventative or prote	ctive fo	ot care (e.g., used special shoes,		P7.	PHYSICIAN VISITS	In the LAST 14 DAYS (or sine facility) how many days has the	ce admis	ssion if less than 14 d	lays in sistant	or	
		inserts, pads, toe separators) Application of dressings (with o	rwitho	ut topical medications)	1.		TION	facility) how many days has the practitioner) examined the res					
		NONE OF ABOVE		an capital file decidency		P8.	PHYSICIAN	In the LAST 14 DAYS (or sin				~	
N1.	TIME	(Check appropriate time peri	ods ou	ver last 7 days)	9-		ORDERS	facility) how many days has the practitioner) changed the resi	dent's or	ders? Do not include	order	ч I	
POL.	AWAKE	Resident awake all or most of til	me (i.e	, naps no more than one hour		_	Concernance of the	renewals without change. (Er			10		
		per time period) in the: Morning	Even	ing	c.	Q2.	OVERALL CHANGE IN	Resident's overall level of self compared to status of 90 day	sufficient s ago (o	rcy has changed sign or since last assessm	ent if le	yas ss	
		Afternoon b.	NON	E OF ABOVE	d.		CARE NEEDS	than 90 days)					
(lf r	esident is co	matose, skip to Section C				1		0. No change 1. Improved- supports, ne	eds less	s more supp		erves	
N2.		(When awake and not receivi	ng trea	atments or ADL care)		P2	SIGNATURE	restrictive le OF PERSON COORDINATIN					
	TIME INVOLVED IN	0. Most-more than 2/3 of time		2. Little—less than 1/3 of time		^{R2.}	JUNATORE	OF PERSON COORDINATIN	SINC/	AGGEGGI/IEN I.			
	ACTIVITIES	1. Some-from 1/3 to 2/3 of tim	e :	3. None									
01.	NUMBER OF MEDICA-	(Record the number of diffen enter "0" if none used)	e <b>nt</b> me	dications used in the last 7 days,			5	Assessment Coordinator (sign	on abov	/e line)			
	TIONS						ate RN Assess igned as comple	ment Coordinator	$-\Gamma$				
03.	INJECTIONS	(Record the number of DAYS	injecti	ons of any type received during		*	gricu as compl	Month	- L-	Day Y	/ear		
<u></u>	DAVID	the last 7 days; enter "0" if non (Record the number of DAYS)											
04.	DAYS RECEIVED	used. Note—enter "1" for long-	acting	meds used less than weekly)									
	THE FOLLOWING	a. Antipsychotic		d. Hypnotic									
	MEDICATION			e. Diuretic	$\vdash$								
		c. Antidepressant		C. Dialeac									

N	um	101	íc	Id	en	ti	fier

Resident

# MINIMUM DATA SET (MDS) - VERSION 2.0

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

#### SECTION W. SUPPLEMENTAL MDS ITEMS

 
 1.
 National Provider ID
 Enter for all assessments and tracking forms, if available.

 1f the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.

 2.
 Influenza Vaccine
 a. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)?

 0.
 No (If No, go to item W2b) 1. Yes (If Yes, go to item W3)

 b.
 If Influenza vaccine not received, state reason: 1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible

 3.
 Pneumococcal Vaccine
 a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b)

 b.
 If IPPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered

 a.
 Is the resident's PPV status up to date? 0. No (If No, go to item W3b)

 b.
 If IPPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered

MDS 2.0 May, 2005

M	OS QUART (OPT	TERLY ASSESSMENT FORM TIONAL VERSION FOR RUG-III 1997 Update)	1	Numeric Ident			_
41. 42. 43. 44a 81.	(OPT RESIDENT NAME ROOM NUMBER ASSESS- MENT REFERENCE DATE OF REENTRY MEDICAL RECORD NO. COMATOSE	Month Day Year b. Original (0) or corrected copy of form (enter number of correction) 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)	E1.		VERBAL EXPRESSIONS       h. Repetitive health complaints—e.g., "Nothing matters: Would rather be dead, What's the use; Regrets having lived so long; Let me de'       h. Repetitive health complaints—e.g., "persistently seeks medical attention, obsessive concern with body functions         b. Repetitive questions—e.g., "Where do go: What do 1 do?       i. Repetitive newsitics complaints—essist extension long; Let me de'         c. Repetitive questions—e.g., "Where do go: What do 1 do?       i. Repetitive newsitics complaints—essist extension reassurance regarding "What do 1 go: What do 1 do?         d. Resistent anger with self or others—e.g., easily annoyed; anger at placement in unsing home; anger at care received to anyone"       j. Unpleasant mood in mornin sleep pattern shows         SAD, APATHETIC, ANXIOUS APPEARANCE       SAD, APATHETIC, ANXIOUS APPEARANCE         f. Expressions of what appearto be unrealistic       m. Repetitive physical	/	
32.	MEMORY/	(Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem (Check all that resident was normally able to recall during			fears—e.g., fear of being abandoned, left alone, being with others         movements—e.g., pading, hand wringing, restlessness fidgeting, picking           g. Recurrent statements that something terrible is about to happen	f	
	ABILITY	Jast 7 days)     a.       Current season     a.       Location of own room     b.       Staffnames/faces     c.       NONE OF ABOVE are recalled     e.	E2.	MOOD PERSIS- TENCE	Dengwan amayimentos p. Reduced social interaction 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	e	
B4. B5.	COGNITIVE SKILLS FOR DALLY DECISION- MAKING INDICATORS OF DELIRUIM- PERIODIC DISOR- DERED THINKING/ AWARENESS	(Made decisions regarding tasks of daily life) 0. INDEPENDENT—decisions consistent/reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required 3. SEVERELY IMPAIRED—never/arely made decisions (Code for behavior in the last 7 days) (Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time]. 0. Behavior not present 1. Behavior present, over last 7 days appears different from resident's usual 2. Behavior present, over last 7 days appears different from resident's usual		(A) ADL SELF SHIFTS d 0. INDEPEN during last 1. SUPERVI last7 days 1 or 2 time 2. LIMITED.	0. No mood     1. Indicators present,     2. Indicators present,     indicators assignment,     2. Indicators present,     indicators assignment,     2. Indicators present,     assignment,     2. Indicators present,     assignment,     2. Indicators present,     2. Indicators,     2. Indit,     2. Indit,     2	LLL s durin ded or	ig nly
C6.	SELF UNDER- STOOD ABILITY TO UNDER- STAND	0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETINIES UNDERSTOOD—ability is limited to making concrete requests 3. RARELYNEVER UNDERSTOOD (Understanding verbal information content—however able) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some part/intent of		OR-Mon 3. EXTENSI period, hel 	heuvening offinns or other nonweignit bearing assistance 3 of more un help provided only 1 or 2 times during last 7 days VE ASS/STAVCE—While resident performed part of activity, over last p of following type(s) provided 3 or more times: bearing support fiperformance during part (but not all) of last 7 days EPENDENCE—Full staff performance of activity during entire 7 days DID NOT OCCUR during entire 7 days	nes – 7-day	
E1.	OTHERS INDICATORS OF DEPRES-	The state of		OVER ALI performan 0. No setup o 1. Setup help 2. One perso	PORT PROVIDED—(Code for MOST SUPPORT PROVIDED)           SHIFTS during last? days; code regardless of resident's self- code classification)           rphysical help from staff (only)           or physical assist           0.5 physical assist           0.5 physical assist           0.5 physical assist           0.5 physical assist	SELF-PERF	SUPPORT B
	SION, ANXIETY, SAD MOOD	<ol> <li>Indicator of this type exhibited up to five days a week</li> <li>Indicator of this type exhibited daily or almost daily (6, 7 days a week)</li> </ol>	a	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		-
			b.	TRANSFER	How resident moves between surfaces—to/from:bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		

#### UPPORTPROVIDED ardless of resident's self-(A) (B) SELF-PERF SUPPORT DL activity itself did not ccur during entire 7 days

MDS 2.0 September, 2000

(A) (B)

_	Nesden	0,000		Numeric Iden	
G1. C.	WALK IN	(A)	(B) H	3. APPLIANCES AND	CONTRACTOR (
d.	ROOM WALK IN	How resident walks between locations in his/her room How resident walks in corridor on unit	+	PROGRAMS	
	CORRIDOR			heck only those	External (cor
e.	LOCOMO- TION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	I In	active diagnoses	r status, medic
f.	LOCOMO- TION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		1. DISEASES	(If none app ENDOCRINI NUTRITION
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis			Diabetes me MUSCULOS
h.	EATING	How resident eats and drinks (regardless of skill), Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)			Hip fracture
I.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes			Aphasia Cerebral pals Cerebrovaso
ŀ	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, wathing/drying face, hands, and perineum (EXCLUDE baths and showers)		2. INFECTIONS	(stroke)
G2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) Code for most dependent in self-performance. An BATHING SELE DEPENDMANCE codes enough balow.	(A)		Antibiotic res (e.g., Methici staph) Clostridium o Conjunctiviti
		1. Supervision—Oversight help only			HIV infection
		2. Physical help limited to transfer only 3. Physical help is part of bathing activity			Pneumonia
		3. Physical help in part of bathing activity 4. Total dependence			Respiratory i (Include only
		8. Activity itself did not occur during entire 7 days		3. OTHER CURRENT	relationship
G3.	TESTFOR	(Code for ability during test in the last 7 days)		DIAGNOSES AND ICD-9	medical trea
	BALANCE	0. Maintained position as required in test		CODES	a
	(see training	<ol> <li>Unsteady, but able to rebalance self without physical support</li> <li>Partial physical support during test;</li> </ol>			
	manual)	or stands (sits) but does not follow directions for test		1. PROBLEM	(Check all p
		3. Not able to attempt test without physical help a. Balance while standing	- 1 ľ	CONDITIONS	indicated)
		b. Balance while sitting-position, trunk control			INDICATOR
9	FUNCTIONAL LIMITATION IN RANGE OF MOTION	(Code for limitations during <b>Iast 7 days</b> that interfered with daily functions placed residents at risk of injury) (B) VOLUNTARY MOVEMENT (A) RANGE OF MOTION (B) VOLUNTARY MOVEMENT 0. No limitation 1. Limitation on one side 2. Limitation on both sides 2. Full loss (A)			Weight gain of more pounds period Inability to lie shortness of
		a. Neck D. Arm—Including shoulder or elbow C. Hand—Including wrist or fingers d. Leg—Including hip or knee E. Foct—Including ankle or toes			Dehydrated; input Insufficient fli consume all/ provided dur
		f. Other limitation or loss			
G6.	MODES OF	(Check all that apply during last 7 days)	J	2. PAIN SYMPTOMS	(Code the hi
	TRANSFER	Bedfast all or most of time Bed raits used for bed mobility b. b.	(	STOP IONS	a. FREQUEN resident co shows evic
G7.	TASK SEGMENTA- TION	Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them 0. No 1. Yes			0. No pain (s) 1. Pain less th 2. Pain daily
H1.	CONTINENCE	SELF-CONTROL CATEGORIES dent's PERFORMANCE OVER ALL SHIFTS)	J	4. ACCIDENTS	(Check all ti
	0. CONTINEN	it—Complete control [includes use of indwelling urinary catheter or ostom does not leak urine or stool]	v		Fell in past 3 Fell in past 3
	1. USUALLY C	CONTINENTBLADDER, incontinent episodes once a week or less; is than weekly	3	5. STABILITY OF CONDITIONS	Conditions/d status unstat
	2. OCCASION BOWEL, on	IALLY INCONTINENT-BLADDER, 2 or more times a week but not daily; ce a week			Chronic problem of the stage distance of the
	3. FREQUEN	TLY INCONTINENT-BLADDER, tended to be incontinent daily, but some			NONE OF A
	control pres 4. INCONTINI	ent (e.g., on day shift); BOWEL, 2-3 times a week ENTHad inadequate control BLADDER, multiple daily episodes;	ĸ	1. ORAL PROBLEMS	Chewingpro Swallowingp NONE OF A
a.	BOWEL, all BOWEL CONTI-	(or almost all) of the time Control of bowel movement, with appliance or bowel continence	ĸ	2. HEIGHT AND	Record (a.) I recent meas
b.	BLADDER	programs, if employed Control of unnary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence		AND WEIGHT	standard fac off. and in nig
	CONTI- NENCE	soak through underpants), with appliances (e.g., foley) or continence programs, if employed	K	3. WEIGHT	a.Weight los
H2.	BOWEL ELIMINATION PATTERN	Diarrhea <u>e.</u> NONE OF ABOVE e Fecal impaction d.		CHANGE	180 days 0. No
	The same	New Street Control Mar.	8		b. Weight ga 180 days

Desident

Mummele Identifier ed toileting plan Indwelling catheter ining program Ostomy present NONE OF ABOVE ndorn) catheter t have a relationship to current ADL status, cognitive status, al treatments, nursing monitoring, or risk of death. (Do not list ly, CHECK the NONE OF ABOVE box) E/METABOLIC/ Hemiplegia/Hemiparesis Multiple sclerosis litus Quadriplegia KELETAL PSYCHIATRIC/MOOD Depression ICAL Manic depressive (bipolar disease) OTHER ular accident NONE OF ABOVE Iy. CHECK the NONE OF ABOVE box) Septicemia istant infection illin resistant Sexually transmitted diseases Tuberculosis difficile (c. diff.) Urinary tract infection in last 30 days Viral hepatitis Wound infection nfection NONE OF ABOVE y those diseases diagnosed in the last 90 days that have a to current ADL status, cognitive status, mood or behavior status tments, nursing monitoring, or risk of death) 1 1 1.1 roblems present in last 7 days unless other time fame is 1 OTHER S OF FLUID Delusions orloss of 3 or swithin a 7 day Edema Fever Hallucinations flat due to breath Internal bleeding Recurrent lung aspirations in last 90 days output exceeds Shortness of breath uid; did NOT almost all liquids ing last 3 days Unsteady gait Vomiting NONE OF ABOVE ghest level of pain present in the last 7 days) ICY with which b. INTENSITY of pain mplains or lence of pain 1. Mild pain 2. Moderate pain kip to J4) 3. Times when pain is horrible or excrutiating nan daily nat apply Hip fracture in last 180 days 0 days Other fracture in last 180 days NONE OF ABOVE 1-180 days iseases make resident's cognitive, ADL, mood or vie--(fluctuating, precarious, or deteriorating) periencing an acute episode or a flare-up of a recurrent or em sease, 6 or fewer months to live 80VE roblem BOVE d. teight in inches and (b.) weight in pounds. Base weight on mo ure in last 30 days; measure weight consistently in accord with itry practice—a.g., in a.m. after voiding, before meal, with shoes thiclothes b. W7 (b.) ss-5 % or more in last 30 days; or 10 % or more in last 1.Yes In—5 % or more in last 30 days; or 10 % or more in last 1.Yes 0.No L 

No.         Note:         Check af the mapping has 7 days         Display intervention of program resolution during the mapping has 7 days           No.         Note:         Check af the mapping has 7 days         Display intervention of program resolution during the mapping has 7 days           No.         Note:         Check af the mapping has 7 days         Display intervention of program resolution during the mapping has 7 days           No.         Note:         Check af the mapping has 7 days         Display intervention of program resolution during the mapping has 7 days           No.         Look has program resolution of the mapping has 7 days         Display intervention of program resolution during the mapping has 7 days         Display intervention of program resolution during the mapping has 7 days           No.         Look has program resolution of the mapping has 7 days         Display intervention of program resolution during the mapping has 7 days           No.         Look has program resolution of the mapping has 7 days         Display intervention of program resolution during the mapping has 7 days           No.         Look has program resolution of the mapping has 7 days         Display intervention of the mapping has 7 days           No.         Look has program resolution on the mapping has 7 days         Display intervention of the mapping has 7 days           No.         Look has program resolution on the mapping has 7 days         Display intervention of the mapping has 7 days           <		Resident						Numeric Ident	ifier						_
Image: section of the sectin of the section of the section	K5.	NUTRI-	(Check all that apply in las	t7 day	s)		P1.	SPECIAL	a. SPECIAL CARE—Check t	eatmen	ts or programs receiv	red du	ing		
Image: Description         Image:		TIONAL		a	1			TREAT-	the last 14 days						
Image: relation to the second of th			Feedersteine			h.			TREATMENTS		Ventilator or receira	tor			
Recent Percent Pe				D.		i.		DURES, AND						١.	
IN PLACE              Lober the property field and each of training of tra	K6.	PARENTERAL	(Skip to Section M if neither	5a nor :	5b is checked)			PROGRAMS		a.	and a based				
Bit Booker Bit Booker		OR ENTERAL INTAKE	a. Code the proportion of total	calorie	s the resident received through				÷	b		ient			
A Provide products of the second provide product of the second product pr			parenteral or tube leedings i	n ule la	st / udys				the state of the state of the state	с.		tia coc	cial	m.	_
A. Code the answerg hubble histole pro duy by for them is 100 or 100 or 200 or 20			1.1% to 25%							d.		ua spe	Ciai	n.	
B. Cost & Berning and Linke per key by to take is bid. Take per key by to tak									Monitoring acute medical	ė.	Hospice care			о.	
NI.         ULCESS         Charles of the number of the second responders of the			b. Code the average fluid inta 0 None	ke per o	day by IV or tube in last 7 days						Pediatric unit			p.	_
NI.         ULCER         Encode the constraint of the set of the constraint of the set of			1.1 to 500 cc/day	4	1.1501 to 2000 cc/day				Los sensitivos - montan		Respite care			q.	
minute information provement as single received or failed over the single and set of the single failed over the single failed ove						1			10 10	<u>g.</u>	Training in skills rec	uired t	0		
A Sign 1. Approximation disapper window pressure is already     by approximation of dispersion in pressure is already     c. Sage 3. A Leff induces to dois layers that pressure is already     c. Sage 3. A Leff induces to dois layers that pressure is already     c. Sage 3. A Leff induces to dois layers that pressure is already     c. Sage 3. A Leff induces to do is by the pressure is already     c. Sage 3. A Leff induces to do is by the pressure is already     c. Sage 3. A Leff induces to do is by the pressure is already     c. Sage 3. A Leff induces to do is by the pressure is already     c. Sage 3. A Leff induces to do is by the pressure is already     c. Sage 3. A Leff induces to do is by the pressure is already     c. Sage 3. A Leff induces to do it must be pressure is already     c. Sage 4. A Leff induces to do it must be provided in last 1. A must be addressed to do it must be provided in last 1. A must be addressed to do it must be provided in last 1. A must be addressed to do it must be provided in last 1. A must be addressed to do its by the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressur	M1.	ULCERS				age			10 N N N	n.	return to the comm	house	e.g.,		
A Sign 1. Approximation disapper window pressure is already     by approximation of dispersion in pressure is already     c. Sage 3. A Leff induces to dois layers that pressure is already     c. Sage 3. A Leff induces to dois layers that pressure is already     c. Sage 3. A Leff induces to dois layers that pressure is already     c. Sage 3. A Leff induces to do is by the pressure is already     c. Sage 3. A Leff induces to do is by the pressure is already     c. Sage 3. A Leff induces to do is by the pressure is already     c. Sage 3. A Leff induces to do is by the pressure is already     c. Sage 3. A Leff induces to do is by the pressure is already     c. Sage 3. A Leff induces to do is by the pressure is already     c. Sage 3. A Leff induces to do it must be pressure is already     c. Sage 4. A Leff induces to do it must be provided in last 1. A must be addressed to do it must be provided in last 1. A must be addressed to do it must be provided in last 1. A must be addressed to do it must be provided in last 1. A must be addressed to do its by the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressure is allow its bead to degree in the pressur			during last 7 days. Code 9 = 9	or mor	e.) [Requires full body exam.]	1 ST				I.	work, shopping, tra				
A La Bickness Carl Analysis an Extension pressure in selected.     B. Sage 2. A partial factors loss of all may dependent of a set of anyone of a set of all models and an extension.     C. Sage 3. A La fickness of all in all experiments of all experiments of all in all experiments of all in all experiments of all indices of all all experiments of all e		cause)	a. Stage 1. A persistent area of	ofskinn	edness (without a break in the	20				j.	and the second s				-
b. Stape 2. A partial induced cost status forms their protects:     b. Stape 2. A partial induced cost status forms their protects:     b. Stape 2. A partial induced cost status forms their stape in protects:     b. Stape 2. A partial induced cost status forms their stape in protects:     b. Stape 2. A partial induced cost status forms their stape in protects:     b. Stape 2. A partial induced cost status form of the stape in protects:     b. Stape 2. A partial induced cost status form of the stape in			skin) that does not	disapp	ear when pressure is relieved.					k.				8.	_
A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is loading of dambino date.     C. Stage 3. A difference of dam is date.     C. Stage 3. A difference of dam is date.     C. Stage 3. A difference of dam is date.     C. Stage 3. A difference of dam is date.     C. Stage 3. A difference of dam is date.     C. Stage 3. A difference of date.     C. Stage 3. A			b. Stage 2. A partial thickness	loss of	skin layers that presents				the following therapies wa	s admi	nistered (for at least	15 mi	s ead	sa di	ay)
Color & Durate provided in the start of days and book and the start of days and the start days and the star			clinically as an abr	asion, b	lister, or shallow crater.				in the last 7 calendar da	ys (Ente	er 0 if none or less ti	han 1	min.	. daily	y)
A. Super-A. Additional social control is social control in the social control is social con			c. Stage 3. A full thickness of	skin is k	est, exposing the subcutaneous				(A) = # of days administere	d for 15	minutes or more	DAYS	м	IIN	
No.         Open acting of uccess colored for the highest stage if the hard days and geoletic in the MT (e, Geone, stages 1, 2, 3, 4, 3).         D. Occupational therapy c. Physical Herapy d. Pressue: (Check colored for the highest stage 1, 2, 2, 4, 3).           NM.         Ortelle staw. Namion. Druite domines. Druite staw. Druite staw. Namion. Druite domines. Druite staw. Druite staw. Namion. Druite domines. Druite staw. Druite staw. Druite staw. Namion. Druite domines. Druite staw. Druite staw. Druite staw. Druite staw. Namion. Druite domines. Druite staw. Druite st			undermining adjac	enttiss	ue.				(B) = total # of minutes pro	vided in	n last 7 days	(A)		(B)	
No.         Comparison for each year diverse confer of the highest stage in the last 7 days and gradial in item M1—d., encode, stage 1, 2, 3, 4, 9, 1         D. Occupational the rargy           MI         Order activity and used in item M1—d., encode, stage 1, 2, 3, 4, 9, 1         E. Physical therapy         E. Physical therapy           MI         Order activity and used by poor circulator in the lower and gradiant stage of third digges)         E. Physical therapy         E. Physical therapy           MI         Order activity and used by poor circulator in the lower and gradiant stage of third digges)         E. Physical therapy         E. Physical therapy           MI         Order activity			d. Stage 4. A full thickness of:	skin and	l subcutan∉ous tissue is lost,				a. Speech - language patholo	ogy and	audiology services		Т		Г
ULCER       and gravitab in Am M III			exposing muscle of	rbone.					b. Occupational therapy				+	$\square$	F
A. Processor ukor—entry lesion caused by processor resulting in damage of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering sizes are a considered in the set of chardering are a considered in the	M2.	TYPE OF										$\vdash$	+	+	$\vdash$
A construction of the lower of the set		ULCER							internet that is			$\vdash$	+	+	$\vdash$
b. Sets its beam-open leafon caused by poor circulation in the lower externities   MI. OTHER SKM. Abraicion Fullades   PRODELBASS   OPRICE LESIONE   Oprice and income of third darges)   Check all full depined   Check all full depined   Sin demonstrating campability of the last 7 days   Check all full depined   And Depined full depined   Check all full depined   And Depined full depined   Check all full depined   Check all full depined   And Depined full depined   Check all full depined   Check all full depined   And Depined full depined   And Depined full depined   And Depined full depined   And Depined full depined				caused	by pressure resulting in damage				d. Respiratory therapy				_		
Mill         OTHER SKM         Aurentikes         Aurentikes <th></th> <th></th> <th></th> <th>aused b</th> <th>v poor circulation in the lower</th> <th></th> <th></th> <th></th> <th>e. Psychological therapy (by</th> <th>any lice</th> <th>nsed mental</th> <th></th> <th></th> <th></th> <th></th>				aused b	v poor circulation in the lower				e. Psychological therapy (by	any lice	nsed mental				
MM.       Order R strikl, Abrains, Builds, Markans, Markans, Builds, Markans, Builds, Markans, Builds, Markans, Builds, Markans, Builds, Markans, Builds, Markans, Markans, Builds, Markans, Markans						102	NUDBING		WS and	ch of the following re	hahili	ation	01	-	
OR         LESIONS         Description of the than lakes, substick (s.g., cancer lesions)           Precessing         Description of the than lakes, substick (s.g., cancer lesions)           Check and Ith apply         Sin description of prior pressure         A           Sin description of prior pressure         E           ATVE CARE         E. Range of motion (setsive)         C. Splitt of the assession           View Care         Note Sin description of pressure releaving device(s) for chair           TREAT:         Pressure releaving device(s) for chair           The application or hydration intervention to manage skin problems         E           Application or hydration intervention to relation to relation the second status of the application of chair relation to relation the second status of the application of chair relation to relation the second status of problems           Mode         FOCO         Resident has one or more bot problems—e.g., corns, calouses, binner device status of the application of chair relation to files than 14 days in factor of the bot chair ce (due than to bed)         D           Mode POCO         PAPLICAL ST 14 DAYS (or since admission of less than 14 days in factor of the chair of corns admission of less than 14 days in factor of the chair of corns admission of less than 14 days in factor of the chair of corns admission of less than 14 days in factor of the chair of corns admission of less than 14 days in factor of the chair of corns admission of less than 14 days in factor of the chair of corns admissin admis admission of less than 14 days in factor of the corns a	M4.		Abrasions, bruises			а.	F3.	<b>REHABILITA-</b>	restorative techniques or pra	ctices v	was provided to the	resid	lent f	or	
PRESENT         Open insides of the Train lacks, dutile, dutiles, duti					b.		TION/				7 day	5			
Image: State and severalized to pain or pressure       0.         Image: State hears out (cher than surgery)       0.         State hear out (cher than surgery)       0.		PRESENT	All a second sec			c.								Γ	_
Interapty during last       An iterapty is bit has a core (last has not core assistance Surgicul vounds, MOXE OF AGO/E       h. Eating or ovallowing Surgicul vounds, MOXE OF AGO/E       h. Eating or ovallowing Surgicul vounds, MOXE OF AGO/E       h. Eating or ovallowing Surgicul vounds, MOXE OF AGO/E         M6.       Possure releving device(s) br chat Turning/repositioning program Autition or hydration intervention to manage skin problems: days days days days days days days days		(Check all			grash, heat rash, herpes zoster	d.			b. Range of motion (active)	<u> </u>	a. Dressing or groo	mina			-
dig/s)       Surgical wounds       g       I.         MS       Start       Non-Rescurrent eleving device(s) for chair       I.         MS       Start       Pressure releving device(s) for chair       I.         MS       Start       Pressure releving device(s) for bed       L.         MINT       Note care       L.         Surgical wound care       E.       E.         Application of dressings (who without topical medications) other than to feel)       L.         Cher preventative or protective kin care (ther than to feel)       L.         MIN CREF       PROLETINE       L.         MIN CREF       Down is start of days       L.         MIN CREF       PROLETINE       L.         MIN CREF       Down is start of days       L.         MIN CREF       Down is start of days       L.         MIN CREF       PROLETINE       Days of an end to the fold on an ing start of days         MIN CREF       Resident has on an ing ons tiget of days		that apply				e.			c. Splint or brace assistance					H	-
No.       Devices       Devices <thdevices< th="" thdvices<=""> <thdevices< th=""> <thd< th=""><th></th><th>during last / days)</th><th></th><th>urgery)</th><th></th><th>r.</th><th></th><th></th><th></th><th></th><th></th><th>~</th><th>ana</th><th>$\vdash$</th><th>-</th></thd<></thdevices<></thdevices<>		during last / days)		urgery)		r.						~	ana	$\vdash$	-
NS.       TREAT       Pressure releving device(s) for chair       In         Check all Interaction of designs (while or hydration intervention to manage skin problems       In       TREAT       Pressure releving device(s) for chair       In         Other       Pressure releving device(s) for chair       In       In       Chair (Base of the Strate o			An an Art of the strength of the second stren			g.			2722 0 0020			mesis	Jare	$\vdash$	_
THEAT   MENTS   MENTS   (Check attriangle possibility program   (Check attriangle possibility production intervention to manage skin problems   (Check attriangle possibility production intervention to manage skin problems   (Check attriangle possibility production intervention to manage skin problems   (Check attriangle possibility production intervention to manage skin problems   (Check attriangle possibility production intervention to manage skin problems   (Check attriangle production intervention to manage skin production intervention (the skin attriangle production intervention) (the skin attriangle production attriangle production attriangle production att	0.05	OKIN	Concernence and a second second	r chair		h.					1.			$\vdash$	_
MENTS       0. Not used       0. Not used         (Chrck all (chrck all)       hubition on hydration intervention to manage skin problems       0.         dargists/r       2. Used class       0. Not used         dargists/r       Surgical wound care       r         Application of obsenting (with or without topical medications) other than to list.       r       r         Application of obsenting (with or without topical medications) other than to list.       n       n         M6.       PCOLEMS Application of obsenting (with or without topical medications) other than to list.       n       n         M6.       PCOLEMS AND CARE       Resident has one or mose top topic/serventable or protective foot care (e.g., used special shoes, findecial core of the sings (with or without topical medications)       n         M7.       Check appropriate time periods over last 7 days) mests, pads, toe separators)       d.         M1.       TIME Avalacet       Check appropriate time periods over last 7 days) mests, pads, toe separators)       d.         M1.       TIME Avalacet       Check appropriate time periods over last 7 days) mests, pads, toe separators)       d.         M1.       TIME Avalacet       Check appropriate time periods over last 7 days; mests, pads, toe separators)       d.         M1.       TIME Avalacet       Check appropriate time periods over last 7 days; mestrick weak all or most other       d	IVD.					a.	-	DEMOSEO		act 7 d				╘	
Image: Check all intervention to manage skin problems       0         Identify all intervention to descings (with or without topical medications) other than to feel       0         Identify all intervention of othermethymedications (other than to feel)       0         In the chast intervention of othermethymedications (other than to feel)       0         Image: Intervention of othermethymedications (other than to feel)       0         Image: Intervention of othermethymedications (other than to feel)       0         Image: Intervention of othermethymedications (other than to feel)       0         Image: Intervention of othermethymedications (other than to feel)       0         Image: Intervention of othermethymedications (other than to feel)       0         Image: Intervention of the foot-engle other than to feel)       0         Image: Intervention of othermethymedications (other than to feel)       0         Image: Intervention of the foot-engle other than to feel)       0         Image: Intervention of the foot-engle other than to feel)       0         Image: Intervention of the foot-engle other than to feel)       0         Image: Intervention of the foot-engle other than to feel)       0 <th></th> <th>MENTS</th> <th></th> <th></th> <th></th> <th>D.</th> <th>P4.</th> <th>AND</th> <th>0. Not used</th> <th>asi / u</th> <th>ays.</th> <th></th> <th></th> <th></th> <th></th>		MENTS				D.	P4.	AND	0. Not used	asi / u	ays.				
Intra Apply       User care       E         darge 3/2       Surgical wound care       Application of dressings (with or without topical medications) other than to feet)       E         Application of other proventative or protective skin care (other than to feet)       E       E         Application of other proventative or protective skin care (other than to feet)       E       E         M0       FOOT       Resident has one or more foot problems—e.g. corns, calouses, an findity how many days has the physician (or authorized assistant or practitione) examined the resident? ( <i>Ethet d'Innere</i> )         M0       FOOT       Resident has one or more foot problems—e.g., corns, calouses, an findity how many days has the physician (or authorized assistant or practitione) examined the resident? ( <i>Ethet d'Innere</i> )         M1       The LAST 14 DAYS (or since admission if less than 14 days in facily how many days has the physician (or authorized assistant or practitione) weat mined the resident? <i>Celled d'Innere</i> )         M2       PROBLEMS       PHYSICLAN         M1       The LAST 14 DAYS (or since admission if less than 14 days in facily how many days has the physician (or authorized assistant or practitione) weat mined the resident? <i>Celled d'Innere</i> )         M3       Recived preventative or protective foot care (e.g., used special shoes, in structural problems in the LAST 14 DAYS (or since admission if less than 14 days in facily how many days fas the physician (or authorized assistant or practitione) weat orders? <i>Do not include order renewals without Change</i> . ( <i>Chied D'Innere</i> )		(Check all			anage skin problems	d.		RESTRAINTS							
ddys)       Surgeal wound care       r.         Application of dressings (with or without topical medications) other than b feat       r.       r.         Application of dressings (with or without topical medications) other than b feat       r.       r.         Application of other types of side rais used (e.g., half rail, one side)       r.         Other preventative or protective skin care (other than to feet)       i.         NB       PCOLETMS       Resident has one or more foot problems—e.g. corns. calcuses         Infection of the foot—e.g., celluitis, purulent drainage       c.         Cher preventative or protective foot care (e.g., used special shoes, and that apply)       in the LAST 14 DAYS (or since admission if less than 14 days in scality) how many dorp has the physician (or subnicized assistant or practitioner) drainage the resident? ( <i>Ether Olf none</i> )         P8       PHYSICLAN       the LAST 14 DAYS (or since admission if less than 14 days in scality) how many dorp has the physician (or subnicized assistant or practitioner) drainage the resident? ( <i>Ether Olf none</i> )         P8       PHYSICLAN       the LAST 14 DAYS (or since admission if less than 14 days in scality) how many dorp has the physician (or subnicized assistant or practioner) change the resident? ( <i>Ether Olf none</i> )         Q2       Over shart       Resident Sower assistant is assistant or practioner) change the resident? ( <i>Ether Olf none</i> )         Q3       NONE OF ABOVE       In the LAST 14 DAYS (or since assistant or practinone) (or datassistant		that apply	Ulcer care			e.								1	
In the LAST 14 DAYS (or since admission if less than 14 days in factive or protective skin care (other than to feet)     In the LAST 14 DAYS (or since admission if less than 14 days in factive or protective skin care)     In the LAST 14 DAYS (or since admission if less than 14 days in factive or mark days has the physician (or authorized assistant or practioner)     PROBLEMS     bunctions on the bot     Interts and the days in factive or protective skin care (e.g., used special shoes, a factive or protective state or practioner)     Application of dressings (with or without topical medications)     Application of dressings (with or without topical medications)     NONE OF ABOVE     None     If resident is comatose, skip to Section O)     No. Bother Comparise of time periods over tast 7 days)     Received preventing time periods over tast 7 days)     Received preventing time periods over tast 7 days)     No. Bother Compared to the section of the se		days)	Surgical wound care			f.			a. — Full bed rails on all ope	n sides	ofbed				
Application of ointments/medications (other than to feet)       h         M6       PCOLT NONE OF ABOVE       Chirp reventative or protective skin care (other than to feet)         M6       PCOLEMS AND CARE       Resident has one or more foot problems—e.g., corns, calouses, and infection of the bot—e.g., celluits, purulent dainage       a.         (Check all that grading 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 practioner) examined the resident? (Chird Olinone)         77       PH SICIAN 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 practioner) changed the resident? (Chird Olinone)         78       PH SICIAN 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 practioner) changed the resident? Of authorized assistant or practioner) changed the resident? If Normal VISITS         78       PH SICIAN In the LAST work and the or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE       In the charst studic and the set of days and or support         70       INTER       Check appropriate time periods over last 7 days) Resident wake all or motic or time (i.e., naps no more than one hour per time period) in the: Anternoon       Scient Nassessment Coordinator (sign on above line)         70       Interesting the number of DAYS injections of any type received during the last 7 days; enter "0" fincene used				or witho	ut topical medications) other than				b. — Other types of side rails	sused (	e.g., halfrail, one side	e)			_
Cher preventative or protective skin care (other than to feel)     AONE OF ABOVE     ACNE ABOVE     ACNE OF ABOVE			10 - 10 - 10 - 10 - 10 - 10 - 10 - 10 -			g.			c. Trunk restraint						_
M6.       POOT Resident has one or more bot problems—e.g., corns, calouses, and D CARE       j.         M6.       FOOT Resident has one or more bot problems—e.g., corns, calouses, and bot of the foot—e.g., celluits, purulent drainage       a.         Dent lesions on the foot that apply during last 7       b.       b.         AND CARE       b.       c.         If that apply during last 7       c.       d.         AND CARE       Naliscalluses timmed during last 90 days       e.         Received preventative or protective foot care (e.g., used special shoes. inserts, pads, toe separatore)       e.         Application of dressings (with or without topical medications)       e.         NNNE OF ABOVE       g.         NNNE OF ABOVE       g.         NNNE (Check all)       c.         Application of dressings (with or without topical medications)       g.         NNNE (Check appropriate time period) in the: Moring       g.         NNNE (CHE Appropriate time period) in the: Moring       Evening         Attemnoon       b.       NONE OF ABOVE         NN2       ONet care for M2so of time       g. Little—less than 1/3 of time         O1.       NUME OF ABOVE       d.         NONE OF ABOVE       d.       d.         Notice Core of time conder of time cole of time (i.e., naps no more than one						<u>n</u> .			d. Limb restraint						
M6.       FOOT PROBLEMS       Resident has one or more foot problems—e.g., corns, calouses, AND CALENS       a.         M6.       FCOT PROBLEMS       Resident has one or more foot problems—e.g., corns, calouses, hindston of the foot—e.g., celluits, purulent drainage       a.         M7.       Check all that apply during last adjust       Open lesions on the foot inserts, pads, toe separators)       PR.       PHYSICIAN PHYSICIAN       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 practitione) charged the resident? ( <i>Enter Olf none</i> )         VI.       Nails/calluses timmed during last 90 days       e.         Application of dressings (with or without topical medications) inserts, pads, toe separators)       f.         Application of dressings (with or without topical medications) Application of dressings (with or without topical medications)       g.         N1.       TIME AWAKE       ( <i>Check appropriate line period s over last 7 days</i> ) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the: Morning       Evening       c.         (If resident is cormatose, skip to Section O       No.NE OF ABOVE       d.       d.         NVOLVED IN [0. Most—more than 2/8 of time metricibes 1. Some—form 1/8 02 of time 3. None       3. None       O. Not derer 1'' fin long aused)         O4.       Record the number of DAYS injections of any type received during the last 7' days, enter '0' if none used)       1. Hyporotic			and the second	e skill c	are (other than to leet)				e. Chair prevents rising						
PROBLEMS AND CALL       bunions, hammertoes, overlapping toes, pain, structural problems AND CALL       a.         PROBLEMS AND CALL       bunions, hammertoes, overlapping toes, pain, structural problems bunions, hammertoes, overlapping toes, pain, structural problems during take programmertoes, overlapping toes, pain, structural problems bunions, hammertoes, overlapping toes, pain, structural problems bunions, hammertoes, overlapping toes, pain, structural problems during take programmertoes, overlapping toes, pain, structural problems bunions, hammertoes, overlapping toes, pain, structural problems bunions, hammertoes, overlapping toes, pain, structural problems during take programmertoes, structural problems bunions, hammertoes, skip to Section O)         N1.       TIME AVERACE INTER       (Check appropriate time periods over last 7 days) Attempon b.       NONE OF ABOVE ADVE OF ABOVE       d.         N2.       AVERACE INTER       (When awake and not receiving treatments or ADL care) INVOLVED IN 0.       Nonse of the number of DAYS injections of any type received during the last 7 days; anter '0' if none used)       Date RN Assessment Coordinator isgned as complete       Month       Day Year         04.       RECEIVED IN INCICA- THE E	Me	FOOT		proble		y.	P7.		In the LAST 14 DAYS (or sind	e admis	sion if less than 14 d	ays in	or	1	
Interced of the local-egg, centures, patient of delays         Check all (Check all participation of the foot         Nails/calluses trimmed during last 90 days         Received preventative or protective foot care (e.g., used special shoes, inserts, pads, to separators)         Application of dressings (with or without topical medications)         N.1.         NII.         NII.         NII.         AWAKE         Period         If resident is comatose, skip to Section O)         N2.       AVERACE INVERACE         NVI.       Check appropriate time periods over last 7 days) attemports         Recident is comatose, skip to Section O)         N2.       AVERACE INVERCE         NVI.       More and not receiving treatments of any type received during the last 7 days; enter "0" incol         NI.       MUMER OF INVOLVED IN 0. Most—more than 26 of time 1. Some—from 1/3b 0.29 of time 2. Little—less than 1/3 of time 2. Little—less than 1/3 of time 3. None         O3.       INJECTIONS         (Record the number of DAYS injections of any type received during the last 7 days; enter "1" in one used)         O4.       DAYS INTERCE         O4.       Averant "1" in one used, "Exclusion of the united of the united exclusions and proteched during the last 7 days; enter "1" in one used, "Exclusion of the number of DAYS injections of any type received during the last 7 days; enter "1" in one used,		PROBLEMS	bunions, hammer toes, overlag	oping to	es, pain, structural problems	а.		19112	practitioner) examined the res	ident? (	Enter 0 if none)	arətəri			
that apply duing last 7 days)       Naliscalluses trimmed duing last 90 days       d.         reavel apply duing last 7 days)       Naliscalluses trimmed duing last 90 days       d.         Application of dressings (with or without topical medications) NONE OF ABOVE       d.         N1.       TIME AWAKE       (Check appropriate time periods over last 7 days) Reserved maxes all or most of time (i.e., naps no more than one hour per time period) in the: Morning       Evening       c.         (If resident is comatose, skip to Section O)       NONE OF ABOVE       d.         N2.       Atternoon       b.       NONE OF ABOVE         (If resident is comatose, skip to Section O)       NONE OF ABOVE       d.         N2.       Atternoon       b.       NONE OF ABOVE         (If resident is comatose, skip to Section O)       NONE OF ABOVE       d.         N2.       AVERAGE TWNE       (When awake and not receiving treatments or ADL care) TWNE       1. Some—from 1/3 to 23 oftime       2. Litle—less than 1/3 oftime Actimuted as a complete         O3.       INJECTIONS       (Record the number of DAYS injections of any type received week)) to a. Antipsycholic       d. Hippotic         O4.       DAYS THORING       (Record the number of DAYS duing last 7 days; enter "0" if none used)       d. Hippotic         O4.       DAYS THORING       (Record the number of DAYS duing last 7 days; enter "0" if none use		AND CARE	Infection of the foot-e.g., cellu	litis, pu	ulent drainage	b.	P8.		In the LAST 14 DAYS (or sind	e admis	sion if less than 14 d	ays in		Γ	
Online wyby       Nalis/calluses trimmed during last 90 days          during last 7       Application of dressings (with or without topical medications)          Application of dressings (with or without topical medications)           AVMAKE            N1.       TIME            AWAKE             Moming             Atternoon             Moming             Moming             Atternoon             N2.       AVERACE       (Mine make and not receiving treatments or ADL care)          INVE       INVE            NVE       NONE            Atternoon             NONE              NVE        Mostemotion 1/3 to 2/						c.		ORDERS	facility) how many days has the practitioner) changed the resid	e physic lent's or	cian (or authorized as iders? Do not include	sistan	or	-	
Inserts, pads, toe separators)       Application of dressings (with or without topical medications)       Image: Charles in the compared to status of 90 days 300 (or since last assessment if less 200 days)         N1.       TIME       (Check appropriate time periods over last 7 days)       g.         N1.       TIME       (Check appropriate time periods over last 7 days)       g.         N1.       TIME       (Check appropriate time periods over last 7 days)       g.         N1.       TIME       (Check appropriate time periods over last 7 days)       g.         N1.       TIME       (Check appropriate time periods over last 7 days)       g.         Noming       a.       Evening       c.         Atternoon       b.       NONE OF ABOVE       d.         (If resident is comatose, skip to Section O)       None       OA       None of the number of DAYS drime       2. Little-less than 1/3 of time         NUMERER OF (Record the number of DAYS injections of any type received during the last 7 days; enter '0' if none used)       Month       Day       Year         O4.       DAYS       (Record the number of DAYS uning last 7 days; enter '0' if none used)       G.       Hyponicic       D.         NUMERCIVED UND       b. Antisychotic       G. Hyponicic       C.       D. Unretic:		during last 7				d.									
Application of dressings (with or without topical medications)       f.         N1.       TIME       (Check appropriate time periods over last 7 days)         Resident avake all or most of time (i.e., naps no more than one hour per time period) in the:       C.         Monter Parkage       None OF ABOVE       d.         N1.       TIME       (Check appropriate time periods over last 7 days)       Evening       c.         Atemoon       b.       NONE OF ABOVE       d.         N2.       AverAGE       (When awake and not receiving treatments or ADL care)       more support         NNE       NOME OF ABOVE       d.         NV.       Average       (When awake and not receiving treatments or ADL care)         NME       None-from 1/3 to 2/3 of time       3. None         O1.       NUMBER OF (Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)       Month       Day         O3.       INJECTIONS       (Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used);       Month       Day         O4.       DAYS       (Record the number of DAYS injections of any type received during the Cartion b. Antisnety       E. Duretic       Duretic		days)	Received preventative or prote	ective fo	ot care (e.g., used special shoes,	e.	Q2.		Resident's overall level of self	sufficien	cy has changed sign	ificant	yas		
NONE OF ABOVE       a.         N1.       TIME         AWAKE       Resident awake all on roos of time (i.e., naps no more than one hour per time period) in the:         Moming       a.         Afternoon       b.         N1.       Afternoon         N1.       NONE OF ABOVE         Atternoon       b.         NONE OF ABOVE       d.         Resident awake all on treceiving treatments or ADL care)       d.         NVOLVED IN       O. Most—more than 205 of time         2. Little—less than 1/3 of time       2. Little—less than 1/3 of time         ACTIVITIE IS       Some—from 1/3 to 23 of time         O1.       NUMBER OF (Record the number of DAYS injections of any type received during the fast 7 days; enter "0" if none used)         O3.       INJECTIONS         O4.       DAYS         RECEIVED       Menter "1" for long-acting meds used lass than weekly)         A.       Antipsychotic         D.       Antipsychotic         O4.       Antipsychotic         D.       Antipsychotic         O4.       Antipsychotic         D.       Antipsychotic         D.       Antipsychotic			5 5 N N	or with o	uttopical medications)	f.		CARE NEEDS	than 90 days)						
N1.       TIME AWAKE       (Check appropriate time periods over last 7 days) Resident avake all or most oftime (Le, naps no more than one hour per time period) in the: Afternoon       Evening       c.         Afternoon       b.       NONE OF ABOVE       d.         (If resident is comatose, skip to Section O)       NONE OF ABOVE       d.         N2       AVERAGE TIME INVOLVED IN       (When awake and not receiving treatments or ADL care) TIME ACTIVITIES       2. Litle—less than 1/3 oftime 3. None       2. Litle—less than 1/3 oftime 3. None         O1.       NUMBER OF (Record the number of different medications used in the last 7 days; met 10'' if none used)       3. None         O3.       INJECTIONS       (Record the number of DAYS uning last 7 days; enter "0" if not the last 7 days; enter "0" if none used)       Weight of the last 7 days; enter "0" if not the last 7 days; enter "0" if none used)         O4.       DAYS RECEIVED US.       (Record the number of DAYS during last 7 days; enter "0" if not the last 7 days; enter "0" if none used)       (Record the number of Lays during last 7 days; enter "0" if not the last 7 days; enter "0" if none used)         O4.       DAYS RECEIVED US.       (Record the number of DAYS during last 7 days; enter "0" if none the last 7 days; enter "0" if none used)       Antipsychotic e. Diuretic						g.							eives	-1	
AWAKE       Resident avake all or most oftime (i.e., naps no more than one hour per time period) in the:       Resident avake all or most oftime (i.e., naps no more than one hour per time period) in the:       Resident avake all or most oftime (i.e., naps no more than one hour	N1.		(Check appropriate time per	iods ov	er last 7 days)				restrictive lev	el of ca	re				
Morning       a.       Evening       c.         Afternoon       b.       NONE OF ABOVE       d.         (If resident is comatose, skip to Section O)       a. Signature of RN Assessment Coordinator (sign on above line)         N2.       AVERAGE TIME INVOLUED IN ACTIVITIES       (When awake and not receiving treatments or ADL care) TIME INVOLUED IN INVECTIVED IN ACTIVITIES       0. Most—more than 2/3 of time ACTIVITIES       2. Litle—less than 1/3 of time 3. None       2. Litle—less than 1/3 of time 3. None         O1.       NUMBER OF MEDICA- TIONS       (Record the number of different medications used in the last 7 days; the last 7 days; enter '0' if none used)       Month       Day         O3.       INJECTIONS       (Record the number of DAYS uning last 7 days; enter '0'' if nont the last 7 days; enter '0'' if none used)       (Record the number of DAYS during last 7 days; enter '0'' if nont the last 7 days; enter '0'' if none used)       a.         O4.       DAYS RECEIVED Used. Note—enter '1'' for long-acting med used less than weekly) a.       a.       Antipsychotic e. Diuretic       d. Hypnotic e. Diuretic		AWAKE	Resident awake all or most of	time (i.e	, naps no more than one hour		R2.	SIGNATURE	OF PERSON COORDINATIN	GTHE	ASSESSMENT:				
(If resident is comatose, skip to Section O)         N2       AVERAGE       (When awake and not receiving treatments or ADL care)         Thite       INVOLVED IN       0. Most—more than 2/3 of time       2. Little—less than 1/3 of time         ACTIVITIES       1. Some—from 1/3 to 2/3 of time       2. Little—less than 1/3 of time         ACTIVITIES       1. Some—from 1/3 to 2/3 of time       3. None         O1. NUMBER OF (Record the number of different medications used in the last 7 days; enter "0" if none used)       Month       Day         O3. INJECTIONS       (Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)       (Record the number of DAYS during last 7 days; enter "0" if not the last 7 days; enter "0" if none used)         O4.       DAYS THE       (Record the number of last 7 days; enter "0" if not the last 7 days; enter "0" if none used)         THE       Antipsycholic       d. Hypnotic         DAYS MEDICATION       C. Data RN Assessment Coordinator				Even	ing	с.									
N2       AVERAGE TIME INVOLUDE IN ACTIVITIES       (When awake and not receiving treatments or ADL care) INVOLUDE IN ACTIVITIES       0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 3. None       2. Litle—less than 1/3 of time 3. None         O1.       NUMBER OF MEDICA- TIONS       (Record the number of DAYS injections of any type received during the last 7 days; enter '0" if none used)       Month       Day         O3.       INJECTIONS       (Record the number of DAYS uning last 7 days; enter "0" if not the last 7 days; enter					E OF ABOVE	d.	a.S	ignature of RN	Assessment Coordinator (sign	on abov	e line)				-
TIME       Most—more than 2/3 of time       2. Little—less than 1/3 of time         INVOLUZE DIN 0. Most—more than 2/3 of time       2. Little—less than 1/3 of time       3. None         O1. NUMBER OF (Record the number of different medications used in the last 7 days, meter 70° if none used)       3. None       Month       Day       Year         O3. INJECTIONS       (Record the number of DAYS injections of any type received during the last 7 days; enter 10° if none used)       (Record the number of DAYS during last 7 days; enter 10° if not used)       4. DAYS         O4.       DAYS       (Record the number of DAYS during last 7 days; enter 10° if not used)       4. Antipsycholic       4. Hyponetic         DHE       Note—enter 11° for long acting mede used less than weekly)       4. Antipsycholic       4. Hyponetic         MEDICATION       b. Antianxitety       e. Diuretic       E. Diuretic															
INVOLVED IN 0. Most—more than 2/3 of time       2. Little—less than 1/3 of time         ACTIVITIES       1. Some—from 1/3 to 2/3 of time       3. None         O1.       NUMBER OF       (Record the number of different medications used in the last 7 days; medications       Image: the last 7 days; medications       Image: the last 7 days; medications used)         O3.       INJECTIONS       (Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)       Image: the last 7 days; enter "0" if not the last 7 days; enter "1" for long-acting meds used less than weekly)         O4.       DAYS THE       a. Antipsychotic       d. Hypnotic         POLLOWING       b. Antianxitely       e. Diuretic	N2.		(When awake and not receiv	ing trea	atments or ADL care)		s	igned as comple							
O1. NUMBER OF NEDICA- TIONS       (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       (Record the number of DAYS during last 7 days; enter "0" if not RECEIVED         THE FOLLCOWING NEDICATION       a. Antipsychotic       d. Hypnotic         WEDICATION       b. Antianxitety       e. Diuretic		INVOLVED IN	0. Most-more than 2/3 of time						Month		Day Y	ear			
MEDICA- TIONS       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       (Record the number of DAYS during last 7 days; enter "0" if not RECEIVED         USA       (Record the number of DAYS during last 7 days; enter "0" if not RECEIVED         THE FOLLOWING       a. Antipsycholic         MEDICATION       b. Antianxitety	-														_
TIONS         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       used. Note—enter "1" for long-acting meds used less than weekly)         THE       a. Antipsychotic         MEDICATION       b. Antianxiety         e. Diuretic	01.			rentme	arcauons used in the last 7 days,										
O4.     DAYS     (Record the number of DAYS during last 7 days; enter "0" if not       RECEIVED     used. Notenter "1" for long-acting made used less than weekly       THE     a. Antipsycholic       MEDICATION     b. Antianxiety   e. Diuretic	L		,												
O4.       DAYS RECEIVED       (Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly THE FOLLOWING       a. Antipsychotic         G4.       DAYS Used. Note—enter "1" for long-acting meds used less than weekly THE       d. Hypnotic         FOLLOWING       D. Antianxiety       e. Diuretic	03.	INJECTIONS													
RECEIVED       used. Note-enter*1* for long-acting meds used less than weekly)         THE       a. Antipsychotic         FOLLOWING       b. Antianxiety         MEDICATION       b. Antianxiety         e. Diuretic	-	DAVID			·										
THE a. Antipsycholic d. Hypnotic d. Hypnotic e. Diuretic e. Diuretic	04.														
WEDICATION b. Antianxiety e. Diuretic		THE	a Antineucharia	1											
C. Antidepressant C. Liureec MDS 2.0 September, 200		MEDICATION	b. Antianxiety												
	L		c. Antidepressant	A Diurotic							MDS 2.	0 Sept	embe	er, 20	000

Numeric	Identifier
THUI INDIA	Parentinet.

Resident

# MINIMUM DATA SET (MDS) - VERSION 2.0

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

### SECTION W. SUPPLEMENTAL MDS ITEMS

 1.
 National Provider ID
 Enter for all assessments and tracking forms, if available, including form is between July 1 and September 30, skip to W3.

 2.
 Influenza Vaccine
 a. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)?

 0.
 No (if No, go to item W2b) 1. Yes (if Yes, go to item W3)

 b.
 If Influenza vaccine not received, state reason: 1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible

 3.
 Pneumococcal Vaccine
 a. Is the resident's PPV status up to date? 0. No (if No, go to item W3b) 1. Yes (if Yes, skip item W3b)

 b.
 If TPPV not received, state reason: 1. Not eligible 2. Offered and declined 5. Not offered 6. Inability to obtain vaccine

 coccal Vaccine
 a. Is the resident's PPV status up to date? 0. No (if No, go to item W3b)

 b.
 If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered

MDS 2.0 May, 2005

RESIDENT NAMEO     A.(FI     A.	A. IDENTIFICATION INFORMATION	SE	CHONAD	. DEMOGRAPHIC INFORMATION [Complete only for stays less than 14 days] (AA8a=8	
1.		a. (First) b. (Middle Initial) c. (Last) d. (J#Sr)	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
2.	GENDER®	1. Male 2. Female			
3.	BIRTHDATE		2	ADMITTED	Month Day Year 1. Private home/apt, with no home health services
4.	ETHNICITY®	3. Black, not of Hispanic origin Hispanic origin		FROM	2. Private homelapt, with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital
5.	SECURITY [®] AND	a. Social Security Number			8. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other
	NUMBERS®		SE 6.	CTION A.	IDENTIFICATION AND BACKGROUND INFORMATION
6.	FACILITY PROVIDER NO.	a. State No.	0.	RECORD NO.	
		b. Federal No.	0.7507		SSESSMENT/DISCHARGE INFORMATION
7.	NO. ["+" if		3	STATUS	a. Code for resident disposition upon discharge 1. Private home/apartment with no home health services
	pending, "N" if not a Medicald				2. Private home/apartment with home health services 3. Board and care/assisted living
8.	REASONS FOR	[NoteOther codes do not apply to this form] a. Primary reason for assessment			4. Another nursing facility 5. Acute care hospital 6. Psychiatric hopital, MR/DD facility
		6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment			7. Rehabilitation hospital 8. Deceased 9. Other
9.	Signatures of	Persons who Completed a Portion of the Accompanying Assessment or			b. Optional State Code
ce nfo jate	rtify that the ac rmation for this as specified. To	companying information accurately reflects resident assessment or tracking resident and that I collected or coordinated collection of this information on the the best of my knowledge, this information was collected in accordance with e and Mecicaid requirements. I understand that this information is used as a	4	DISCHARGE	Date of death or discharge

Numeric Identifier

 $\boldsymbol{\Theta}$  = Key items for computerized resident tracking

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

Numeric	Identifier

Resident

# MINIMUM DATA SET (MDS) - VERSION 2.0

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

### SECTION W. SUPPLEMENTAL MDS ITEMS

 
 Institutional Provider
 Enter for all assessments and tracking forms, if available.

 If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.

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

 0. No (If No, go to item W2b)
 1. Yes (If Yes, go to item W3)

 b. If Influenza vaccine not received, state reason: 1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible

 3. Pneumococcal Vaccine
 a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b)

 b. If PPV not received, state reason: 1. Not eligible
 1. Yes (If Yes, skip item W3b)

 b. If offered 3. Institution obtain vaccine
 a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b)

 b. If PPV not received, state reason: 1. Not eligible
 1. Not eligible

 2. Offered and declined 5. Not offered
 1. Yes (If Yes, skip item W3b)

 b. If PPV not received, state reason: 1. Not eligible
 1. Not eligible

 2. Offered and declined 3. Not offered
 3. Not offered

MDS 2.0 May, 2005

Numeric Identifier

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

### REENTRY TRACKING FORM

1.	RESIDENT NAME O								
		a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)				
2.	GENDER®	1. Male	2. Female						
	BIRTHDATE	Month		Year					
4.	RACE/ ETHNICITY®	1. American Inc 2. Asian/Pacific 3. Black, not of		4. Hispanic 5. White, not of Hispanic ori					
5.	SOCIAL SECURITY® AND MEDICARE NUMBERS® [C in 1" box if non med. no.]	a. Social Secur							
6.	FACILITY PROVIDER NO.0	a. State No.							
7.	MEDICAID NO. ["+" If pending. "N" If not a Medicaid recipient] 0								
8.	REASONS FOR ASSESS- MENT	NoteOther codes do not apply to this form] a. Primary reason for assessment 9. Reentry							
9.	Signatures of Tracking Form		Completed a Portion of the	e Accompanying	Assessmento				
nfo jate pas ion ati nes aub	rmation for this as specified. To licable Medicar is for ensuring to n federal funds. on in the govern s of this informa stantial crimina	resident and the the best of my e and Medicaid hat residents re I further unders iment-funded he tion, and that Ir I, civil, and/or a	formation accurately reflect it i collected or coordinated knowledge, this information requirements. I understam celve appropriate and qualit tand that payment of such tand that payment of such that payment of such that payments of such that payments of the celve appropriate and that payments of the that the information by this fi	collection of this in t was collected in a d that this informat y care, and as a b rederal funds and c tioned on the accur to or may subject m submitting false in	formation on the accordance with ion is used as a asis for paymen ontinued partici- racy and truthful y organization to formation. I also				
-	Signature and T	ìtle		Sections	Date				
-									
0									

## SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

4a.	DATE OF REENTRY	Date of reentry
4b.	ADMITTED FROM (AT REENTRY)	Private home/apt, with no home health services     Private home/apt, with home health services     Soard and care/assisted living/group home     Auturing home     S. Acute care hospital     Psychiatric hospital, MR/DD facility     T. Rehabilitation hospital     Other
6.	MEDICAL RECORD NO.	

O = Key items for computerized resident tracking

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

Numeric	Identifier
THUI INDIA	Parentinet.

Resident_

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

SECTION W. SUPPLEMENTAL MDS ITEMS

1.	National Provider ID	Enter for all assessments and tracking forms, if available.
		his assessment or the discharge date of this discharge a between July 1 and September 30, skip to W3,
2.	Influenza Vaccine	a. Did the resident receive the influenza vaccine in this facility for this year's influenza season (October 1 through March 31)?
V	<b>72 i</b>	No (ffNo, go to item W2b)     For Units, no to from W2b)     The Units, no to from W2b)     The Units, no to from W2b)     The Units of the Control of the Second Sec
	Pneumo- coccal Vaccine a	a. Is the resident's PPV status up to date? 0. No. (if No, go to item W3b) 1. Yes (IFVes, skip item W3b) 7. FRP, bet weaterd, Garneston, Secondary 1. Not eligible 2. Offered and declined

MDS 2.0 May, 2005

### MINIMUM DATA SET (MDS) - VERSION 2.0

### FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

**Correction Request Form** 

Use this form (1) to request correction of error(s) in an MDS assessment record or error(s) in an MDS Discharge or Reentry Tracking form record that has been previously accepted into the State MDS database, (2) to identify the inaccurate record, and (3) to attest to the correction request. A correction request can be made to either MODIFY or INACTIVATE a record.

TO MODIFY A RECORD IN THE STATE DATABASE:

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

- TO INACTIVATE A RECORD IN THE STATE DATABASE: 1. Complete this correction request form; 2. Create an electronic record of the Correction Request Form; and 3. Electronically submit this Correction Request record to the MDS database at the State.

THI: ERF the	S SECTION I ROR. (In this erroneous	DENTIFIES THE ASSESSMENT OR TRACKING FORM THAT IS IN section, reproduce the information EXACTLY as it appeared in record, even if the information is wrong. This information is	In EXACTLY as it appeared in swords. This information is te diatabase.) <ul> <li>Data entry enc</li> <li>Data entry enc</li> <li>Software product encr</li> <li>Atta entry encr</li> <li>Software product encr</li> <li>Software product encr</li> <li>Atta entry encr</li> <li>Software product encr</li> <li>Soft</li></ul>		
Prior AA1	RESIDENT				c . Software product error
	RROR. (In this section, reproduce the inform cessary in order to locate the record in exercises of the record in the inform cessary in order to locate the record in marking centre in the inform cessary in order to locate the record in marking centre in the record in the record in the record in the record in the record in the record in the record in the record in set of the record in the record in the second in in the record in the record in the second in the r	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)			d. Item coding error
Prior AA2		1. Male 2. Female	SMENT OR TRACKING FORM THAT IS IN information is XACTLY as it appeared in rimation is XACTLY as it appeared is XACTLY as it appeared is XACTLY if the rimation is XACTLY as it appeared is XACTLY if the rimation is XACTLY as it is XACTLY if		
Prior AA3	BIRTHDATE			-	
Prior AAS			Interaction control in the State database.       PCR         Interaction is working this information is in the information is a control of the information is working this information is in the information is working the information is information is working the information is information is working the information is the information is working the informatis working the information is working the information is		
Print		ECORD SECTION.       FCR.         In this section, reproduce the information EXACTY as it appeared in in rinks section, reproduce the information EXACTY as it appeared in in rinks section, reproduce the information EXACTY as it appeared in in rinks section, reproduce the information EXACTY as it appeared in in rinks section, reproduce the information EXACTY as it appeared in in rinks section, reproduce the information exact the information in EXACTY as it appeared in in order to locate the record in the State database.)            CRE			
AAS		1. Admission assessment (required by day 14)			c.Inadvertent submission of inappropriate record
		Significant correction of prior full assessment     Cuarterly review assessment     Significant correction of prior quarterly assessment			
		0. NONE OF ABOVE DISCHARGE TRACKING (Complete Prior Date item Prior R4 ONLY)	-		
		6. Discharged—return not anticipated 7. Discharged—return anticipated	ATS.		RN COORDINATOR ATTESTATION OF COMPLETION
		8. Discharged prior to completing initial assessment REENTRY TRACKING (Complete Prior Date item Prior A4a ONLY)			a (Fireh h /l art) c (Téin)
		b. Codes for assessments required for Medicare PPS or the State 1. Medicare 5 day assessment	ľ	SIGNATURE	artinati artinati artinati
		3. Medicare 60 day assessment 4. Medicare 90 day assessment 5. Medicare readmission/ietum assessment	AT6.		
		7. Medicare 14 day assessment	AT7		
	PRIORDATE	Complete Prior A3a if Primary Reason (Prior AA8a) equals 1, 2, 3, 4, 5, 10, or 0. Complete Prior R4 if Primary Reason (Prior AA8a) equals 5, 7, or 8.	RACKING FORM THAT IS IN       Inat apply, then skip to AT3       Inat apply, then skip to AT3         EXACTLY as it appeared in wrong. This information is o database.)       Inat apply, then skip to AT3       Inat apply, then skip to AT3         c.(Last)       d.(MSP)       Inat apply, then skip to AT3       Inat apply, then skip to AT3         c.(Last)       d.(MSP)       Inat apply, then skip to AT3       Inat apply, then skip to AT3         d.(MSP)       Inat apply, then skip to AT3       Inat apply, then skip to AT3       Inat apply, then skip to AT3         d.(MSP)       Inat apply, then skip to AT3       Inat apply, then skip to AT3       Inat apply, then skip to AT3         d.(MSP)       Inat apply, then skip to AT3       Inat apply, then skip to AT3       Inat apply, then skip to AT3         d.(Inst)       Inat apply, then skip to AT3       Inat apply, then skip to AT3       Inat apply, then skip to AT3         d.(Intra-Checked please specify:       Intra apply, then skip to AT3       Intra apply, then skip to AT3       Intra apply, then skip to AT3         a.Tat Action and the I collowing reasons; the ck all test one of the following reasons; the ck all test one of the following reasons; the ck all the stap to AT3       Intra apply, the AT4         a.Tat Action Ata Action apply, the analytic test apply apply apply test apply, the apply appl	resident and that I collected or coordinated collection of this information on the the best of my knowledge, this information was collected in accordance with re and Medicald requirements. I understand that this information is used as a that residents receive appropriate and quality care, and as a basis for payment	
Prior A3.	REFERENCE				
Prior			SMENT OR TRACKING FORM THAT IS IN Information EXACTLY as it appeared in ormation is warg. This information is in the state database.) <ul> <li>C. Software product enor</li> <li>D. Data entry enor</li> <li>C. Software product enor</li> <li>d. Item coding enor</li> <li>e. Other encr</li> <li>("70%" "Dec "checked please specify:</li> <li>("70%" "Checked please specify:</li></ul>		
R4,	DAIE				
Prior	DATEOF		1		
A4a	PR RECORD SECTION.       max apply draws by iterask pito ATS         Section (Deproduce the information EXACTLY as it appeared in this section, reproduce the information EXACTLY as it appeared in the information is section.       in an apply draws by iterask pito ATS         Section (Deproduce the information EXACTLY as it appeared in this section, reproduce the information is section.       in an apply draws by iterask pito ATS         RECORD SECTION.       Deba entry error       c. Data entry error         Section (Deproduce the information EXACTLY as it appeared in the State database.)       c. Software product error         RECORD SECTION.       Effective (Control in the State database.)       c. Software product error         BRTHANE       Immediate information (Control in the State database.)       c. Software product error         BRTHANE       Immediate information (Control in the State database.)       c. Software product error         BRTHANE       Immediate information (Control information (Control information information (Control information informatin information information informatin informatin				
		Month Day Year	OR TRACKING FORM THAT IS IN tation EXACTLY as it appeared in in is wrong. This information is State database.)       Inat apply then skip to AT3 a. Transcription error b. Data entry error c. Software product error d. Item coding error e. Other error if "Other" checked please specify:		
1		Logy real	1.0		

CORRECTION ATTESTATION SECTION. COMPLETE THIS SECTION TO EXPLAIN AND ATTEST TO THE CORRECT REQUEST

AT1.	ATTESTATION SEQUENCE NUMBER	(Enter total number of attestations for this record, including the present one)	_
ATZ	ACTION REQUESTED	1.MODIFY record in error (Attach and submit a COMPLETE assess- ment or tracking form. Do NOT submit the corrected items ONLY.	¥
		Proceed to item AT3 below; 2. INACTIVE record in error. (Do NOT submit an assessment or track- ing form. Submit the correction request only. Skip to item AT4.)	

MDS 2.0 September, 2000

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## 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 .

Medication Name and Dose Ordered. Record the name of the medication and dose ordered.
 Route of Administration (RA). Code the Route of Administration using the following list:

A). Code the Route of Administ	ration using the following list:
5=subcutaneous (SQ)	8=inhalation
6=rectal (R)	9=enteral tube
7-topical	10=other
	5=subcutaneous (SQ) 6=rectal (R)

3. Frequency. Code the number of times per day, week, or month the medication is administered using the following list:

PR=(PRN) as necessary	2D=(BID) two times daily QO=	every other day
1H=(QH) every hour	(includes every 12 hrs)	4W=4 times each week
2H=(Q2H) every two hours	3D=(TID) three times daily	5W=five times each week
3H=(Q3H) every three hours	4D=(QID) four times daily	6W=six times each week
4H=(Q4H) every four hours	5D=five times daily	1M=(Q month) once every month
6H=(Q6H) every six hours	1W=(Q week) once each wk	2M=twice every month
8H=(Q8H) every eight hours	2W=two times every week	C=continuous
1D=(QD or HS) once daily	3W=three times every week	O=other
	Th. 1.1 1 . C. 11 .	4

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.

1. Medication Name and Dose Ordered	2. RA	3. Freq	4. AA	5. PRN-n	6.	ND	сс	ode	5	
					П	П	Τ			T
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Numeric Identifier

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

#### BASIC ASSESSMENT TRACKING FORM

1.2.8	s of Persons who Completed a Portion of the Accomp orm		RESIDENT
ident assessment or trackin	e accompanying information accurately reflects resident this resident and that I collected or coordinated collection	a. (First) b. (Middle Initial) c. (Last) d. (JdSr)	
collected in accordance with	. To the best of my knowledge, this information was colle	1.Male 2.Female	GENDER®
e, and as a basis for paymer al funds and continued partic d on the accuracy and truthfu	licare and Medicaid requirements. I understand that this ing that residents receive appropriate and quality care, an nds. I further understand that payment of such federal fun vermment-funded health care programs is conditioned on the sum of the sum	Month Dev Year	BIRTHDATE
iay subject my organization t itting false information. I als on its behalf.	xmation, and that I may be personally subject to or may subject to or may subject to or may subject to administrative penalties for submitting a authorized to submit this information by this facility on it	2.Asian/Pacific Islander 5.White, not of 3.Black, not of Hispanic origin Hispanic origin	ETHNICITY
Sections Dat	nd Title Se	a. Social Security Number	SOCIAL
		AND	
		o wedicare number (or comparable railroad insurance number)	NUMBER S ^Q
			[C in 1" box if non med. no.]
с.	a. State No.		
			PROVIDER NO.
			NO.
		b. Federal No.	
			MEDICAID
			NO. ["+" If pending, "N"
			if not a Medicaid
			recipient
			500
		a. Primary reason for assessment 1. Admission assessment (regulared by day 14)	ASSESS-
		2 Annual assessment 3. Significant change in status assessment	IVIE: N I
		<ol><li>Significant correction of prior full assessment</li></ol>	1 1
		5. Outriefy review assessment 10. Significant correction of prior quarterly assessment 0. NONE OF ABOVE	
		b, Codes for assessments required for Medicare PPS or the State 1. Medicare 5 day assessment 2. Medicare 30 day assessment	
		3. Medicare 60 day assessment 4. Medicare 90 day assessment	
		5. Medicare readmission/return assessment	
		7. Medicare 14 day assessment	
		Medicare 80 day assessment     Medicare 80 day assessment     Medicare 80 day assessment     Medicare readmission/return assessment     Other state 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.)

 $\Theta$  = Key items for computerized resident tracking

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

## MDS MEDICARE PPS ASSESSMENT FORM (VERSION JULY 2002)

	(VEF	RSION JULY 2002)			Numeric Identifier
AB5.	RESIDEN- TIAL HISTORY 5 YEARS PRIOR TO ENTRY	(Check all settings resident lived in during 5 years prior to date of 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/spychiatric setting e. MR/DD setting	C4	MAKING SELF UNDER- STOOD	(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
A1.	RESIDENT NAME ROOM NUMBER	f. NONE OF ABOVE a. (First) b. (Middle Initial) c. (Last) d. (J#Sr)	C6.	ABILITY TO UNDER- STAND OTHERS	(Understanding verbal information content—however able) 0.UNDERSTANDS 1.USUALLY UNDERSTANDS—may miss some pert/intent of message 2.SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication
A3.	ASSESS- MENT REFERENCE DATE	a. Last day of MDS observation period Morth Day Year	D1.	VISION	3. RARELYNEVER UNDERSTANDS (Ability to see in adequate light and with glasses if used) 0. ADECUATE—sees fine detail, including regular print in newspapers/books 1. IMPA/RED—sees large print, but not regular print in newspapers/
A4a	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospital in last 00 days (or since last assessment or admission if less than 90 days) Month Day Year 1. Never matried 3. Widowed 5. Divorced			In International Internationa International International International International Internati
A6.	STATUS MEDICAL RECORD NO.	2. Married 4. Separated	E1.	INDICATORS OF DEPRES-	shapes; eyes do not appear to follow objects (Code for indicators observed in last 30 days, krespective of the assumed cause) 0. Indicator not exhibited in last 30 days
A 10.	ADVANCED DIRECTIVES	(For those items with supporting documentation in the medical record, check all that apply)		SION, ANXIETY, SAD MOOD	
B1.	COMATOSE	b. Do not resuscitate c. Do not hospitalize (Persistant vagetative state/ho discernible consciousness) 0. No 1. Yes (If Yes, skip to Section G)			VERBAL EXPRESSIONS IN. Repetitive health OF DISTRESS complaints—e.g. persistently seeks medical attention, obsessive
B2.	MEMORY	(Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory coblem			statements—e.g., "Nothing concern with body functions matters: Would rather be dead; What's the use; Regrets having lived so long. Let me die" b. Repetitive questions—e.g., persistently seeks attention/ reassurance regarding
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     e. NONE OF ABOVE are recalled			"Vihare do i go: What do i         schedules, moals, laundry, clothing, relationship issues           c. Repetitive verbalizations— e.g., caling out for help, ("God help me")         SLEEP-CYCLE ISSUES
B4.	COGNITIVE SKILLS FOR DAILY DECISION- MAKING	(Made decisions regarding tasks of daily life) 0. INDEPENDENT—decisions consistentireasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions			d. Persistent anger with self or others, e.g., easily annoyed, anger at. placement in nursing home; anger at care received       k. Insomnia/change in usual sleep pattern         SAD, APATHETIC, ANXIOUS APPERANCE       SAD, APATHETIC, ANXIOUS APPERANCE         e. Self deprecation — e.g., "I am nothing; I am of no usa to anyone"       I. Sad, pained, worried facial expressions — e.g., furrowed brows.
B5.	INDICATORS OF DELIRIUM— PERIODIC DISOR- DERED THINKING/ AWARENESS	(Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time]. 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)			f. Expressions of what appear to be unrealistic leafs—e.g., ear of being abandone, 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, heve a heart attack
		b. PERIODS OF ALTERED PERCEPTION OR AVARENESS OF SURROUNDINGS—(e.g., moves ips or talks to someone not present; beleves he/she is somewhere else; contuses night and day) c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambing from subject to	E2.	MOOD PERSIS- TENCE	p. Reduced social interaction One or more Indicators of depressed, sad or anxious mood were not easily aftered by aftempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood 1. Indicators present, 2. Indicators present,
		Content in conservation intervation of nambing from subject to subject loses train of thought)     Conservation intervation intervation changes; repetitive physical movements or calling out)     e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)     f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)		1	indicators easily altered not easily altered

OhIB 0938-0739 expiration date 12/31/2002

MDS 2.0 PPS July 2002

BEHAVIORAL	(A) Behavioral symptom frequency in last 7 days			G3.	TEST FOR	(Code for ability during test in the l	ast 7 days)			
SYMPTOMS	0. Behavior not exhibited in last 7 days		- 1		BALANCE	0. Maintained position as required	in test			
	1. Behavior of this type occurred 1 to 3 days in last 7 days		- 1		(see training	<ol> <li>Unsteady, but able to rebalance</li> <li>Partial physical support during t</li> </ol>	self without physical support est:			
	2. Behavior of this type occurred 4 to 6 days, but less than daily		- 1		manual)	or stands (sits) but does not follo	ow directions for test			
	3. Behavior of this type occurred daily		- I			<ol> <li>Not able to attempt test without a. Balance while standing</li> </ol>	physical help	_		
	(B) Sehavioral symptom alterability in last 7 days		- 1				truck control	H		
			- 1	GA	FUNCTIONAL	b. Balance while sitting—position. (Code for limitations during last 7)		ictics		
	0. Behavior not present OR behavior was easily altered	185		1	LIMITATION	placed residents at risk of injury)				
	1. Behavior was not easily altered	(A)	(8)		IN RANGE OF MOTION	(A) RANGE OF MOTION 0. No limitation	(B) VOLUNTARY MOVEN 0. No loss	IENT		
	<ul> <li>WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)</li> </ul>				MOTION	1. Limitation on one side 2. Limitation on both sides	1. Partial loss 2. Full loss	(A)		
	b. VERBALLY ABUSIVE BEHA/IORAL SYMPTOMS (others were threatened, screamed at, cursed at)					a, Neck b. Arm—Including shoulder or elb	ow	-		
	c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)					c. Hand—Including wrist or fingers d. Leg—Including hip or knee	5	F		
	d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming,	-				e. Foot—Including ankle or toes				
	self-abusive acts, sexual behavior or disrobing in public,					f. Other limitation or loss				
	smeared/threw food/feces, hoarding, rummaged through others'			G5.		(Check if applied during last 7 days)				
	belongings)				LOCOMO- TION	b. Wheeled self				
	<ul> <li>RESISTS CARE (resisted taking medications/injections, ADL assistance, or eating)</li> </ul>			G6.	MODES OF	(Check all that apply cluring last 7 days	2			
(A) ADL SEU	F-PERFORMANCE—(Code for resident's PERFORMANCE OVER )	LL		30.	THE & ALCONTROL	a. Bedfast all or most of time	·			
SHIFTS d	luring last 7 days—Not including setup)		- I		-7000106050000- 					
	IDENT-No help or oversight -OR- Help/oversight provided only 1	or 2				<li>b. Bed rails used for bed mobility or transfer</li>				
	ng last 7 days	2020		G7.	TASK	Some or all of ADL activities were	broken into subtasks during last	7		
last 7 days	<ol> <li>SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days</li> </ol>				TION	days so that resident could perform them 0. No 1. Yes				
	ASSISTANCE—Resident highly involved in activity; received physical	helo	_ I	11.		E SELF-CONTROL CATEGORIES nt's PERFORMANCE OVER ALL SHIFTS				
in guided	ded maneuvering of limbs or other nonweight bearing assistance 3 or more times				ing a weekne		ne Second a second a se	-		
	ore help provided only 1 or 2 times during last 7 days VEASSISTANCE—While resident performed part of activity, over las	7-da	v		devicethat	NT—Complete control [includes use of indwelling urinary catheter or osto t does not leak urine or stool]				
<ul> <li>particle help of following type(s) provided 3 or more times:</li> <li>Weight-bearing support</li> <li>Full staff performance during part (but not all) of last 7 days</li> </ul>					1. USUALLY C BOWEL, let	CONTINENT—BLADDER, incontin ss than weekly	ent episodes once a week or les	6;		
			- 1		2. OCCASION	VALLY INCONTINENT-BLADDER	R, 2 or more times a week but no	t dail		
					BCWEL, on	ce a week				
8. ACTIVITY	CTIVITY DID NOT OCCUR during entire 7 days					3. FREQUENTLY INCONTINENT-BLADDER, tended to be incontinent daily, but				
	(B) ADL SUPPORT PROVIDED-(Code for MOST SUPPORT PROVIDED OVER ALL					ent (e.g., on day shift); BOWEL, 2-	3 times a week			
classificat	ing last 7 days; code regardless of resident's self-performance (on)	(A)	(B)		4. INCONTIN	ENT-Had inadequate control BLA	DDER, multiple daily episodes;			
	or physical help from staff	ERF	1.			(or almost all) of the time		-		
<ol> <li>Setup het</li> <li>One perso</li> </ol>	o only on physical assist 8. ADL activity itself did not	LF-PERF	SUPPORT	a.	BOWEL CONTI-	Control of bowel movement, with	appliance or bowel continence			
3. Two+ pers	ions physical assist occur during entire 7days	SEL	2		NENCE	programs, if employed				
BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed			b.	BLADDER CONTI- NENCE	Control of urinary bladder function soak through underpants), with ap programs, if employed	i (if dribbles, volume insufficient to opliances (e.g., foley) or continen	ce		
TRANSFER	How resident moves between surfaces-to/from: bed, chair,			H2.	BOWEL	c. Diarrhea		+		
	wheelchair, standing position (EXCLUDE to/from bath/toilet)				ELIMINATION PATTERN	d. Fecal impaction				
WALK IN	How resident walks between locations in his/her room			H3.		a. Any scheduled toileting plan	d. Indwelling cathe	tor		
				1900	AND	b. Bladder retraining program	L Ostomy present	- T		
ROOM WALK IN										
MALL OF IN	How resident walks in corridor on unit				PROGRAMS	c. External (condom) catheter				
WALK IN CORRIDOR LOCOMO- TION	How resident walks in corridor on unit How resident moves between locations in his/her room and adjucent corridor on same floor. If in wheelchair, self-sufficiency once in chair				Section I : che					
WALK IN CORRIDOR LOCOMO- TION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair			cog	Section I : che nitive status, me	c. External (condom) catheter				
WALK IN CORRIDOR LOCOMO- TION ON UNIT LOCOMO- TION	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has			cog dea	Section I : che nitive status, m th. (Do not list in	c. External (condom) catheter	eatments, nursing monitoring, or	risk		
WALK IN CORRIDOR LOCOMO- TION ON UNIT LOCOMO- TION OFF UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on only one floor, how resident moves to and from distant areas.			cog	Section I : che nitive status, m th. (Do not list in	c. External (condom) catheter eck only those diseases that have ood and behavior status, medical tr nactive diagnoses) a. Diabetes melitus	eatments, nursing monitoring, or	risk		
WALK IN CORRIDOR LOCOMO- TION ON UNIT LOCOMO- TION OFF UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair			cog dea	Section I : che nitive status, m th. (Do not list in	c. External (condom) catheter teck only those diseases that have ood and behavior status, medical tr active diagnoses) a. Diabetes melitus d. Arteriosclerotic heart	eatments, nursing monitoring, or v. Hemiplegia/Hemipares w. Multiple scierosis	risk		
WALK IN CORRIDOR LOCOMO- TION ON UNIT LOCOMO- TION OFF UNIT DRESSING	How resident moves between locations in his/her room and adjucent corridor on same floor. If in wheelchair, self-sufficiency once in chair How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on only one floor, how resident moves to and from distant areas.			cog dea	Section I : che nitive status, m th. (Do not list in	c. External (condom) catheter sck only those diseases that have ood and behavior status, medical tr active diagnoses) a. Diabetes melitus d. Arteriosclerotic heart disease (ASHD)	v. Hemiplegia/Hemipares w. Multiple sclerosis x. Paraplegia	risk		
WALK IN CORRIDOR LOCOMO- TION ON UNIT LOCOMO- TION OFF UNIT DRESSING EATING	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair How resident puts on, fistens, and takes off all items of clothing, including donning/removing prosthesis: How resident eats and drinks (regardess of skill). Includes intake of			cog dea	Section I : che nitive status, m th. (Do not list in	c. External (condom) catheter teck only those diseases that have ood and behavior status, medical tr nactive diagnoses) a. Diabetes meltus d. Arteriosclerotic heart disease (ASHD) f. Congestive heart failure	v. Hemiplegia/Hemipares w. Multiple sclerosis X. Paraplegia 2. Cuadriplegia	risk		
WALK IN CORRIDOR LOCOMO- TION ON UNIT LOCOMO- TION OFF UNIT DRESSING EATING	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair How resident pats on, fistens, and takes of all items of clothing, including donning/removing prosthesis. How resident eats and drinks (regardless of skill). Includes intake of nourshment by other means (e.g., tube feeding, total parenteral			cog dea	Section I : che nitive status, m th. (Do not list in	c. External (condom) catheter sck only those diseases that have ood and behavior status, medical tr active diagnoses) a. Diabetes melitus d. Arteriosclerotic heart disease (ASHD)	v. Hemplegia/Hemplegia/ W. Multiple scierosis X. Paraplegia 2. Ouzdriplegia ee. Depression	risk is		
WALK IN CORRIDOR LOCOMO- TION ON UNIT LOCOMO- TION OFF UNIT DRESSING EATING	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair How resident puts on, fistens, and takes off all items of clothing, including doning/removing prosthesis How resident eats and clinks (regardless of skill). Includes intake of nourishment by other meens (e.g., tube feeding, total parenteral nutrition)			cog dea	Section I : che nitive status, m th. (Do not list in	c. External (condom) catheter sck only those diseases that have ood and behavior status, medical tr active diagnoses) a. Diabetes melitus d. Arteriosclerotic heart disease (ASHD) f. Congestive heart failure J. Peripheral vascular disease	v. Hemiplegia/Hemipares w. Multiple scierosis X. Paraplegia 2. Cuadriplegia ee. Depression ff. Manic depressive (bipc	risk is		
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WALK IN CORRIDOR LOCOMO- TION ON UNIT LOCOMO- TION OFF UNIT DRESSING EATING	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair How resident pats on, fistens, and takes of all items of clothing, including donning/removing prosthesis. How resident eats and drinks (regardless of skill). Includes intake of nourshment by other means (e.g., tube feeding, total parenteral			cog dea	Section I : che nitive status, m th. (Do not list in	c. External (condom) catheter sck only those diseases that have ood and behavior status, medical tr active diagnoses) a. Diabetes melitus d. Arteriosclerotic heart disease (ASHD) f. Congestive heart failure J. Peripheral vascular disease m. Hip fracture r. Aphasia	V. Hemiplegia/Hemipares     W. Multiple scierosis     X. Paraplegia     E. Depression     ff. Manic depressive (bjpc disease)     gg. Schizophrenia	risk (		
WALK IN CORRIDOR LOCOMO- TION ON UNIT LOCOMO- TION OFF UNIT DRESSING EATING EATING	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair How resident pats on, fistens, and takes of all items of clothing, including donning/removing prosthesis. How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition). How resident uses the toilet room (or commode, bedpan, urinal); banifier on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes.			cog dea	Section I : che nitive status, m th. (Do not list in	c. External (condom) catheter sck only those diseases that have ood and behavior status, medical tr active diagnoses) a. Diabetes melitus d. Arteriosclerotic heart disease (ASHD) f. Congestive heart failure j. Peripheral vascular disease m. Hip facture r. Aphasia s. Cerebral palsy	v. Hemiplegia/Hemipares     v. Multiple scierosis     v. Multiple scierosis     v. Multiple scierosis     v. Paraplegia     c. Cuadripiegia     ee. Depression     ff. Manic depressive (bipo disease)     gs. Schizophrenia     hh. Asthma	risk is		
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WALK IN CORRIDOR LOCOMO- TION ON UNIT LOCOMO- TION OFF UNIT DRESSING EATING EATING PERSONAL HYGIENE BATHING	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair How resident puts on, fistens, and takes off all items of clothing, including donning/temoving prosthesis How resident eats and clinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition) How resident uses the toilet room (or commode, bedpan, urinal); transfer on/for toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes How resident maintains personal hygiene, including combing hair, brushing text, shaving, applying makeup, washing/driving face, hands, and perineum (EXCLUDE baths and showers) How resident takes full-body bathshower, sponge bath, and transfer unit of full-bihower (EXCLUDE washing of back and transfer sindicut of full-bihower (EXCLUDE) to back and			l11.	Section I : che nitive status, m th. (Do not list in	c. External (condom) catheter cond and behavior status, medical tr nactive diagnoses) a. Diabetes melitus d. Arteriosclerotic heart disease (ASHD) f. Congestive heart failure J. Peripheral vascular disease m. Hip fracture r. Aphasia s. Cerebral palsy t. Cerebral palsy t. Cerebraul accident (stroke) (If none apply, CHECK the NONE OF AU	v. Hemiplegia/Hemipares     v. Multiple scierosis     x. Paraplegia     2. Ouadripriegia     ec. Depression     ff. Manic depressive (bipo disease)     gs. Schizophrenia     hh. Asthma     il. Emphysema/COPD	risk is		
WALK IN CORRIDOR LOCOMO- TION ON UNIT LOCOMO- TION OFF UNIT DRESSING EATING EATING PERSONAL HYGIENE BATHING	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair How resident pats on, fistens, and takes of all items of clothing, including donning/removing prosthesis. How resident eats and drinks (regardless of skill). Includes intake of noursihment by other means (e.g., tube feeding, total parenteral nutrition) How resident uses the toilet room (or commode, bedpan, urinal); transfer ontoff toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes How resident uses the toilet room (or commode, bedpan, urinal); transfer adjusts clothes How resident takes full-body bath/shower, sponge bath, and transfers in/out of fublishower (EXCLUDE washing of back and hair). Code for most dependent in self-patrimance.			l11.	Section I : che nitive status, m th. (Do not list in DISEASES	c. External (condom) catheter csck only those diseases that have cod and behavior status, medical tr nactive diagnoses) a. Diabetes melitus d. Arteriosclerotic heart disease (ASHD) f. Congestive heart failure J. Peripheral vascular disease m. Hip fracture r. Aphasia s. Cerebral palsy t. Cerebral palsy t. Cerebravascular accident (stroke) (If none apply, CHECK the NONE OF AL a. Antibiotic resistant fe.g. Methicilin resistant	v. Hemiplegia/Hemipares     v. Multiple scierosis     X. Paraplegia     2. Quadriplegia     ec. Depression     ff. Manic depressive (bipo disease)     gg. Schizophrenia     hh. Aathma     il. Emphysema/COPD	risk is		
WALK N CORRIDOR LOCOMO- TION ON UNIT LOCOMO- TION OFF UNIT COLETUSE PERSONAL HYGIENE BATHING	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair How resident pats on, fistens, and takes of all items of clothing, including donning/removing prosthesis How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition) How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes How resident takes full-body bath/showers, sponge bath, and transfers in/out of tub/shower (EXCLUDE baths and showers) How resident takes full-body bath/shower, sponge bath, and transites in/out of tub/shower (EXCLUDE washing of back and hair); Code for most dependent in <i>self-pat/smanace</i> . (A) BATHING SELF PERFORMANCE codes appear below			l11.	Section I : che nitive status, m th. (Do not list in DISEASES	c. External (condom) catheter cond and behavior status, medical tr nactive diagnoses) a. Diabetes melitus d. Arteriosclerotic heart disease (ASHD) f. Congestive heart failure J. Peripheral vascular disease m. Hip fracture r. Aphasia s. Cerebral palsy t. Cerebroascular accident (stroke) (If none apply, CHECK the NONE OF Al a. Antibiotic resistant infection (e.g. Methicillin resistant staph)	v. Hemiplegia/Hemipares     v. Multiple scierosis     x. Paraplegia     2. Ouadripriegia     ec. Depression     ff. Manic depressive (bipo disease)     gs. Schizophrenia     hh. Asthma     il. Emphysema/COPD	risk is		
WALK N CORRIDOR LOCOMO- TION ON UNIT LOCOMO- TION OFF UNIT DRESSING EATING EATING FOILET USE PERSONAL HYGIENE BATHING	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair How resident puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition) How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes How resident takes full-body bath/shower, sponge bath, and transfers in off to flub. Advense (EXCLUDE baths and showers) How resident takes full-body bath/shower, sponge bath, and transfers indivit of flubshower (EXCLUDE washing of back and hait); Code for most dependent in self-performance. (A) BATHING SELF PERFORMANCE codes appear below 0. Independent—No help provided		(A)	l11.	Section I : che nitive status, m th. (Do not list in DISEASES	c. External (condom) catheter cck only those diseases that hav cool and behavior status, medical tr active disposes) a. Diabetes melitus d. Arteriosclerotic heart disease (ASHD) f. Congestive heart failure j. Peripheral vascular disease m. Hip fracture r. Aphasia s. Cerebral palsy t. Cerebral palsy t. Cerebral palsy t. Cerebral palsy dif none apply, CHECK the NONE OF Al a. Antibiotic resistant infection (e.g. Methicillin resistant staph) b. Clostridium difficile (c. diff.)	eatments, nursing monitoring, or v. Hemiplegia/Hemipares w. Multiple scierosis x. Paraplegia e. Depression ff. Manic depressive (bipc disease) gg. Schizophrenia hh. Asthma il. Emphysema/COPD 30VEbox) g. Septicernia h. Seevally transmitted	risk is		
WALK IN CORRIDOR LOCOMO- TION ON UNIT LOCOMO- TION OFF UNIT DRESSING EATING TOILET USE PERSONAL HYGIENE BATHING	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair How resident puts on, fistens, and takes off all flems of clothing, including donning/temoving prosthesis How resident uses the toilet room (or commode, bedpan, urinal); transfer onloff toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes How resident maintains personal hygiene, including combing hair, bruching taelb, shaving, apphyling makey, washing/dining face, hands, and perineum (EXCLUDE baths and showers) How resident takes full-body bathshower, sponge bath, and transfer ont of tubih.tower (EXCLUDE washing of back and hair). Code for most dependent in self-performance. (A) BATHING SELF PERFORMANCE codes appear below 0. Independent—No help provided 1. Supervision—Oversight help only		(A)	l11.	Section I : che nitive status, m th. (Do not list in DISEASES	c. External (condom) catheter c. Karnal (condom) catheter c. Conly those diseases that have cood and behavior status, medical in active diagnoses) a. Diabetes melitus d. Arteriosclerotic heart disease (ASHD) f. Congestive heart failure J. Peripheral vascular disease m. Hip fracture r. Aphasia s. Cerebral palsy L. Cerebrovascular accident (stroke) (ff. none apply, CHECK the NONE OFAI a. Antibiote cost ant indexton (staph) D. Clostridum dificile (c. diff) c. Conjunctivitis	v. Hemiplegia/Hemipares     v. Multiple scierosis     X. Paraplegia     Z. Quadriplegia     ec. Depression     ff. Manic depressive (bipo disease)     gg. Schizophrenia     hh. Asthma     il. Emphysema/COPD     Sopticemia     h. Sequally transmitted diseases     L. Tuberculosis	risk (		
WALK IN CORRIDOR LOCOMO- TION ON UNIT LOCOMO- TION OFF UNIT DRESSING EATING TOILET USE PERSONAL HYGIENE BATHING	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair. How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair How resident pats on, fistens, and takes of fall Rems of clothing, including donning/removing prosthesis. How resident eats and drinks (regardless of skill). Includes intake of noursihment by other means (e.g., tube feeding, total parenteral nutrition). How resident uses the toilet room (or commode, bedpan, urinal); brainsfer and/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes. How resident takes fail-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair); Code for most dependent in <i>self-patrmana.</i> (A) BATHING SELF PERFFORMANCE codes appear below 0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to transfer only		(A)	l11.	Section I : che nitive status, m th. (Do not list in DISEASES	c. External (condom) catheter cck only those diseases that have cool and behavior status, medical tr active disposes) a. Diabetes melitus d. Arteriosclerotic heart disease (ASHD) f. Congestive heart failure j. Peripheral vascular disease m. Hip fracture r. Aphasia s. Cerebral palsy t. Cerebral palsy t. Cerebral palsy t. Cerebral palsy dif none apply, CHECK the NONE OF Al a. Antibiotic resistant infection (e.g. Methicillin resistant staph) b. Clostridium difficile (c. diff.)	eatments, nursing monitoring, or v. Hemiplegia/Hemipares w. Multiple scierosis x. Paraplegia e. Depression ff. Manic depressive (bipo disease) gg. Schizophrenia hh. Asthma ii. Emphysema/COPD 30VE box) g. Septicernia h. Secually transmitted diseases L. Tuberculosis J. Urinary tract infection in ii.att 30 days	risk (		
WALK IN CORRIDOR LOCOMO- TION ON UNIT LOCOMO- TION OFF UNIT DRESSING EATING TOILET USE PERSONAL HYGIENE BATHING	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair How resident pats on, fastens, and takes off all items of clothing. Including donning/removing prosthesis How resident tests and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition) How resident uses the toilet room (or commode, bedpan, urinal); transfer on/diff toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes How resident maintains personal hygiene, including combing hair, brushing tesk, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers) How resident takes full-body bath/shower, sponge bath, and transfers in/du of fub/shower (EXCLUDE washing of back and hair.) Code for most dependent in self-performance. (A) BATHING SELF PERFORMANCE codes appear below 0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to tarafer only 3. Physical help in part of bathing activity.		(A)	l11.	Section I : che nitive status, m th. (Do not list in DISEASES	c. External (condom) catheter c. Karnal (condom) catheter c. Conly those diseases that have cood and behavior status, medical in active diagnoses) a. Diabetes melitus d. Arteriosclerotic heart disease (ASHD) f. Congestive heart failure J. Peripheral vascular disease m. Hip fracture r. Aphasia s. Cerebral palsy L. Cerebrovascular accident (stroke) (ff. none apply, CHECK the NONE OFAI a. Antibiote cost ant indexton (staph) D. Clostridum dificile (c. diff) c. Conjunctivitis	v. Hemiplegia/Hemipares     v. Multiple scierosis     v. Multiple scierosis     v. Multiple scierosis     v. Multiple scierosis     v. Aurapiegia     v. Cuadripriegia     ec. Depression     ff. Manic depressive (bipo disease)     gg. Schizophrenia     hh. Asthma     il. Emphysema/COPD     Sopticernia     h. Sexually transmitted diseases     i. Tuberculosis     j. Urinary tract infection in Instat of days     k. Viral hepatitis	risk (		
WALK IN CORRIDOR CORRIDOR INCOMO- TION OFF UNIT DRESSING EATING TOILET USE PERSONAL HYGIENE BATHING	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair. How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair How resident pats on, fistens, and takes of fall Rems of clothing, including donning/removing prosthesis. How resident eats and drinks (regardless of skill). Includes intake of noursihment by other means (e.g., tube feeding, total parenteral nutrition). How resident uses the toilet room (or commode, bedpan, urinal); brainsfer and/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes. How resident takes fail-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair); Code for most dependent in <i>self-patrmana.</i> (A) BATHING SELF PERFFORMANCE codes appear below 0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to transfer only		(A)	l11.	Section I : che nitive status, m th. (Do not list in DISEASES	c. External (condom) catheter cck only those diseases that have cod and behavior status, medical tr active diagnoses) a. Diabetes melitus d. Arteriosclerotic heart disease (ASHD) f. Congestive heart failure j. Peripheral vascular disease m. Hip fracture r. Aphasia s. Cerebral palsy t. Cerebrovascular accident (stroke) (ff none apply, CHECK the NONE OF AI a. Antibiotic resitant infection (e.g. Methicillin resistant staph) b. Clostridium difficile (c. diff) c. Conjunctivitis d. HIV infection	eatments, nursing monitoring, or v. Hemiplegia/Hemipares w. Multiple scierosis x. Paraplegia e. Depression ff. Manic depressive (bipo disease) gg. Schizophrenia hh. Asthma ii. Emphysema/COPD 30VE box) g. Septicernia h. Secually transmitted diseases L. Tuberculosis J. Urinary tract infection in ii.att 30 days	risk (		

13.55	OTHER		M2.	TYPE OF (For each type of ulcer, code for the highest stage in the last 7 days using		
	CURRENT	• [[[]]]		ULCER	scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)	
	AND ICD-9 CODES	b.	11		<ul> <li>Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue</li> </ul>	
11.	PROBLEM	(Check all problems present in last 7 days unless other time frame is indicated)			b. Stasis ulcer-open lesion caused by poor circulation in the lower extremities	
		INDICATORS OF FLUID STATUS c. Delusions a. Visioht gain or loss of 3 or g. Edema	M3.	HISTORY OF RESOLVED ULCERS	Resident had an ulcer that was resolved or cured in LAST 90 DAYS D. No 1. Yes	
		a. Weight gain or loss of 3 or g. Edema	M4.	OTHER SKIN PROBLEMS	a. Abrasions, bruises b. Burns (second or third degree)	
		b. Inability to lie flat due to J. Internal bleeding	11	OR LESIONS PRESENT	c. Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)	
		c. Dehydrated: output Last 90 days	11	(Check all that	d. Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster	
		exceeds input I. Shortness of breath d. Insufficient fluid; did NOT D. Unstandy mit		apply during last 7 days)	<ul> <li>Skin desensitized to pain or pressure</li> <li>Skin tears or cuts (other than surgery)</li> </ul>	
		G. Insufficient fluid; did NOT     consume all/almost all     liquids provided during last     3 days			g. Surgical wounds h. NONE OF ABOVE	
J2,	PAIN	(Code the highest level of pain present in the last 7 days)	M5.	SKIN	a. Pressure relieving device(s) for chair	
	SYMPTOMS	a. FREQUENCY with which b. INTENSITY of pain seident complains or	11	TREAT- MENTS	b. Pressure relieving device(s) for bed	
		shows evidence of pain		(Check all that	<ul> <li>C. Turning/repositioning program</li> <li>d. Nutrition or hydration intervention to manage skin problems</li> </ul>	
		0. No pain (skip to J4) 2. Moderate pain 3. Times when pain is horrible		apply during last 7 days)	e, Ulcer care	
		1. Pain less than daily 3. Times when pain is nomble 2. Pain daily or excruciating			f. Surgical wound care	
J4.	ACCIDENTS	(Check all that apply) c. Hip fracture in last 180 days	11		g. Application of dressings (with or without topical medications) other than to feet	
		a. Fell in past 30 days d. Other Facture in last 180 days days			h. Application of ointments/medications (other than to feet)	
		e. NONE OF ABOVE			L Other preventative or protective skin care (other than to feet) L NONE OF ABOVE	
J5.	STABILITY OF	<ol> <li>Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating)</li> </ol>	M6.	FOOT	a. Resident has one or more foot problems—e.g., corns, callouses,	
	CONDITIONS	b. Resident experiencing an acute episode or a flare-up of a recurrent.		PROBLEMS AND CARE	bunions, hammer toes, overlapping toes, pain, structural problems b. Infection of the foot-e.g., cellulitis, purulent drainage	
		or chronic problem c. End-stage disease, 6 or fewer months to live		(Check all that	c. Open lesions on the foot	
	d. NONE OF ABOVE			apply during ast 7 days)	d. Nails/calluses trimmed during last 90 days	
(1.	ORAL PROBLEMS	a. Chewing problem b. Swallowing problem		LOSINDO-NOLI.	<ul> <li>Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)</li> </ul>	
K2.	HEIGHT	Record (a.) height in inches and (b.) weight in pounds. Base weight on most			f. Application of dressings (with or without topical medications)	
	AND WEIGHT	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 night-lothes a. HT (os) b. WT (in) b.	N1.	TIME	g. NONE OF ABOVE (Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:	
кз.	WEIGHT	a. Weight loss—5 % or more in last 30 days; or 10 % or more in last	11		a. Morning c. Evening b. Afternoon d. NONE OF ABOVE	
	CHANGE	180 days 0. No 1. Yes	(If	resident is co	matose, skip to Section O)	
		b. Weight gain—5 % or more in last 30 days; or 10 % or more in last 180 days	N2.	TIME INVOLVED IN	(When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None	
		0. No 1. Yes (Check all that apply in last 7 days)		ACTIVITIES	(Record the number of different medications used in the last 7 days; enter	
K5.	NUTRI- TIONAL APPROACH-		01			
K5.	TIONAL APPROACH-	a. Parenteral/IV h. On a planned weight	01.	MEDICA- TIONS	"0" il none used)	
0.526	TIONAL APPROACH- ES	a. Parenteral/IV h. On a planned weight change program b. Feeding tube		MEDICA-	"0" if none used) (Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)	
0.526	TIONAL APPROACH- ES PARENTERAL OR ENTERAL	A. Parenteral/IV     h. On a planned weight     change program     (Skip to Section M If neither 5a nor 5b is checked)		MEDICA- TIONS	(Record the number of DAYS injections of any type received during the has? days; enter "0" if none used) (Record the number of DAYS during has? days; enter "0" if not used.	
0.025	TIONAL APPROACH- ES PARENTERAL	A. Parenteral/IV     b. Feeding tube     (Skip to Section III if neither 5a nor 5b is checked)     A. Code the proportion of total calories the resident received through     parenteral or tube feedings in the last 7 days	03.	MEDICA- TIONS INJECTIONS DAYS RECEIVED THE	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)	
	TIONAL APPROACH- ES PARENTERAL OR ENTERAL	A. Parenteral/IV     b. Feeding tube     (Skip to Section M if neither 5a nor 5b is checked)     a. Code the proportion of total calorites the resident received through     parenteral or tube feedings in the last 7 days     0. None     3. 51% to 75%     1. 1% to 25%     4. 76% to 100%	03.	MEDICA- TIONS INJECTIONS DAYS RECEIVED	(Record the number of DAYS injections of any type received during the last? days; enter "0" if none used; (Record the number of DAYS during last? days; enter "0" if not used. Note—enter "1" for iong-acting media used last than weekly) a. Anthyspectolic b. Anthanxiety d. Hypenotic b. Anthanxiety e. Diuretic	
0.025	TIONAL APPROACH- ES PARENTERAL OR ENTERAL	A. Parenteral/IV     b. Feeding tube     (Skip to Section IV II neither 5a nor 5b is checked)     a. Code the proportion of total calories the resident received through     parenteral or tube feedings in the last 7 days     0. None     3. 51% to 75%     1.1% to 25%     4. 76% to 150%     2.26% to 50%     b. Code the average fluid intake per day by IV or tube in last 7 days     0. None     3. 1001 to 1500 cc/day	03.	MEDICA- TIONS INJECTIONS DAYS RECEIVED THE FOLLOWING MEDICATION SPECIAL TREAT-	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used; (Record the number of DAYS during last 7 days; enter "0" if not used. Note—enter "1" for iong-acting meds used less than weekly) a. Antipsycholic d. Hypnotic	
	TIONAL APPROACH- ES PARENTERAL OR ENTERAL	a. Parenteral/IV     b. Feeding tube     b. Feeding tube     change program     (Skip to Section M if neither 5a nor 5b is checked)     a. Code the proportion of total calories the resident received through     parenteral or tube feedings in the last 7 days     0. None         3. 51% to 75%     1.1% to 25%     2.26% to 50%     b. Code the average fluid intake per day by IV or tube in last 7 days	03.	MEDICA- TIONS INJECTIONS DAYS RECEIVED THE FOLLOWING MEDICATION SPECIAL TREAT- MENTS, PROCE-	(Record the number of DAYS injections of any type received during the Ast 7 days; enter "0" if none used; (Record the number of DAYS during Ast 7 days; enter "0" if not used. Note	
K6.	TIONAL APPROACH- ES PARENTERAL OR ENTERAL	A. Parenteral/IV     b. Feeding tube     Call of the proportion of total calories the resident received through     parenteral or tube feedings in the last 7 days     0. None     3. 51% to 75%     1.1% to 25%     4. 76% to 100%     2.26% to 50%     0. Code the average fluid intake per day by IV or tube in last 7 days     0. None     3.1001 to 1500 cc/day     4.1501 to 2000 cc/day     5.2001 or more cc/day	03.	MEDICA- TIONS INJECTIONS DAYS RECEIVED THE FOLLOWING MEDICATION SPECIAL TREAT- MENTS, MENTS,	(Record the number of DAYS injections of any type received during the hast? days: enter "0" if none used) (Record the number of DAYS during hast? days: enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly) a. Antipsychotic b. Antianxiety c. Antidepressant a. SPECIAL CARE—Check treatments or programs received during the last 14 days TREATMENTS a. Chemotherapy PROGRAMS m. Alcohol/drug treatment	
K6.	ULCERS (Due to any	A. Parenteral/IV     b. Feeding tube     Call of the proportion of total calories the resident received through     parenteral or tube feedings in the last 7 days     0. None     3. 51% to 75%     1.1% to 25%     4. 76% to 100%     2.26% to 50%     0. Code the average fluid intake per day by IV or tube in last 7 days     0. None     3.1001 to 1500 cc/day     4.1501 to 2000 cc/day     5.2001 or more cc/day	03.	MEDICA- TIONS INJECTIONS DAYS RECEIVED THE FOLLOWING MEDICATION SPECIAL TREAT- MENTS, PROCE- DURES, AND DURES, AND	(Record the number of DAYS injections of any type received during the kas? days: enter "0" if none used) (Record the number of DAYS during last? days: enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly) a. Antipsychotic b. Antianxiety c. Antidepressant a. SPECIAL CARE—Check treatments or programs received during the last 14 days TREATMENTS a. Chemotherapy b. Dialysis	
K6.	ULCERS	A. Parenteral/IV     b. Feeding tube     Call of the section M if neither Sa nor Sb is checked)     Call of the proportion of total calories the resident received through     parenteral or tube feedings in the last 7 days     O. None         3. 151% to 75%     1.1% to 25%     4. 76% to 100%     Cade the average fluid intake per day by IV or tube in last 7 days     O. None         3. 1001 to 1500 cc/day         4. 1501 to 2000 cc/day         2.501 to 1000 cc/day         4. 1501 to 2000 cc/day         2.501 to 1000 cc/day         4. 1501 to 2000 cc/day         2.501 to 1000 cc/day         4. 2001 or more cc/day         7.2501 to 2000 cc/day         4. 2501 to 2000 cc/day	03.	MEDICA- TIONS INJECTIONS DAYS RECEIVED THE FOLLOWING MEDICATION SPECIAL TREAT- MENTS, PROCE- DURES, AND DURES, AND	(Record the number of DAYS injections of any type received during the kas? days: enter "O" if nome used) (Record the number of DAYS during last? days: enter "O" if not used. Note—enter "1" for long-acting meds used less than weekly) a. Antipsychotic b. Antianxiety c. Antidepressant a. SPECIAL CARE—Check treatments or programs received during the last 14 days TREATMENTS a. Chemotherapy b. Dialysis	
K6.	ULCERS (Due to any	a. Parenteral/IV     b. Feeding tube     b. Feeding tube     change program     b. Feeding tube     (Skip to Section M if neither 5a nor 5b is checked)     a. Code the proportion of total calories the resident received through     parenteral or tube feedings in the last 7 days     0. None         3. 15/4 to 75%     1. 1% to 25%     4. 76% to 100%     2. 26% to 50%     b. Code the average fluid intake per day by IV or tube in last 7 days     0. None         3. 1001 to 1500 cc/day     2. 501 to 1000 cc/day     4. 1501 to 2000 cc/day     Case. If none present at a stage, record 70° (zero). Code all that apply     during last 7 days. Code 9 = 9 or more.) [Requires full body exam.]     a. Stage 1. A persitent area of skin redness (without a break in the     skin) that does not disappear when presents     b. Stage 2. A partial thickness loss of skin layers that presents	03.	MEDICA- TIONS INJECTIONS DAYS RECEIVED THE FOLLOWING MEDICATION SPECIAL TREAT- MENTS, PROCE- DURES, AND DURES, AND	(Record the number of DAYS injections of any type received during the     Ast7 days; enter "0" if none used)     (Record the number of DAYS during last7 days; enter "0" if not used.     Note—enter "1" for long-acting mads used less than weekly)     a. Antibyscholic     Antidopressant     a. SPECIAL CARE—Check treatments or programs received     during the last 14 days     TREATMENTS     a. Chemotherapy     b. Dislysis     c. IV medication     Interview of the medicat     Montoring acute medicat	
0.025	ULCERS (Due to any	a. Parenteral/IV       h. On a planned weight change program         b. Feeding tube	03.	MEDICA- TIONS INJECTIONS DAYS RECEIVED THE FOLLOWING MEDICATION SPECIAL TREAT- MENTS, PROCE- DURES, AND DURES, AND	(Record the number of DAYS injections of any type received during the     Ast7 days; enter "0" if none used)     (Record the number of DAYS during last7 days; enter "0" if not used.     Note—enter "1" for long-acting meds used less than weekly)     a. Antipsycholic     b. Antianxiety     c. Antidepressant  a. SPECIAL CARE—Check treatments or programs received     during the last 14 days  TREATMENTS     a. Chemotherapy     b. Dialyses     c. N/ medication     d. Intakeoutput     e. Monstoring acute modicat     condition	
K6.	ULCERS (Due to any	a. Parenteral/IV     b. Feeding tube     b. Feeding tube     change program     b. Feeding tube     (Skip to Section M if neither 5a nor 5b is checked)     a. Code the proportion of total calories the resident received through     parenteral or tube feedings in the last 7 days     0. None         3. 151% to 75%     1. 1% to 25%     4. 76% to 100%     2. 26% to 50%     b. Code the average fluid intake per day by IV or tube in last 7 days     0. None         3. 1001 to 1500 cc/day     2. 501 to 1000 cc/day     4. 1501 to 2000 cc/day     2. 501 to 1000 cc/day     5. 2001 or more cc/day     (Record the number of ulcers at each ulcer stage—regardless of     cause. If none present at a stage, record '0' (czero). Code all that apply     duting last 7 days. Code 9 = 9 or more.) [Requires full body exam.]     a. Stage 1. A persistent area of skin redness (without a break in the     skin) that does not disappear when presents     clinically as an abrasion, bisler, or shallow crater.     c. Stage 3. A full thickness loss of skin layers that presents     clinically as an abrasion, bisler, or shallow crater.     c. Stage 3. A full thickness loss of skin layers that presents     clinically as en abrasion, bisler, or shallow crater.	03.	MEDICA- TIONS INJECTIONS DAYS RECEIVED THE FOLLOWING MEDICATION SPECIAL TREAT- MENTS, PROCE- DURES, AND DURES, AND	(Record the number of DAYS injections of any type received during the     Ast7 days; enter "0" if none used)     (Record the number of DAYS during last7 days; enter "0" if not used.     Note——enter "1" for long-acting mads used less than weekly)     a. Antipsycholic     b. Antianoidely     c. Antidepressant      a. SPECIAL CARE—Check treatments or programs received     during the last 14 days      TREATMENTS     a. Chemotherapy     b. Dialysis     c. Noredication     m. Alcoholdrug treatment     program     c. Noredication     m. Alcoholdrug treatment     program     r. Alcoholdrug treatment     secure     care unit     o. Hospice care     p. Pediatric unit     f. Ostomy care     c. Downed therapy	
K6.	ULCERS (Due to any	A. Parenteral/IV     b. Feeding tube     Call of the section M if neither 5a nor 5b is checked)     Call of the proportion of total calories the resident received through     parenteral or tube feedings in the last 7 days     O. None         3. 15% to 75%     1.1% to 25%         4.76% to 100%     Call of the average fluid intake per day by IV or tube in last 7 days     O. None         3.1001 to 1500 cc/day     Call of the average fluid intake per day by IV or tube in last 7 days     O. None         3.1001 to 1500 cc/day     Call of the average fluid intake per day by IV or tube in last 7 days     O. None         3.1001 to 1500 cc/day     Call of the average fluid intake per day by IV or tube in last 7 days     O. None         3.1001 to 1500 cc/day     Call of the present as a stage, record 10° (zero). Code all that apply     duing last 7 days. Code 9 = 9 or mora.) [Requires full body exam.]     A. Stage 1. A persistent area of skin rechees (without a break in the         skin) that does not disappear when presents is relieved.     b. Stage 2. A partial thickness loss of skin layers that presents     Caincelly as an abrasion, bister, or shallow crater.     c. Stage 3. A full thickness of takin is lost, exposing the subcutaneous     tissues - present as a deep crater with or without     undermining adjacent tissue.	03.	MEDICA- TIONS INJECTIONS DAYS RECEIVED THE FOLLOWING MEDICATION SPECIAL TREAT- MENTS, PROCE- DURES, AND DURES, AND	(Record the number of DAYS injections of any type received during the Ast7 days; enter "0" if non-aused)         (Record the number of DAYS during Ast7 days; enter "0" if not used.         (Record the number of DAYS during Ast7 days; enter "0" if not used.         Noteenter "1" for iong-acting mach used less than weekly)         a. Antipsycholic       d. Hypnotic         b. Antianoiety       e. Duretic         c. Antidepressant       e. Duretic         a. SPECIAL CARECheck treatments or programs received during the last 14 days         TREATMENTS       PROGRAMS         a. Chemotherapy       m. Alcohuk/drug treatment program         b. Dialyses       m. Alcohuk/drug treatment strong         c. If medication       m. Alcohuk/drug treatment program         c. Nontoring acute medicat conditiont       e. Hospice care         c. Oxygen thecapy       m. Respite care         h. Radiation       exercised care	
K6.	ULCERS (Due to any	a. Parenteral/IV     b. Feeding tube     b. Feeding tube     change program     b. Feeding tube     (Skip to Section M if neither 5a nor 5b is checked)     a. Code the proportion of total calories the resident received through     parenteral or tube feedings in the last 7 days     0. None         3. 151% to 75%     1. 1% to 25%     4. 76% to 100%     2. 26% to 50%     b. Code the average fluid intake per day by IV or tube in last 7 days     0. None         3. 1001 to 1500 cc/day     2. 501 to 1000 cc/day     4. 1501 to 2000 cc/day     2. 501 to 1000 cc/day     5. 2001 or more cc/day     (Record the number of ulcers at each ulcer stage—regardless of     cause. If none present at a stage, record '0' (czero). Code all that apply     duting last 7 days. Code 9 = 9 or more.) [Requires full body exam.]     a. Stage 1. A persistent area of skin redness (without a break in the     skin) that does not disappear when presents     clinically as an abrasion, bisler, or shallow crater.     c. Stage 3. A full thickness loss of skin layers that presents     clinically as an abrasion, bisler, or shallow crater.     c. Stage 3. A full thickness loss of skin layers that presents     clinically as en abrasion, bisler, or shallow crater.	03.	MEDICA- TIONS INJECTIONS DAYS RECEIVED THE FOLLOWING MEDICATION SPECIAL TREAT- MENTS, PROCE- DURES, AND DURES, AND	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if nore used)         (Record the number of DAYS during last 7 days; enter "0" if not used.         Note	
K6.	ULCERS (Due to any	a. Parenteral/IV     b. Feeding tube     b. Feeding tube     change program     b. Feeding tube     (Skip to Section M if neither 5a nor 5b is checked)     a. Code the proportion of total calories the neident received through     parenteral or tube feedings in the last 7 days     0. None         3. 1001 to 1500 cc/day     2.26% to 50%     b. Code the average fluid intake per day by IV or tube in last 7 days     0. None         3. 1001 to 1500 cc/day     2.65% to 50%     b. Code the average fluid intake per day by IV or tube in last 7 days     0. None         3. 1001 to 1500 cc/day     2.65% to 50%     code the average fluid intake per day by IV or tube in last 7 days     0. None         3. 1001 to 1500 cc/day     2.65% to 50%     code the number of ulcers at each ulcer stage—regardless of     duing last 7 days. Code 9 = 9 or mora.) [Requires full body example     duing last 7 days. Code 9 = 9 or mora.) [Requires full body example     tube without a break in the     skin) that does not disappear when presents is relieved.     b. Stage 2. A partial thickness loss of skin layes that presents         clinically as an abrasion, bister, or shallow crater.     c. Stage 3. A full thickness of skin layer exposing the subcutaneous     tissues - presents as a deep crater with or without     undermining adjacent tissue.     d. Stage 4. A full thickness of skin and subcutaneous tissue is lost.	03.	MEDICA- TIONS INJECTIONS DAYS RECEIVED THE FOLL OWING MEDICATION SPECIAL TREAT- MENTS, PROCE- DURES, AND DURES, AND	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if non-acting medu used feas than weekly)         (Record the number of DAYS during last 7 days; enter "0" if not used.         (Record the number of DAYS during last 7 days; enter "0" if not used.         Noteenter "1" for iong-acting medu used less than weekly)         a. Antipsychotic       d. Hypnotic         b. Antianisty       e. Duretic         c. Antidepressant       e. Duretic         a. SPECIAL CARECheck treatments or programs received during the last 14 days         TREATMENTS       m. Alcohol/drug treatment programs         a. Chemotherapy       m. Alcohol/drug treatment program         b. Dielyses       m. Alcohol/drug treatment corgoration         c. I/ medication       m. Alcohol/drug treatment         d. Intakeloutput       m. Alcohol/drug treatment         e. Montoring acute modication       m. Alcohol/drug treatment         f. Ostomy care       g. Respite care         g. Daygen therapy       m. Respite care         h. Realation       m. Stating the stating to stating the pointed to return to the community (e.g., taking medications, hoose work, stating to stating to stating treatment	

lesident Identifie	r						Numeric Identifier			
P1. SPECIAL TREAT- MENTS, PROCE-	b. THERAPIES - Record the number of days and total minutes each of the following therepies was administered (for at least 15 minutes a day) in the last 7 calendar days (Entor 0 if none or loss than 15 min daily) [Note - count only post admission therapiles]				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 renewals without change. (Enter 0 if none)			
PROGRAM			DAYS (A)	MIN (B)	Q1.	DISCHARGE	a. Resident expresses/indicates preference to return to the community			
0-000-0-000	a. Speech - language pathology an	id audiology services	$\square$	+++			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)			
	b. Occupational therapy									
	c. Physical therapy	c. Physical therapy					0. No 2. Within 31-90 days			
	d. Respiratory therapy	d. Respiratory therapy		02	OVERALL	Within 30 days     S. Discharge status uncertain     Resident's overall level of self sufficiency has changed significantly as				
	<ul> <li>Psychological therapy (by any lic professional)</li> </ul>	censed mental health			42	CHANGE IN	compared to status of 90 days ago (or since last assessment if less than 90 days)			
P3. NURSING REHABILIT TION/ RESTOR	IA- restorative techniques or practice more than or equal to 15 minu	es was provided to tes per day in the l	the reside	ents for			0. No change 1. Improved—receives 2. Deteriorated—receives fewer supports, needs more support less restrictive level of care			
ATIVE CAP	RE a. Range of motion (passive)	f. Walking	1		R2.	SIGNATURE	OF PERSON COORDINATING THE ASSESSMENT:			
	b. Frange of motion (active)		g or greemin	. —						
	c. Splint or brace assistance	1 30000	h. Eating or swallowing			a. Signature of RN Assessment Coordinator (sign on above line)				
	TRAINING AND SKILL	1	es realized to 22.024		b. Date RN Assessment Coordinator signed as complete					
	PRACTICE IN:		tion/prosthes	sis care			Month Day Year			
	d. Bed mobility	J. Commun	lication		T1.		Skip unless this is a Medicare 5 day or Medicare readmission/return			
	e, Transfer	k. Other				TREATMENTS	The second s			
P4. DEVICES		7 days:				PROCE-	b. OR DERED THERAPIES—Has physician ordered any of the following therapies to begin in FIRST 14 days of stay—physical			
RESTRAIN	TS 0. Not used					DURES	therapy, occupational therapy, or speech pathology service?			
	1. Used less than daily 2. Used daily						0.No 1.Yes			
	Bed rails			-			c. Through day15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.			
		aFull bed rails on all open sides of bed								
	b	b. —Other types of side rails used (e.g., half rail, one side) c. Trunk restraint					d. Through day15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered.			
	d. Limb restraint									
	e. Chair prevents rising	e. Chair prevents rising			T3.	CASE MIX	Medicare			
P7. PHYSICIA VISITS	In the LAST 14 DAYS (or since a facility) how many days has the p practitioner) examined the reside	admission if less tha obysician (or authori ent? (Enter 0 if none)	n 14 days zed assista	in ant or		GROUP	Medicare State			

MDS 2.0 PPS July 2002

Numeric	c Identifier
14 MILLING IN	- ragination

Resident

## MINIMUM DATA SET (MDS) - VERSION 2.0

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

## SECTION W. SUPPLEMENTAL MDS ITEMS

 1.
 National Provider ID
 Enter for all assessments and tracking forms, if available, If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.

 2.
 Influenza Vaccine
 a. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)?

 0.
 No (if No, go to item W2b)

 1.
 Yes (if Yes, go to item W3)

 b.
 If Influenza vaccine ont received, state reason: 1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible

 3.
 Pneumococcal Vaccine
 a. Is the resident's PPV status up to date? 0. No (if No, go to item W3b)

 b.
 If PPV not received, state reason: 1. Not eligible
 1. Yes (if Yes, skip item W3b)

 b.
 If PPV not received, state reason: 1. Not eligible
 1. Yes (if Yes, skip item W3b)

 b.
 If PPV not received, state reason: 1. Not eligible
 2. Offered and declined

 3.
 Not eligible
 2. Offered and declined

MDS 2.0 May, 2005

## REFERENCES

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- Epps CD. Recognizing pain in the institutionalized elder with dementia. *Geriatr Nurs*. 2001;22(2):71-79.
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   AHCA. Available at: <u>http://www.ahca.org/research/oscar_patient.htm</u>. Accessed April 15, 2006.
- 4. Lowe S. Census Bureau releases new data on residents of adult correctional facilities, nursing homes and other group quarters annual data also pain diverse portrait of nation's race, ethnic and ancestry group. U.S. Census Bureau. Available at: http://www.census.gov/Press-

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