MDS QUARTERLY ASSESSMENT FORM
(OPTIONAL VERSION FOR RUG-III 1997 Update)

Numeric Identifier _____

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

A2. ROOM NUMBER

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

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

A6. MEDICAL RECORD NO.

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

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

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

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

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

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

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

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

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

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD

VERBAL EXPRESSIONS OF DISTRESS
a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"
b. Repetitive questions—e.g., "*Where do I go; What do I do?*"
c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")
d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received
e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"
f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others
g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack
h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions
i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues

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

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

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

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

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

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

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

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

(B) ADL SUPPORT PROVIDED—(***Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless*** *of resident's self-performance classification*)
0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
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)		

Resident_____ Numeric Identifier _____

G1.			(A)	(B)
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

G2. BATHING

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) ***Code for most dependent*** *in self-performance.*

(A) BATHING SELF PERFORMANCE codes appear below

	(A)
0. Independent—No help provided	
1. Supervision—Oversight help only	
2. Physical help limited to transfer only	
3. Physical help in part of bathing activity	
4. Total dependence	
8. Activity itself did not occur during entire 7 days	

G3. TEST FOR BALANCE (see training manual)

(*Code for ability during test in the* ***last 7 days***)

0. Maintained position as required in test
1. Unsteady, but able to rebalance self without physical support
2. Partial physical support during test; or stands (sits) but does not follow directions for test
3. Not able to attempt test without physical help

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

G4. FUNCTIONAL LIMITATION IN RANGE OF MOTION

(*Code for limitations during* ***last 7 days*** *that interfered with daily functions or placed residents at risk of injury*)

(A) *RANGE OF MOTION*
0. No limitation
1. Limitation on one side
2. Limitation on both sides

(B) *VOLUNTARY MOVEMENT*
0. No loss
1. Partial loss
2. Full loss

	(A)	(B)
a. Neck		
b. Arm—Including shoulder or elbow		
c. Hand—Including wrist or fingers		
d. Leg—Including hip or knee		
e. Foot—Including ankle or toes		
f. Other limitation or loss		

G6. MODES OF TRANSFER

(***Check all that apply*** *during* ***last 7 days***)

Bedfast all or most of time	a.	*NONE OF ABOVE*	f.
Bed rails used for bed mobility or transfer	b.		

G7. TASK SEGMENTATION

Some or all of ADL activities were broken into subtasks during **last 7 days** so that resident could perform them
0. No 1. Yes

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

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

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed	
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed	

H2. BOWEL ELIMINATION PATTERN

Diarrhea	c.	*NONE OF ABOVE*	e.
Fecal impaction	d.		

H3. APPLIANCES AND PROGRAMS

Any scheduled toileting plan	a.	Indwelling catheter	d.
Bladder retraining program	b.	Ostomy present	i.
External (condom) catheter	c.	*NONE OF ABOVE*	j.

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

I1. DISEASES (***If none apply, CHECK the NONE OF ABOVE box***)

ENDOCRINE/METABOLIC/ NUTRITIONAL		Hemiplegia/Hemiparesis	v.
		Multiple sclerosis	w.
Diabetes mellitus	a.	Quadriplegia	z.
MUSCULOSKELETAL		**PSYCHIATRIC/MOOD**	
Hip fracture	m.	Depression	ee.
NEUROLOGICAL		Manic depressive (bipolar disease)	ff.
Aphasia	r.	**OTHER**	
Cerebral palsy	s.	*NONE OF ABOVE*	rr.
Cerebrovascular accident (stroke)	t.		

I2. INFECTIONS (***If none apply, CHECK the NONE OF ABOVE box***)

Antibiotic resistant infection (e.g., Methicillin resistant staph)	a.	Septicemia	g.
		Sexually transmitted diseases	h.
Clostridium difficile (c. diff.)	b.	Tuberculosis	i.
Conjunctivitis	c.	Urinary tract infection **in last 30 days**	j.
HIV infection	d.	Viral hepatitis	k.
Pneumonia	e.	Wound infection	l.
Respiratory infection	f.	NONE OF ABOVE	m.

I3. OTHER CURRENT DIAGNOSES AND ICD-9 CODES

(*Include* ***only those diseases diagnosed in the last 90 days that have a relationship*** *to current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death*)

a. _____ | | | | • | |

b. | | | | • | |

J1. PROBLEM CONDITIONS

(***Check all problems present*** *in* ***last 7 days*** *unless other time frame is indicated*)

INDICATORS OF FLUID STATUS		**OTHER**	
		Delusions	e.
Weight gain or loss of 3 or more pounds within a 7 day period	a.	Edema	g.
		Fever	h.
Inability to lie flat due to shortness of breath	b.	Hallucinations	i.
		Internal bleeding	j.
Dehydrated; output exceeds input	c.	Recurrent lung aspirations in **last 90 days**	k.
		Shortness of breath	l.
Insufficient fluid; did **NOT** consume all/almost all liquids provided during **last 3 days**	d.	Unsteady gait	n.
		Vomiting	o.
		NONE OF ABOVE	p.

J2. PAIN SYMPTOMS

(*Code the* ***highest level of pain*** *present in the* ***last 7 days***)

a. FREQUENCY with which resident complains or shows evidence of pain
0. No pain (***skip to J4***)
1. Pain less than daily
2. Pain daily

b. INTENSITY of pain
1. Mild pain
2. Moderate pain
3. Times when pain is horrible or excrutiating

J4. ACCIDENTS

(***Check all that apply***)

Fell in **past 30 days**	a.	Hip fracture in **last 180 days**	c.
		Other fracture in **last 180 days**	d.
Fell in **past 31-180 days**	b.	*NONE OF ABOVE*	e.

J5. STABILITY OF CONDITIONS

Conditions/diseases make resident's cognitive, ADL, mood or behavior status unstable—(fluctuating, precarious, or deteriorating)	a.
Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem	b.
End-stage disease, 6 or fewer months to live	c.
NONE OF ABOVE	d.

K1. ORAL PROBLEMS

Chewing problem	a.
Swallowing problem	b.
NONE OF ABOVE	d.

K2. HEIGHT AND WEIGHT

Record ***(a.) height in inches*** *and* ***(b.) weight in pounds****. Base weight on most recent measure in* ***last 30 days****; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes*

a. HT (in.) | | **b.** WT (lb.) | | |

K3. WEIGHT CHANGE

a. Weight loss—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**
0. No 1. Yes

b. Weight gain—5 % or more in **last 30 days**; or 10 % or more in **last 180 days**
0. No 1. Yes

Resident_____ Numeric Identifier _____

K5. NUTRITIONAL APPROACHES (***Check all that apply in last 7 days***)

Parenteral/IV — a.
Feeding tube — b.
On a planned weight change program — h.
NONE OF ABOVE — i.

K6. PARENTERAL OR ENTERAL INTAKE (***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
1. 1% to 25%
2. 26% to 50%
3. 51% to 75%
4. 76% to 100%

b. Code the average **fluid intake** per day by IV or tube in **last 7 days**
0. None
1. 1 to 500 cc/day
2. 501 to 1000 cc/day
3. 1001 to 1500 cc/day
4. 1501 to 2000 cc/day
5. 2001 or more cc/day

M1. ULCERS (Due to any cause)

*(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during **last 7 days**. Code 9 = 9 or more.)* ***[Requires full body exam.]***

Number at Stage

a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.

b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues - presents as a deep crater with or without undermining adjacent tissue.

d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

M2. TYPE OF ULCER (*For each type of ulcer, **code for the highest stage in the last 7 days** using scale in item M1—i.e., 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 extremities

M4. OTHER SKIN PROBLEMS OR LESIONS PRESENT (***Check all that apply** during **last 7 days***)

Abrasions, bruises — a.
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.

M5. SKIN TREATMENTS (***Check all that apply** during **last 7 days)***

Pressure relieving device(s) for chair — a.
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.

M6. FOOT PROBLEMS AND CARE (***Check all that apply** during **last 7 days)***

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 — c.
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 — g.

N1. TIME AWAKE (***Check appropriate time periods over last 7 days***)

Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:
Morning — a.
Afternoon — b.
Evening — c.
NONE OF ABOVE — d.

(If resident is comatose, skip to Section O)

N2. AVERAGE TIME INVOLVED IN ACTIVITIES (**When awake and not receiving treatments or ADL care**)

0. Most—more than 2/3 of time
1. Some—from 1/3 to 2/3 of time
2. Little—less than 1/3 of time
3. None

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

O3. INJECTIONS (***Record the number of DAYS** injections of any type received during the **last 7 days**; enter "0" if none used*)

O4. DAYS RECEIVED THE FOLLOWING MEDICATION (***Record the number of DAYS** during **last 7 days**; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly*)

a. Antipsychotic
b. Antianxiety
c. Antidepressant
d. Hypnotic
e. Diuretic

P1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

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

TREATMENTS
Chemotherapy — a.
Dialysis — b.
IV medication — c.
Intake/output — d.
Monitoring acute medical condition — e.
Ostomy care — f.
Oxygen therapy — g.
Radiation — h.
Suctioning — i.
Tracheostomy care — j.
Transfusions — k.
Ventilator or respirator — l.

PROGRAMS
Alcohol/drug treatment program — m.
Alzheimer's/dementia special care unit — n.
Hospice care — o.
Pediatric unit — p.
Respite care — q.
Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs) — r.
NONE OF ABOVE — s.

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

(A) = # of days administered for **15 minutes or more** **(B) = total # of minutes** provided in **last 7 days**	DAYS (A)	MIN (B)
a. Speech - language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		

P3. NURSING REHABILITATION/ RESTORATIVE CARE

*Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was **provided to the resident for more than or equal to 15 minutes per day in the last 7 days** (Enter 0 if none or less than 15 min. daily.)*

a. Range of motion (passive)
b. Range of motion (active)
c. Splint or brace assistance

TRAINING AND SKILL PRACTICE IN:
d. Bed mobility
e. Transfer
f. Walking
g. Dressing or grooming
h. Eating or swallowing
i. Amputation/prosthesis care
j. Communication
k. Other

P4. DEVICES AND RESTRAINTS

*Use the following codes for **last 7 days**:*
0. Not used
1. Used less than daily
2. Used daily

Bed rails
a. — Full bed rails on all open sides of bed
b. — Other types of side rails used (e.g., half rail, one side)
c. Trunk restraint
d. Limb restraint
e. Chair prevents rising

P7. PHYSICIAN VISITS

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

P8. PHYSICIAN ORDERS

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

Q2. OVERALL CHANGE IN CARE NEEDS

Resident's overall level of self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change
1. Improved—receives fewer supports, needs less restrictive level of care
2. Deteriorated—receives more support

R2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

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

b. Date RN Assessment Coordinator signed as complete — Month / Day / Year

Numeric Identifier_____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ④	**a.** (First) **b.** (Middle Initial) **c.** (Last) **d.** (Jr/Sr)
2.	GENDER ④	1. Male 2. Female
3.	BIRTHDATE ④	Month — Day — Year
4.	RACE/ ④ ETHNICITY	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY ④ AND MEDICARE NUMBERS ④ [C in 1st box if non med. no.]	**a.** Social Security Number **b.** Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ④	**a.** State No. **b.** Federal No.
7.	MEDICAID NO. *["+" if pending, "N" if not a Medicaid recipient]* ④	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] **a.** Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly 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* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking 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 applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents 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 participation in the government-funded health care programs is conditioned on the accuracy and truthfulness 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 false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature and Title	Sections	Date
a.			
b.			
c.			
d.			
e.			
f.			
g.			
h.			
i.			
j.			
k.			
l.			

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.)

④ = Key items for computerized resident tracking

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