Has the ASC implemented policies and practices aimed at reducing the risk of surgical site infections that are aligned with published evidence-based guidelines?

☐ Yes

Specify the evidence-based guidelines: _____

_____

☐ No

Does the ASC monitor compliance with published evidence-based guidelines for reducing the risk of surgical site infections?

☐ Yes

☐ No

Has the ASC assigned responsibility for oversight of implementing policies and practices aimed at reducing the risk of surgical site infections?

☐ Yes

Specify: _____

☐ No

Does the ASC have a work plan in place that identifies adequate resources, assigned accountabilities, and a time line for full implementation of policies and practices aimed at reducing the risk of surgical site infections?

☐ Yes

☐ No

Does the ASC educate health care workers involved in surgical procedures about health care associated infections and the importance of prevention? Check all that apply.

☐ Yes, when hired

☐ Yes, when involvement in surgical procedures is added to job responsibilities

☐ Yes, annually

☐ No

Prior to undergoing a surgical procedure, does the ASC educate patients about surgical site infection prevention?

☐ Yes

☐ No

Does the ASC monitor compliance with published evidence-based guidelines for antimicrobial prophylaxis?

☐ Yes

☐ No

Does the ASC monitor compliance with published evidence-based guidelines for hair removal?

☐ Yes

☐ No

What methods does the ASC use to conduct surveillance for surgical site infections? Check all that apply.

☐ Direct examination of patient's wound during follow-up visits

☐ Review of medical records

☐ Surgeon surveys by mail or telephone

☐ Patient surveys by mail or telephone

☐ Other
Specify: _____

_____

_____

Does the ASC conduct surveillance for surgical site infections following procedures that do not involve implantable devices?

☐ Yes, for 30 days after the procedure

☐ Yes, for 3 months after the procedure

☐ Yes, for 6 months after the procedure

☐ Yes, for at least one year after the procedure

☐ No

Does the ASC conduct surveillance for surgical site infections for at least one year following procedures involving implantable devices?

☐ Yes

☐ No

Does the ASC monitor surgical site infection rates?

☐ Yes, for certain procedures

☐ Yes, for all procedures

☐ No

Does the ASC monitor other infection prevention measures that are aligned with published evidence-based guidelines?

☐ Yes
Specify: _____

_____

☐ No

Does the ASC provide data on infection prevention outcome and process measures to interested parties? Check all that apply.

☐ Yes, to the ASC's surgeons

☐ Yes, to the ASC's nurses

☐ Yes, to the ASC's other staff

☐ Yes, to the ASC's patients

☐ Yes, to an accreditation agency or a regulatory agency

Specify: _____

☐ Yes, to others
Specify: _____

☐ No

Does the ASC have a written plan in place for responding to infection outbreaks that may potentially overwhelm its resources?

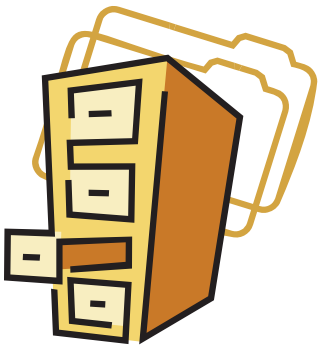
☐ Yes

☐ No

Department of Human Services

Permanent Administrative Rule Time Line

Rule Title: Infection Reporting Rules
Rule Number(s): 409-023-0000 to 409-023-0035
Action: Permanent Rule(s) - Adopt



Proposed Effective Date:
July 1, 2009

5/4/09	☐	Program provides rule coordinator (RC) with draft rule text, filing documents, and list of interested parties
5/12/09	☐	RC notifies legislators
5/15/09	☐	RC files documents with Secretary of State (SOS)*
6/2/09	☐	RC notifies interested parties
6/1/09	☐	Notice posted in SOS bulletin*
after 6/21/09	☐	Hearing date (RC and program attend)*
7/1/09	☐	RC files final documents with SOS and legislative counsel
7/1/09	☐	Rule effective date

*not applicable to temporary rules

CHAPTER 409
DEPARTMENT OF HUMAN SERVICES,
OFFICE FOR OREGON HEALTH POLICY AND RESEARCH

DIVISION 23
HEALTH CARE FACILITY INFECTION REPORTING

Health Care Acquired Infection Reporting and Public Disclosure

409-023-0000
Definitions

The following definitions apply to OAR 409-023-0000 to 409-023-0035:

(xx) "MDS" means the Centers for Medicare and Medicaid Services' Minimum Data Set nursing home resident assessment and screening tool, version 2.0 or its successor, including but not limited to manuals, forms, software, and databases.

(xx) "NICU" means a specialty intensive care unit that serves only neonatal patients.

(xx) "SCIP-Inf-6" means the HAI process measure published by SCIP defined as surgery patients with appropriate hair removal.

(xx) "VLBW" means very low birth weight as defined by VON.

(xx) "VON" means the Vermont Oxford Network or its successor.

Stat. Auth.: ORS 442.838, 442.420(3)(d)
Stats. Implemented: ORS 442.838, 442.405

409-023-0010
HAI Reporting for Hospitals

(1) Hospitals shall begin collecting data for HAI outcome and process measures for the HAI reporting program for services provided on and after January 1, 2009, except:.

(a) NICUs shall begin collecting data for HAI outcome and process measures for the HAI reporting program for services provided on and after January 1, 2010.

(b) Hospitals shall report the SCIP-Inf-6 process measure for the HAI reporting program for services provided on and after January 1, 2010.

(6)

(c)

1. The NHSN field "Discharge Date" is mandatory for all outcome measures

2. The NHSN field "BSI Contributed to Death" is mandatory for CLABSI reporting

3. The NHSN field "SSI Contributed to Death" is mandatory for SSI reporting

(7) Each hospital shall report on a quarterly basis according to 409-023-0010(1) the following HAI process measures:

(a) SCIP-Inf-1;

(b) SCIP-Inf-2;

(c) SCIP-Inf-3; and

(d) SCIP-Inf-6.

(9) For NICUs the HAI reporting system for outcome measures shall be VON. Each Oregon hospital with a NICU shall comply with processes and methods prescribed by VON for the VLBW database including but not limited to definitions, data collection, data submission, and administrative and training requirements. Each Oregon hospital shall:

(a) Authorize disclosure of VON data to the Office as necessary for compliance with these rules, including but not limited to facility identifiers.

(b) Submit NICU data to VON according to the quarterly data submission deadlines established by VON in its annual publication "Member Instructions for Submitting Electronic Data" (or its successor).

(10) Each hospital shall complete an annual survey defined by the Office of influenza vaccination of staff and submit the completed survey to the Office.

(a) The survey shall include, but not be limited to, questions regarding influenza vaccine coverage of facility staff and volunteers:

(A) Number of staff and volunteers with a documented influenza vaccination during the previous influenza season.

(B) Number of staff and volunteers with a documented medical contraindication to influenza vaccination during the previous influenza season.

(C) Number of staff and volunteers with a documented refusal of influenza vaccination during the previous influenza season.

(D) Facility assessment of influenza vaccine coverage of facility staff and volunteers during the previous influenza season and plans to improve vaccine coverage of facility staff and volunteers during the upcoming influenza season.

Stat. Auth.: ORS 442.838, 442.420(3)(d)
Stats. Implemented: ORS 442.838, 442.405

(4) Each ASC shall complete a survey of evidenced-based elements of patient safety performance as defined by the Office..

(5) The survey shall be submitted annually by each ASC to the Office no later than 30 days after receipt of survey.

Stat. Auth.: ORS 442.838, 442.420(3)(d)
Stats. Implemented: ORS 442.838, 442.405

409.023.0120
HAI Reporting for Long Term Care Facilities

(1) The HAI Reporting System for outcome measures shall be MDS and reporting will be mandatory beginning January 1, 2010.

(2) Reportable HAI outcome measures are:

(a) Urinary tract infection in the last 30 days.

(3) Each LTC facility shall comply with reporting processes and methods prescribed by CMS for MDS. This includes but is not limited to definitions, data collection, data submission, and administrative and training requirements.

(4) Each LTC facility shall complete an annual survey as defined by the Office of influenza vaccination of staff and submit the completed survey to the Office.

(a) The survey shall include, but not be limited to, questions regarding influenza vaccine coverage of facility staff and volunteers:

(A) Number of staff and volunteers with a documented influenza vaccination during the previous influenza season.

(B) Number of staff and volunteers with a documented medical contraindication to influenza vaccination during the previous influenza season.

(C) Number of staff and volunteers with a documented refusal of influenza vaccination during the previous influenza season.

(D) Facility assessment of influenza vaccine coverage of facility staff and volunteers during the previous influenza season and plans to improve vaccine coverage of facility staff and volunteers during the upcoming influenza season.

(5) Unless otherwise directed by the Administrator, the HAI reporting period shall be:

(a) Quarterly for outcome measures, effective for the entire calendar year.

Stat. Auth.: ORS 442.838, 442.420(3)(d)
Stats. Implemented: ORS 442.838, 442.405

NHSN:
First Look at the Data

As of May 5, 2009

Office for Oregon Health Policy and Research

NHSN Reporting

- 49 hospitals have joined the State of Oregon reporting group
  - 25 hospitals are tracking more types of infections than required
- Three hospitals have received exemptions from NHSN reporting
  - Another is probably exempt (waiting for their application)
- Five hospitals are making good-faith efforts to comply

Device-Associated Module

CLABSI

Population	CL days	Infections	Rate*
Oregon, 2009	9,811	9	9.2
NHSN, 2006	635,256	1,602	25.2

* - Infections per 10,000 CL days

Mean number of days from admission to CLABSI: 9.6

Procedure-Associated Module

Surgical Site Infections

Code	Procedures	Infections	Proportion
CBGB	473	14	3.0%
CBGC	91	0	0.0%
KPRO	1349	9	0.7%

KPRO SSIs

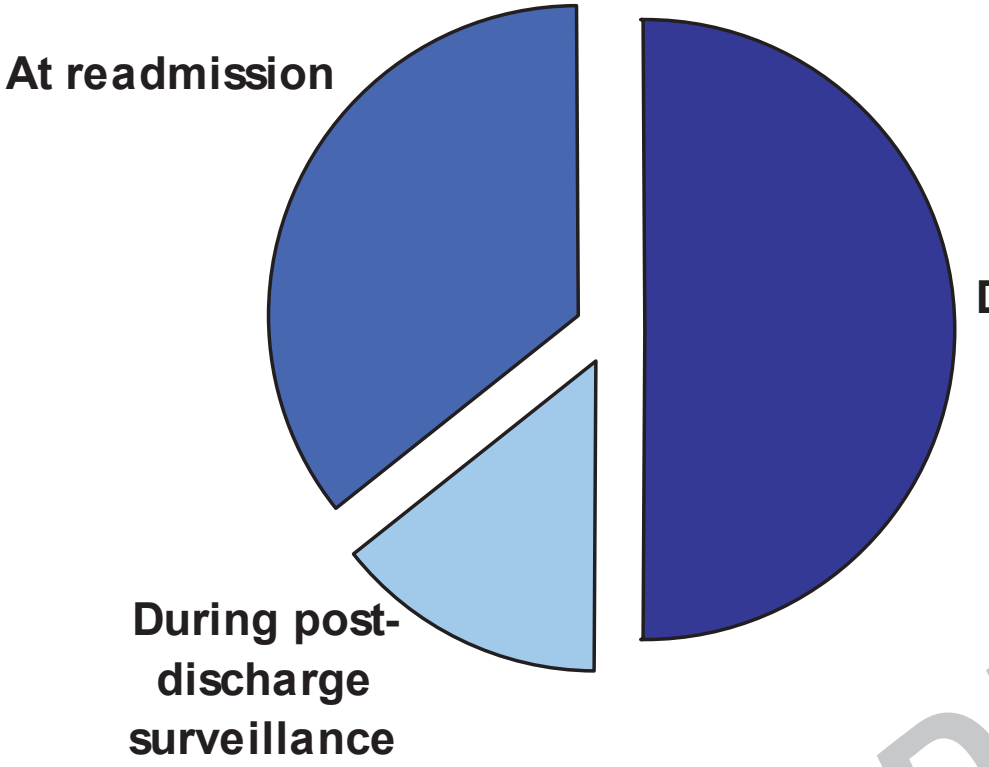
Risk	Procedures	Infections	Proportion
0	542	1	0.2%
1	635	5	0.8%
2,3	172	3	1.7%

CBGB SSIs

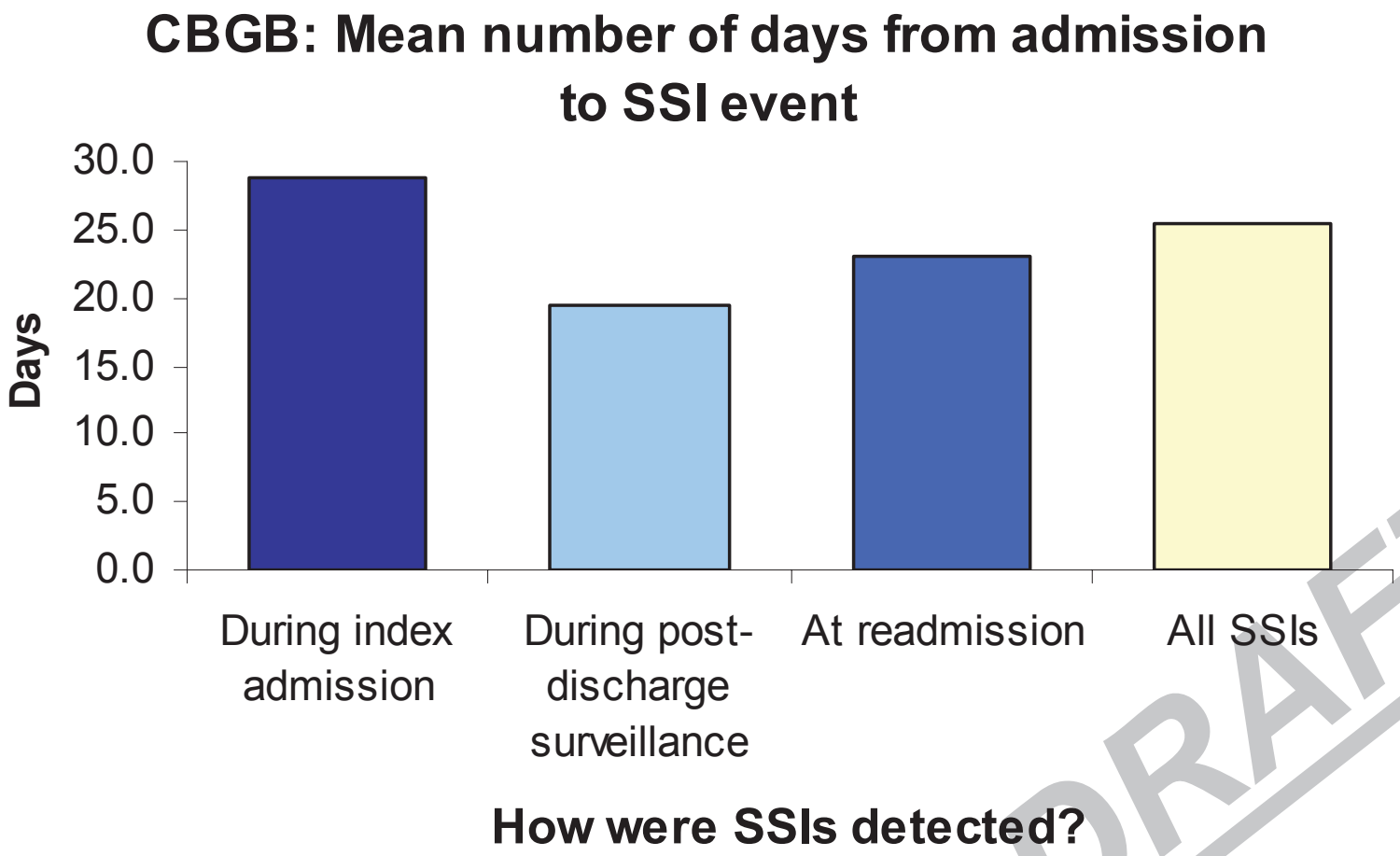
Risk	Procedures	Infections	Proportion
0,1	2	79	2.5%
2,3	12	394	3.0%

Detecting SSIs

CBGB: How were SSIs detected?

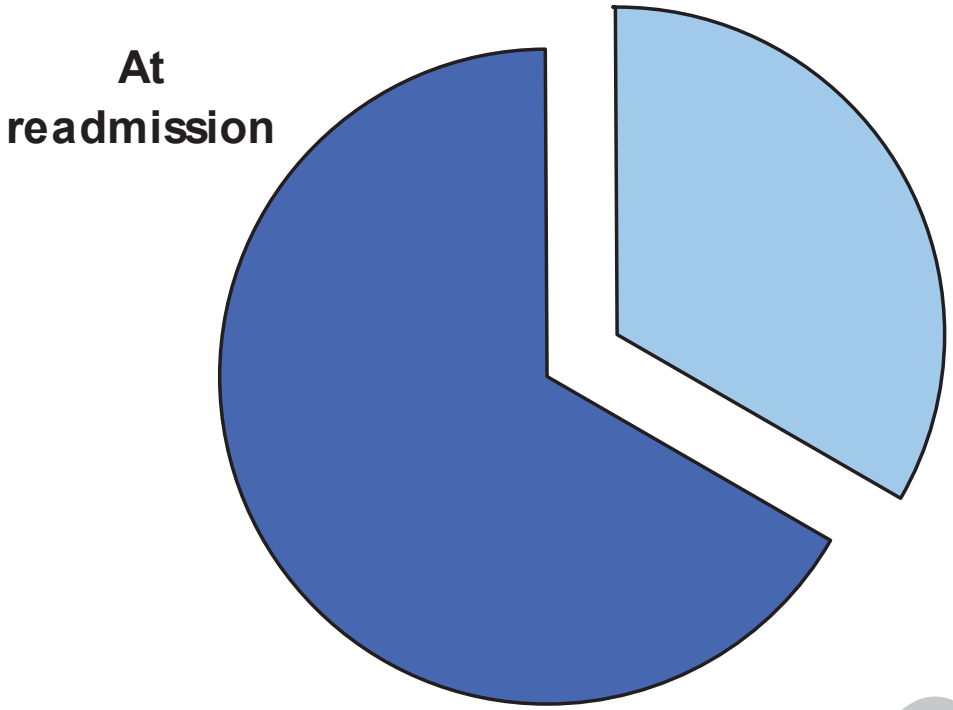


Detecting SSIs

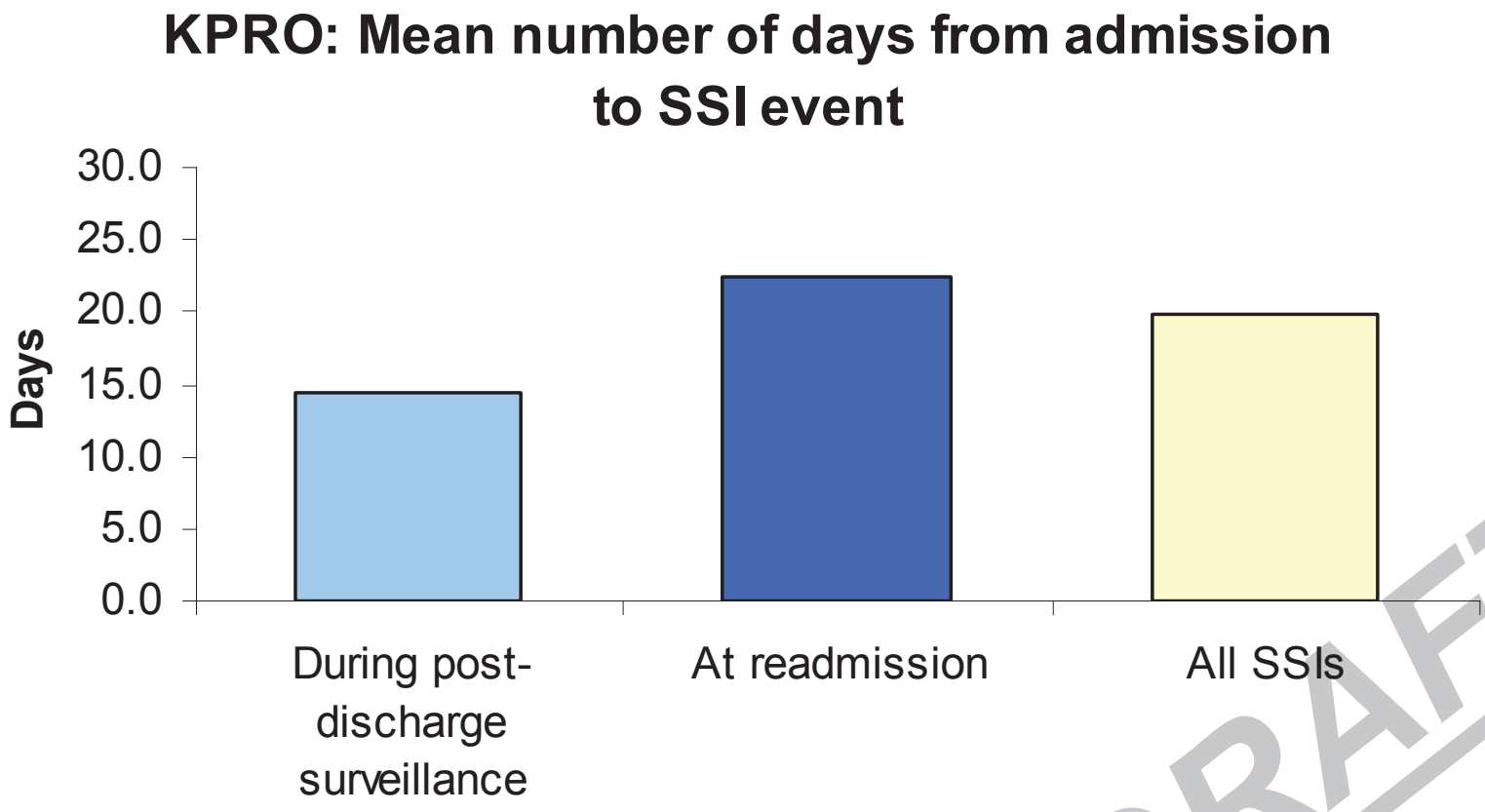


Detecting SSIs

KPRO: How were SSIs detected?



Detecting SSIs



How were SSIs detected?

Pathogens

Isolates	Pathogen
2	Candida species
1	Clostridium perfringens
1	Enterobacter cloacae
4	Enterococcus species
2	Escherichia coli
2	Klebsiella pneumoniae
2	Pseudomonas species
8	Staphylococcus aureus
8	Staphylococcus coagulase negative
1	Streptococcus group B
1	Yeast
32	Total

Pathogen Resistance

Group B Strep

Medication	Tested	Resistant
Ampicillin	1	0
Clindamycin	1	1
Erythromycin	1	1
Vancomycin	1	0

Enterobacter cloacae

Medication	Tested	Resistant
Amikacin	1	0
Cefepime	1	0
Ceftazidime	1	1
Ciprofloxacin	1	1
Imipenem	1	0
Levofloxacin	1	1

Escherichia coli

Medication	Tested	Resistant
Ceftriaxone	2	0
Ciprofloxacin	2	1
Imipenem	1	0
Levofloxacin	1	1
Meropenem	1	0

Staphylococcus aureus

Medication	Tested	Resistant
Clindamycin	8	2
Erythromycin	8	4
Oxacillin	8	3
TMZ	8	0
Vancomycin	8	0

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

⊛ = Key items for computerized resident tracking

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

□esident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1. DATE OF ENTRY

Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date

Month — Day — Year

2. ADMITTED FROM (AT ENTRY)

1. Private home/apt. with no home health services
2. Private home/apt. with home health services
3. Board and care/assisted living/group home
4. Nursing home
5. Acute care hospital
6. Psychiatric hospital, M□/DD facility
7. □ehabilitation hospital
8. Other

3. LIVED ALONE (PRIOR TO ENTRY)

0. No
1. Yes
2. In other facility

4. □IP CODE OF PRIOR PRIMARY RESIDENCE

5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY

(***Check all settings*** *resident* ***lived in*** *during 5 years prior to date of entry given in item AB1 above)*

- Prior stay at this nursing home — a.
- Stay in other nursing home — b.
- Other residential facility—board and care home, assisted living, group home — c.
- MH/psychiatric setting — d.
- M□/DD setting — e.
- *NONE OF ABOVE* — f.

6. LIFETIME OCCUPATION(S) [Put "/" between two occupations]

7. EDUCATION (*Highest Level Completed*)

1. No schooling
2. 8th grade/less
3. 9-11 grades
4. High school
5. Technical or trade school
6. Some college
7. Bachelor□s degree
8. □raduate degree

8. LANGUAGE

(□*ode for correct response*)

a. Primary Language

0. English 1. Spanish 2. French 3. Other

b. If other, specify

9. MENTAL HEALTH HISTORY

Does resident□s □E□O□D 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 M□/DD status that were manifested before age 22, and are likely to continue indefinitely*)

- Not applicable—no M□/DD (Skip to AB11) — a.
- M□/DD with organic condition
  - Down□s syndrome — b.
  - Autism — c.
  - Epilepsy — d.
  - Other organic condition related to M□/DD — e.
- M□/DD with no organic condition — f.

11. DATE BACKGROUND INFORMATION COMPLETED

Month — Day — Year

SECTION AC. CUSTOMARY ROUTINE

1. CUSTOMARY ROUTINE

(***In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home***)

(***Check all that apply.*** *If all information □NKNOWN, check last box only.*)

CYCLE OF DAILY EVENTS

- Stays up late at night (e.g., after 9 pm) — a.
- Naps regularly during day (at least 1 hour) — b.
- □oes out 1□days a week — c.
- Stays busy with hobbies, reading, or fixed daily routine — d.
- Spends most of time alone or watching TV — e.
- Moves independently indoors (with appliances, if used) — f.
- □se of tobacco products at least daily — g.
- *NONE OF ABOVE* — h.

EATING PATTERNS

- Distinct food preferences — i.
- Eats between meals all or most days — j.
- □se of alcoholic beverage(s) at least weekly — k.
- *NONE OF ABOVE* — l.

ADL PATTERNS

- In bedclothes much of day — m.
- Wakens to toilet all or most nights — n.
- Has irregular bowel movement pattern — o.
- Showers for bathing — p.
- Bathing in PM — q.
- *NONE OF ABOVE* — r.

INVOLVEMENT PATTERNS

- Daily contact with relatives/close friends — s.
- □sually attends church, temple, synagogue (etc.) — t.
- Finds strength in faith — u.
- Daily animal companion/presence — v.
- Involved in group activities — w.
- *NONE OF ABOVE* — x.

UNKNO□ N—□esident/family unable to provide information — y.

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET□

a. Signature of □N Assessment □oordinator — Date

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
b.		
c.		
d.		
e.		
f.		
g.		

□esident _____ Numeric Identifier _____

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

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

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

2. ROOM NUMBER

3. 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)

4a. 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

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

6. MEDICAL RECORD NO.

7. CURRENT PAYMENT SOURCES FOR N.H. STAY
(*Billing Office to indicate* ***check all that apply in last 30 days***)

Medicaid per diem	a.	VA per diem	f.
Medicare per diem	b.	Self or family pays for full per diem	g.
Medicare ancillary part A	c.	Medicaid resident liability or Medicare co-payment	h.
Medicare ancillary part B	d.	Private insurance per diem (including co-payment)	i.
□HAMP□S per diem	e.	Other per diem	j.

8. REASONS FOR ASSESSMENT
[Note—If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed]

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
6. Discharged—return not anticipated
7. Discharged—return anticipated
8. Discharged prior to completing initial assessment
9. □eentry
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. RESPONSIBILITY/ LEGAL GUARDIAN
(***Check all that apply***)

Legal guardian	a.	Durable power attorney/financial	d.
Other legal oversight	b.	Family member responsible	e.
Durable power of attorney/health care	c.	Patient responsible for self	f.
		NONE OF ABOVE	g.

10. ADVANCED DIRECTIVES
(*For those items with supporting* ***documentation*** *in the medical record,* ***check all that apply***)

Living will	a.	Feeding restrictions	f.
Do not resuscitate	b.	Medication restrictions	g.
Do not hospitalize	c.	Other treatment restrictions	h.
Organ donation	d.		
Autopsy request	e.	*NONE OF ABOVE*	i.

SECTION B. COGNITIVE PATTERNS

1. COMATOSE (*Persistent vegetative state/no discernible consciousness*)
0. No 1. Yes (**If yes, skip to Section G**)

2. MEMORY (□ecall 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

3. MEMORY/ RECALL ABILITY
(***Check all*** *that resident was* ***normally able to recall during last 7 days***)

□urrent season	a.	That he/she is in a nursing home	d.
Location of own room	b.		
Staff names/faces	c.	*NONE OF ABOVE* are recalled	e.

4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING
(*Made decisions regarding tasks of daily life*)
0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDEN□E*—some difficulty in new situations only
2. *MODE□ATELY IMPAI□ED*—decisions poor□cues/supervision required
3. *SEVE□ELY IMPAI□ED*—never/rarely made decisions

5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ A□ ARENESS
(□ode 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 DIST□A□TED—(e.g., difficulty paying attention□gets sidetracked)
b. PE□IODS OF ALTE□ED PE□□EPTION O□ AWA□ENESS OF S□□□O□NDIN□S—(e.g., moves lips or talks to someone not present□believes he/she is somewhere else□confuses night and day)
c. EPISODES OF DISO□□ANI□ED SPEE□H—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject□loses train of thought)
d. PE□IODS OF □ESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc□frequent position changes□repetitive physical movements or calling out)
e. PE□IODS OF LETHA□□Y—(e.g., sluggishness□staring into space□ difficult to arouse□little body movement)
f. MENTAL F□N□TION VA□IES OVE□ THE □O□□SE OF THE DAY—(e.g., sometimes better, sometimes worse□behaviors sometimes present, sometimes not)

6. CHANGE IN COGNITIVE STATUS
□esident□s cognitive status, skills, or abilities have 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

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING
(*With hearing appliance, if used*)
0. *HEA□S ADEQ□ATELY*—normal talk, TV, phone
1. *MINIMAL DIFFI□□LTY* when not in quiet setting
2. *HEA□S IN SPE□IAL SIT□ATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly
3. *HI□HLY IMPAI□ED*/absence of useful hearing

2. COMMUNICATION DEVICES/ TECHNIQUES
(***Check all that apply*** *during last 7 days*)

Hearing aid, present and used	a.
Hearing aid, present and not used regularly	b.
Other receptive comm. techniques used (e.g., lip reading)	c.
NONE OF ABOVE	d.

3. MODES OF E□PRESSION
(***Check all used*** *by resident to make needs known*)

Speech	a.	Signs/gestures/sounds	d.
Writing messages to express or clarify needs	b.	□ommunication board	e.
		Other	f.
American sign language or Braille	c.	*NONE OF ABOVE*	g.

4. MAKING SELF UNDERSTOOD
(*Expressing information content—however able*)
0. □NDE□STOOD
1. □S□ALLY □NDE□STOOD—difficulty finding words or finishing thoughts
2. *SOMETIMES* □NDE□STOOD—ability is limited to making concrete requests
3. □A□ELY/NEVE□ □NDE□STOOD

5. SPEECH CLARITY
(□ode for speech in the ***last 7 days***)
0. □LEA□ SPEE□H—distinct, intelligible words
1. □N□LEA□ SPEE□H—slurred, mumbled words
2. *NO SPEE□H*—absence of spoken words

6. ABILITY TO UNDERSTAND OTHERS
(□nderstanding verbal information content—*however able*)
0. □NDE□STANDS
1. □S□ALLY □NDE□STANDS—may miss some part/intent of message
2. *SOMETIMES* □NDE□STANDS—responds adequately to simple, direct communication
3. □A□ELY/NEVE□ □NDE□STANDS

7. CHANGE IN COMMUNICATION/ HEARING
□esident□s ability to express, understand, or hear information 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

□esident _____ Numeric Identifier _____

SECTION D. VISION PATTERNS

1.	VISION	(*Ability to see in adequate light and with glasses if used*) 0. *ADEQ□ATE*—sees fine detail, including regular print in newspapers/books 1. *IMPAI□ED*—sees large print, but not regular print in newspapers/ books 2. *MODE□ATELY IMPAI□ED*—limited vision□not able to see newspaper headlines, but can identify objects 3. *HI□HLY IMPAI□ED*—object identification in question, but eyes appear to follow objects 4. *SEVE□ELY IMPAI□ED*—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, bumps into people and objects, misjudges placement of chair when seating self)	a.
		Experiences any of following□sees halos or rings around lights□sees flashes of light□sees □curtains□over eyes	b.
		NONE OF ABOVE	c.
3.	VISUAL APPLIANCES	□lasses□contact lenses□magnifying glass 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRES-SION, AN□IETY, SAD MOOD

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

VERBAL E□PRESSIONS OF DISTRESS

a. □esident made negative statements—e.g., □*Nothing matters□Would rather be dead□What's the use□ □egrets having lived so long□Let me die*□

b. □epetitive questions—e.g., □*Where do I go□What do I do*□□

c. □epetitive verbalizations—e.g., calling out for help, (□□*od 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. □ecurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack

h. □epetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions

i. □epetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues

SLEEP-CYCLE ISSUES

j. □npleasant mood in morning

k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, AN□IOUS APPEARANCE

l. Sad, pained, worried facial expressions—e.g., furrowed brows

m. □rying, tearfulness

n. □epetitive 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. □educed social interaction

2.	MOOD PERSIS-TENCE	**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	
3.	CHANGE IN MOOD	□esident's mood 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	

4. 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 O□ behavior was easily altered
1. Behavior was not easily altered

	(A)	(B)
a. WANDE□IN□ (moved with no rational purpose, seemingly oblivious to needs or safety)		
b. VE□BALLY AB□SIVE BEHAVIO□AL SYMPTOMS (others were threatened, screamed at, cursed at)		
c. PHYSI□ALLY AB□SIVE BEHAVIO□AL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
d. SO□IALLY INAPP□OP□IATE/DIS□□PTIVE BEHAVIO□AL 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. □ESISTS □A□E (resisted taking medications/ injections, ADL assistance, or eating)		

5.	CHANGE IN BEHAVIORAL SYMPTOMS	□esident'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	

SECTION F. PSYCHOSOCIAL □ ELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVE-MENT	At ease interacting with others	a.
		At ease doing planned or structured activities	b.
		At ease doing self-initiated activities	c.
		Establishes own goals	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)	e.
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED RELATION-SHIPS	□overt/open conflict with or repeated criticism of staff	a.
		□nhappy with roommate	b.
		□nhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family/friends	d.
		Absence of personal contact with family/friends	e.
		□ecent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b.
		□esident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	c.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PE□FO□MAN□E—(***Code*** *for resident's* ***PERFORMANCE OVER ALL SHIFTS during last 7 days***—*Not including setup*)

0. *INDEPENDENT*—No help or oversight —O□— Help/oversight provided only 1 or 2 times during last 7 days
1. S□PE□VISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —O□— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTAN□E*—□esident highly involved in activity□received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —O□—More help provided only 1 or 2 times during last 7 days
3. *E□TENSIVE ASSISTAN□E*—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 DEPENDEN□E*—Full staff performance of activity during entire 7 days
8. *A□TIVITY DID NOT O□□□□* during entire 7 days

(B) ADL S□PPO□T P□OVIDED—(***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-PE□F	(B) S□PPO□T
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 (E□□L□DE to/from bath/toilet)		
c.	□ALK IN ROOM	How resident walks between locations in his/her room		
d.	□ALK IN CORRIDOR	How resident walks in corridor on unit		
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		
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		
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 (E□□L□DE baths and showers)		

2. BATHING

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (E□□L□DE washing of back and hair.) ***Code for most dependent*** *in self-performance and support.* **(A)** BATHIN□ SELF-PE□FO□MAN□E codes appear below

	(A)	(B)
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 (*Bathing support codes are as defined in* ***Item 1, code B above***)		

3. TEST FOR BALANCE (see training manual)

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

0. Maintained position as required in test
1. □nsteady, 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	

4. FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)

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

(A) □*AN□E OF MOTION*: 0. No limitation; 1. Limitation on one side; 2. Limitation on both sides

(B) *VOL□NTA□Y 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		

5. MODES OF LOCOMO-TION

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

□ane/walker/crutch	a.	Wheelchair primary mode of locomotion	d.
Wheeled self	b.		
Other person wheeled	c.	*NONE OF ABOVE*	e.

6. MODES OF TRANSFER

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

Bedfast all or most of time	a.	Lifted mechanically	d.
Bed rails used for bed mobility or transfer	b.	Transfer aid (e.g., slide board, trapeze, cane, walker, brace)	e.
Lifted manually	c.	*NONE OF ABOVE*	f.

7. 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

8. ADL FUNCTIONAL REHABILITA-TION POTENTIAL

□esident believes he/she is capable of increased independence in at least some ADLs	a.
Direct care staff believe resident is capable of increased independence in at least some ADLs	b.
□esident able to perform tasks/activity but is very slow	c.
Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings	d.
NONE OF ABOVE	e.

9. CHANGE IN ADL FUNCTION

□esident□s ADL self-performance 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

SECTION H. CONTINENCE IN LAST 14 DAYS

1. □ONTINEN□E SELF-□ONT□OL □ATE□O□IES (***Code for resident□s PERFORMANCE OVER ALL SHIFTS***)

0. □*ONTINENT*—□omplete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]*

1. □*S□ALLY □ONTINENT*—BLADDE□, incontinent episodes once a week or less□ BOWEL, less than weekly

2. *O□□ASIONALLY IN□ONTINENT*—BLADDE□, 2 or more times a week but not daily□ BOWEL, once a week

3. *F□EQ□ENTLY IN□ONTINENT*—BLADDE□, tended to be incontinent daily, but some control present (e.g., on day shift)□BOWEL, 2-3 times a week

4. *IN□ONTINENT*—Had inadequate control BLADDE□, multiple daily episodes□ BOWEL, all (or almost all) of the time

a. BO□ EL CONTI-NENCE

□ontrol of bowel movement, with appliance or bowel continence programs, if employed

b. BLADDER CONTI-NENCE

□ontrol of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed

2. BO□ EL ELIMINATION PATTERN

Bowel elimination pattern regular—at least one movement every three days

□onstipation

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

3. APPLIANCES AND PROGRAMS

Any scheduled toileting plan	a.	Did not use toilet room/ commode/urinal	f.
Bladder retraining program	b.	Pads/briefs used	g.
External (condom) catheter	c.	Enemas/irrigation	h.
Indwelling catheter	d.	Ostomy present	i.
Intermittent catheter	e.	*NONE OF ABOVE*	j.

4. CHANGE IN URINARY CONTI-NENCE

□esident□s urinary continence 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

SECTION I. DISEASE DIAGNOSES

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)

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

ENDOCRINE/METABOLIC/ NUTRITIONAL		Hemiplegia/Hemiparesis	v.
		Multiple sclerosis	w.
Diabetes mellitus	a.	Paraplegia	x.
Hyperthyroidism	b.	Parkinson□s disease	y.
Hypothyroidism	c.	Quadriplegia	□.
HEART/CIRCULATION		Seizure disorder	aa.
Arteriosclerotic heart disease (ASHD)	d.	Transient ischemic attack (TIA)	bb.
		Traumatic brain injury	cc.
□ardiac dysrhythmias	e.	**PSYCHIATRIC/MOOD**	
□ongestive heart failure	f.	Anxiety disorder	dd.
Deep vein thrombosis	g.	Depression	ee.
Hypertension	h.	Manic depression (bipolar disease)	ff.
Hypotension	i.		
Peripheral vascular disease	j.	Schizophrenia	gg.
Other cardiovascular disease	k.	**PULMONARY**	
MUSCULOSKELETAL		Asthma	hh.
Arthritis	l.	Emphysema/□OPD	ii.
Hip fracture	m.	**SENSORY**	
Missing limb (e.g., amputation)	n.	□ataracts	jj.
Osteoporosis	o.	Diabetic retinopathy	kk.
Pathological bone fracture	p.	□laucoma	ll.
NEUROLOGICAL		Macular degeneration	mm.
Alzheimer□s disease	q.	**OTHER**	
Aphasia	r.	Allergies	nn.
□erebral palsy	s.	Anemia	oo.
□erebrovascular accident (stroke)	t.	□ancer	pp.
		□enal failure	qq.
Dementia other than Alzheimer□s disease	u.	*NONE OF ABOVE*	rr.

2. 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.
□lostridium difficile (c. diff.)	b.	Tuberculosis	i.
□onjunctivitis	c.	□rinary tract infection **in last 30 days**	j.
HIV infection	d.	Viral hepatitis	k.
Pneumonia	e.	Wound infection	l.
□espiratory infection	f.	NONE OF ABOVE	m.

3. OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES

a. _____ | | | | □ | |
b. _____ | | | | □ | |
c. _____ | | | | □ | |
d. _____ | | | | □ | |
e. _____ | | | | □ | |

SECTION □. HEALTH CONDITIONS

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

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

2.	**PAIN SYMPTOMS**	(□ode 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* □4**) 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 sites*** *that apply in* ***last 7 days***)	
		Back pain a.	Incisional pain f.
		Bone pain b.	Joint pain (other than hip) g.
		□hest pain while doing usual activities c.	Soft tissue pain (e.g., lesion, muscle) h.
		Headache d.	Stomach pain i.
		Hip pain e.	Other j.
4.	**ACCIDENTS**	(***Check all that apply***)	
		Fell in **past 30 days** a.	Hip fracture in **last 180 days** c.
		Fell in **past 31-180 days** b.	Other fracture in **last 180 days** d.
			NONE OF ABOVE e.
5.	**STABILITY OF CONDITIONS**	□onditions/diseases make resident□s cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating) a.	
		□esident 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.	

SECTION K. ORAL/NUTRITIONAL STATUS

1.	**ORAL PROBLEMS**	□hewing problem a.	
		Swallowing problem b.	
		Mouth pain c.	
		NONE OF ABOVE d.	
2.	**HEIGHT AND □ EIGHT**	□ecord ***(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.) ☐☐☐	
3.	**□ EIGHT CHANGE**	**a. □ eight loss**—5 □ or more in **last 30 days** □or 10 □ or more in **last 180 days** 0. No 1. Yes	
		b. □ eight gain—5 □ or more in **last 30 days** □or 10 □ or more in **last 180 days** 0. No 1. Yes	
4.	**NUTRI-TIONAL PROBLEMS**	□omplains about the taste of many foods a.	Leaves 25□ or more of food uneaten at most meals c.
		□egular or repetitive complaints of hunger b.	*NONE OF ABOVE* d.
5.	**NUTRI-TIONAL APPROACH-ES**	(***Check all that apply in last 7 days***)	
		Parenteral/IV a.	Dietary supplement between meals f.
		Feeding tube b.	
		Mechanically altered diet c.	Plate guard, stabilized built-up utensil, etc. g.
		Syringe (oral feeding) d.	
		Therapeutic diet e.	On a planned weight change program h.
			NONE OF ABOVE i.
6.	**PARENTERAL OR ENTERAL INTAKE**	(***Skip to Section L if neither 5a nor 5b is checked***) **a.** □ode 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□ **b.** □ode the average **fluid intake** per day by IV or tube in **last 7 days** 0. None 3. 1001 to 1500 cc/day 1. 1 to 500 cc/day 4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day 5. 2001 or more cc/day	

SECTION L. ORAL/DENTAL STATUS

1.	**ORAL STATUS AND DISEASE PREVENTION**	Debris (soft, easily movable substances) present in mouth prior to going to bed at night a.	
		Has dentures or removable bridge b.	
		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 g.	

SECTION M. SKIN CONDITION

1.	**ULCERS (Due to any cause)**	(□ecord the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record □0□(zero). □ode all that apply during ***last 7 days***. □ode 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*)	
		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	
3.	**HISTORY OF RESOLVED ULCERS**	□esident had an ulcer that was resolved or cured **in LAST 90 DAYS** 0. No 1. Yes	
4.	**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.
		□ashes—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 TREAT-MENTS**	(***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.
		□lcer 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 PROBLEMS AND CARE**	(***Check all that apply*** *during* ***last 7 days)***	
		□esident 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.
		□eceived 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.

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	**TIME A□ AKE**	(***Check appropriate time periods over last 7 days***) □esident awake all or most of time (i.e., naps no more than one hour per time period) in the□	
		Morning a.	Evening c.
		Afternoon b.	*NONE OF ABOVE* d.
(If resident is comatose, skip to Section O)			
2.	**AVERAGE TIME INVOLVED IN ACTIVITIES**	(□ **hen 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	
3.	**PREFERRED ACTIVITY SETTINGS**	(***Check all settings*** *in which activities are* ***preferred***)	
		Own room a.	Outside facility d.
		Day/activity room b.	
		Inside NH/off unit c.	*NONE OF ABOVE* e.
4.	**GENERAL ACTIVITY PREFER-ENCES (adapted to resident□s current abilities)**	(***Check all PREFERENCES*** *whether or not activity is currently available to resident*)	
		□ards/other games a.	Trips/shopping g.
		□rafts/arts b.	Walking/wheeling outdoors h.
		Exercise/sports c.	Watching TV i.
		Music d.	□ardening or plants j.
		□eading/writing e.	Talking or conversing k.
		Spiritual/religious activities f.	Helping others l.
			NONE OF ABOVE m.

5.	PREFERS CHANGE IN DAILY ROUTINE	□ode for resident preferences in daily routines 0. No change 1. Slight change 2. Major change	
		a. Type of activities in which resident is currently involved	
		b. Extent of resident involvement in activities	

SECTION O. MEDICATIONS

1.	NUMBER OF MEDICATIONS	(*Record the number of different medications used in the last 7 days*□enter □0□if none used)	
2.	NE□ MEDICATIONS	(□esident currently receiving medications that were initiated during the *last 90 days*) 0. No 1. Yes	
3.	IN□ECTIONS	(*Record the number of DAYS injections of any type received during the last 7 days*□enter □0□if none used)	
4.	DAYS RECEIVED THE FOLLO□ ING 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	

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

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

TREATMENTS

- □hemotherapy (a.)
- Dialysis (b.)
- IV medication (c.)
- Intake/output (d.)
- Monitoring acute medical condition (e.)
- Ostomy care (f.)
- Oxygen therapy (g.)
- □adiation (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.)
- □espite 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 - □ecord 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]

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

2.	INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	(**Check all interventions or strategies used in last 7 days**—no matter where received)	
		Special behavior symptom evaluation program	a.
		Evaluation by a licensed mental health specialist in **last 90 days**	b.
		□roup therapy	c.
		□esident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage	d.
		□eorientation—e.g., cueing	e.
		NONE OF ABOVE	f.
3.	NURSING REHABILITATION/ RESTORATIVE CARE	□ecord the N□MBE□ 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. □ange of motion (passive)
- b. □ange 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. □ommunication
- k. Other

4.	DEVICES AND RESTRAINTS	(□se the following codes for ***last 7 days***□) 0. Not used 1. □sed less than daily 2. □sed 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. □hair prevents rising	
5.	HOSPITAL STAY(S)	□ecord 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.	EMERGENCY ROOM (ER) VISIT(S)	□ecord number of times resident visited E□ without an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no E□ 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 0 if none*)	
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	

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE POTENTIAL	a. □esident expresses/indicates preference to return to the community 0. No 1. Yes	
		b. □esident has a support person who is positive towards discharge 0. No 1. Yes	
		c. Stay projected to be of a short duration— discharge projected **within 90 days** (do not include expected discharge due to death) 0. No 2. Within 31-90 days 1. Within 30 days 3. Discharge status uncertain	
2.	OVERALL CHANGE IN CARE NEEDS	□esident□s overall 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	

SECTION R. ASSESSMENT INFORMATION

1.	PARTICIPATION IN ASSESSMENT	a. □esident□	0. No	1. Yes		
		b. Family□	0. No	1. Yes	2. No family	
		c. Significant other□	0. No	1. Yes	2. None	

2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT□

a. Signature of □N Assessment □oordinator (sign on above line)

b. Date □N Assessment □oordinator signed as complete — — (Month — Day — Year)

SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1. SPECIAL TREATMENTS AND PROCEDURES

a. RECREATION THERAPY—*Enter number of days and total minutes of recreation therapy administered* (***for at least 15 minutes a day***) *in the* ***last 7 days*** (*Enter 0 if none*)

	DAYS (A)	MIN (B)
(A) □□ **of days** administered for 15 minutes or more		
(B) □ **total** □ **of minutes** provided in last 7 days		

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 FI□ST 14 days of stay—physical therapy, occupational therapy, or speech pathology service*□
0. No 1. Yes

If not ordered, skip to item 2

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. □ALKING □ HEN MOST SELF SUFFICIENT

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

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

Skip to item 3 if resident did not walk in last 7 days

(***FOR FOLLO□ ING FIVE ITEMS, BASE CODING ON THE EPISODE □ HEN THE RESIDENT □ ALKED THE FARTHEST □ ITHOUT SITTING DO□ N. INCLUDE □ ALKING DURING REHABILITATION SESSIONS.***)

a. Furthest distance walked without sitting down during this episode.

0. 150□feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. Time walked without sitting down during this episode.

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31□minutes

c. Self-Performance in walking during this episode.

0. *INDEPENDENT*—No help or oversight
1. *S□PE□VISION*—Oversight, encouragement or cueing provided
2. *LIMITED ASSISTAN□E*—□esident highly involved in walking□ received physical help in guided maneuvering of limbs or other nonweight bearing assistance
3. *E□TENSIVE ASSISTAN□E*—□esident received weight bearing assistance while walking

d. □ alking support provided associated with this episode (code regardless of resident's self-performance classification).

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two□persons physical assist

e. Parallel bars used by resident in association with this episode.

0. No 1. Yes

3. CASE MI□ GROUP

Medicare | | | | | | **State** | | | | | |

MINIMUM DATA SET (MDS) - *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

SECTION □. SUPPLEMENTAL MDS ITEMS

1.	**National Provider ID**	Enter for all assessments and tracking forms, if available.	
		If the A□D of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.	
2.	**Influen□a 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. □eceived outside of this facility 3. Not eligible 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine	
3.	**Pneumo-coccal 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 PPV not received, state reason□ 1. Not eligible 2. Offered and declined 3. Not offered	

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

Numeric Identifier _____

□esident□s Name□	Medical □ecord No.□

1. □heck if □AP is triggered.
2. For each triggered □AP, use the □AP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident□s status.

   □Describe□
   - — Nature of the condition (may include presence or lack of objective data and subjective complaints).
   - — □omplications and risk factors that affect your decision to proceed to care planning.
   - — Factors that must be considered in developing individualized care plan interventions.
   - — Need for referrals/further evaluation by appropriate health professionals.

   □Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered □AP and the type(s) of care plan interventions that are appropriate for a particular resident.

   □Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
3. Indicate under the Location of □AP Assessment Documentation column where information related to the □AP assessment can be found.
4. For each triggered □AP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The □are Planning Decision column must be completed within 7 days of completing the □AI (MDS and □APs).

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

B. _____

1. Signature of □N □oordinator for □AP Assessment Process

2. ☐☐ — ☐☐ — ☐☐☐☐ (Month — Day — Year)

_____

3. Signature of Person □ompleting □are Planning Decision

4. ☐☐ — ☐☐ — ☐☐☐☐ (Month — Day — Year)

Health Care Acquire Infection Public Reporting

Who would be involved in the partnership with QCorp?

Why does this partnership make sense?

What are the responsibilities for OHPR and QCorp?

OHPR (HCAIAC) responsibilities:

- Convene workgroup of members of the HCAIAC, QCorp staff and web developer to produce objectives, principles and timelines
- Provide all content and data necessary to achieve agreed upon objectives, principles and timelines.
- Provide funding support for development of agreed upon format and display

QCorp responsibilities

- Allow web developer to be available for development of objectives, principles and timelines for web development
- Be an active participant in the development of objectives, principles and timelines
- Provide recommendations of "consumer-centric" language and presentation
- Provide feedback from website once "live" to OHPR to continue to evaluate the effectiveness

What will be publicly reported in the first year (2009)?

- All Oregon acute care hospitals are required to report for services beginning on or after January 1, 2009
    - For outcome measures, hospitals are required to us the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN) for the following:
        - Central line-associated bloodstream infections (CLABSI)
            - Report infections from medical ICUs, surgical ICUs, or combined medical/surgical ICUs
            - This does not apply to ICUs where at least 80% of the patients receive specialized critical care (neurosurgical ICUs, oncology ICUs, neonatal ICUs, etc.)
        - Three types of surgical site infections
            - Coronary artery bypass graft with both chest and donor incisions (CBGB)
            - Coronary artery bypass graft with chest incision only (CBGC)
            - Knee prosthesis (KPRO)
    - For process measures, hospitals are required to report on a quarterly basis the following:
        - SCIP-Inf-1: prophylactic antibiotic received within one hour prior to surgical incision;
        - SCIP-Inf-2: prophylactic antibiotic selection for surgical patients and
        - SCIP-Inf-3: antibiotics discontinued within 24 hours after surgery end time (48 hours for cardiac patients).
- Requirements for this program will be expanded to include additional requirements for facilities and/or additional facilities reporting (i.e. ambulatory surgery centers, nursing facilities, outpatient dialysis centers, free standing birthing centers)

What are the next steps in order to move this process forward?

- Approval from the QCorp Board/Executive Group to move forward
- Agreement for funding depending on above result between OHPR and QCorp

Dates to consider

- July 1, 2009: OHPR and QCorp agreement must be in place for initial development work
- July 1, 2009: New reporting requirements in effect
- January 1, 2010: HAI report due