

Section A**Identification Information****A1200. Marital Status**

Enter Code

1. **Never married**
2. **Married**
3. **Widowed**
4. **Separated**
5. **Divorced**

A1300. Optional Resident Items**A. Medical record number:****B. Room number:****C. Name by which resident prefers to be addressed:****D. Lifetime occupation(s) - put "/" between two occupations:****A1600. Entry Date (date of this admission/reentry into the facility)**

| | | | | | | | |
|----------------------|---|----------------------|---|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | - | <input type="text"/> | - | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Month | | Day | | Year | | | |

A1700. Type of Entry

Enter Code

1. **Admission**
2. **Reentry**

A1800. Entered From

Enter Code

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
99. **Other**

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

| | | | | | | | |
|----------------------|---|----------------------|---|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | - | <input type="text"/> | - | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Month | | Day | | Year | | | |

Section J**Health Conditions****J0700. Should the Staff Assessment for Pain be Conducted?**

Enter Code

0. **No** (J0400 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)
 1. **Yes** (J0400 = 9) → Continue to J0800, Indicators of Pain or Possible Pain

Staff Assessment for Pain**J0800. Indicators of Pain or Possible Pain** in the last 5 days

↓ Check all that apply

- A. Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)
 B. Vocal complaints of pain (e.g., that hurts, ouch, stop)
 C. Facial expressions (e.g., grimaces, wincing, wrinkled forehead, furrowed brow, clenched teeth or jaw)
 D. Protective body movements or postures (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
 Z. None of these signs observed or documented → If checked, skip to J1100, Shortness of Breath (dyspnea)

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days

Enter Code

Frequency with which resident complains or shows evidence of pain or possible pain

1. **Indicators of pain** or possible pain observed **1 to 2 days**
 2. **Indicators of pain** or possible pain observed **3 to 4 days**
 3. **Indicators of pain** or possible pain observed **daily**

Other Health Conditions**J1100. Shortness of Breath (dyspnea)**

↓ Check all that apply

- A. Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
 B. Shortness of breath or trouble breathing **when sitting at rest**
 C. Shortness of breath or trouble breathing **when lying flat**
 Z. None of the above

J1400. Prognosis

Enter Code

Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation)

0. **No**
 1. **Yes**

J1550. Problem Conditions

↓ Check all that apply

- A. Fever**
 B. Vomiting
 C. Dehydrated

Section M**Skin Conditions****Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage****M0100. Determination of Pressure Ulcer Risk**

↓ Check all that apply

- A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device**
- B. Formal assessment instrument/tool** (e.g., Braden, Norton, or other)
- C. Clinical assessment**
- Z. None of the above**

M0150. Risk of Pressure UlcersEnter Code **Is this resident at risk of developing pressure ulcers?**

0. **No**
1. **Yes**

M0210. Unhealed Pressure Ulcer(s)Enter Code **Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?**

0. **No** → Skip to M0900, Healed Pressure Ulcers
1. **Yes** → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

| | |
|--|---|
| Enter Number <input type="checkbox"/> | <p>A. Number of Stage 1 pressure ulcers Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues</p> |
| Enter Number <input type="checkbox"/> | <p>B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister</p> <p>1. Number of Stage 2 pressure ulcers - If 0 → Skip to M0300C, Stage 3</p> |
| Enter Number <input type="checkbox"/> | <p>2. Number of these Stage 2 pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission</p> <p>3. Date of oldest Stage 2 pressure ulcer - Enter dashes if date is unknown: <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Month Day Year</p> |
| Enter Number <input type="checkbox"/> | <p>C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling</p> <p>1. Number of Stage 3 pressure ulcers - If 0 → Skip to M0300D, Stage 4</p> |
| Enter Number <input type="checkbox"/> | <p>2. Number of these Stage 3 pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission</p> |
| Enter Number <input type="checkbox"/> | <p>D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling</p> <p>1. Number of Stage 4 pressure ulcers - If 0 → Skip to M0300E, Unstageable: Non-removable dressing</p> |
| Enter Number <input type="checkbox"/> | <p>2. Number of these Stage 4 pressure ulcers that were present upon admission/reentry - enter how many were noted at the time of admission</p> |

M0300 continued on next page

Section O**Special Treatments, Procedures, and Programs****O0100. Special Treatments, Procedures, and Programs**Check all of the following treatments, procedures, and programs that were performed during the last **14 days**

| 1. While NOT a Resident Performed while NOT a resident of this facility and within the last 14 days . Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank 2. While a Resident Performed while a resident of this facility and within the last 14 days | 1. While NOT a Resident | 2. While a Resident |
|---|--|------------------------------------|
| ↓ Check all that apply ↓ | | |
| Cancer Treatments | | |
| A. Chemotherapy | | <input type="checkbox"/> |
| B. Radiation | | <input type="checkbox"/> |
| Respiratory Treatments | | |
| C. Oxygen therapy | | <input type="checkbox"/> |
| E. Tracheostomy care | | <input type="checkbox"/> |
| F. Ventilator or respirator | | <input type="checkbox"/> |
| Other | | |
| H. IV medications | | <input type="checkbox"/> |
| I. Transfusions | | <input type="checkbox"/> |
| J. Dialysis | | <input type="checkbox"/> |
| K. Hospice care | | <input type="checkbox"/> |
| M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions) | | <input type="checkbox"/> |

O0250. Influenza Vaccine - Refer to current version of RAI manual for current flu season and reporting period

| | |
|--|---|
| Enter Code <input type="checkbox"/> | A. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season? 0. No → Skip to O0250C, If Influenza vaccine not received, state reason 1. Yes → Continue to O0250B, Date vaccine received |
| | B. Date vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date? <div style="display: flex; align-items: center; justify-content: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="margin: 0 5px;">-</div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <div style="display: flex; justify-content: space-around; width: 100%; margin-top: 5px;"> Month Day Year </div> |
| Enter Code <input type="checkbox"/> | C. If Influenza vaccine not received, state reason: 1. Resident not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible - medical contraindication 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine due to a declared shortage 9. None of the above |

O0300. Pneumococcal Vaccine

| | |
|--|---|
| Enter Code <input type="checkbox"/> | A. Is the resident's Pneumococcal vaccination up to date? 0. No → Continue to O0300B, If Pneumococcal vaccine not received, state reason 1. Yes → Skip to O0400, Therapies |
| Enter Code <input type="checkbox"/> | B. If Pneumococcal vaccine not received, state reason: 1. Not eligible - medical contraindication 2. Offered and declined 3. Not offered |

Section O**Special Treatments, Procedures, and Programs****O0400. Therapies**

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Days

A. Speech-Language Pathology and Audiology Services

- Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days
- Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days
- Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B, Occupational Therapy

- Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days
- Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started
- Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

| | | | | | | | | | |
|-------|--|---|-----|--|---|------|--|--|--|
| | | - | | | - | | | | |
| Month | | | Day | | | Year | | | |

| | | | | | | | | | |
|-------|--|---|-----|--|---|------|--|--|--|
| | | - | | | - | | | | |
| Month | | | Day | | | Year | | | |

B. Occupational Therapy

- Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days
- Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days
- Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C, Physical Therapy

- Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days
- Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started
- Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

| | | | | | | | | | |
|-------|--|---|-----|--|---|------|--|--|--|
| | | - | | | - | | | | |
| Month | | | Day | | | Year | | | |

| | | | | | | | | | |
|-------|--|---|-----|--|---|------|--|--|--|
| | | - | | | - | | | | |
| Month | | | Day | | | Year | | | |

C. Physical Therapy

- Individual minutes** - record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days
- Concurrent minutes** - record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days
- Group minutes** - record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400D, Respiratory Therapy

- Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days
- Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started
- Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

| | | | | | | | | | |
|-------|--|---|-----|--|---|------|--|--|--|
| | | - | | | - | | | | |
| Month | | | Day | | | Year | | | |

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|-------|--|---|-----|--|---|------|--|--|--|
| | | - | | | - | | | | |
| Month | | | Day | | | Year | | | |

D. Respiratory Therapy

- Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Days

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Days

Enter Number of Days

Section O**Special Treatments, Procedures, and Programs****O0500. Restorative Nursing Programs**

Record the **number of days** each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

| Number of Days | Technique |
|--------------------------|---------------------------------|
| <input type="checkbox"/> | A. Range of motion (passive) |
| <input type="checkbox"/> | B. Range of motion (active) |
| <input type="checkbox"/> | C. Splint or brace assistance |
| Number of Days | Training and Skill Practice In: |
| <input type="checkbox"/> | D. Bed mobility |
| <input type="checkbox"/> | E. Transfer |
| <input type="checkbox"/> | F. Walking |
| <input type="checkbox"/> | G. Dressing and/or grooming |
| <input type="checkbox"/> | H. Eating and/or swallowing |
| <input type="checkbox"/> | I. Amputation/prostheses care |
| <input type="checkbox"/> | J. Communication |

O0600. Physician Examinations

| | |
|---|--|
| Enter Days <input type="text"/> <input type="text"/> | Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) examine the resident? |
|---|--|

O0700. Physician Orders

| | |
|---|--|
| Enter Days <input type="text"/> <input type="text"/> | Over the last 14 days, on how many days did the physician (or authorized assistant or practitioner) change the resident's orders? |
|---|--|