

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

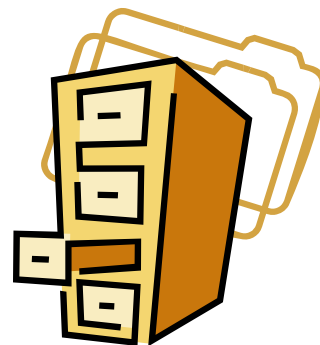


Department of Human Services

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

409.023.0120

HAI Reporting for Ambulatory Surgery Centers

- (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

DRAFT

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

DRAFT

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

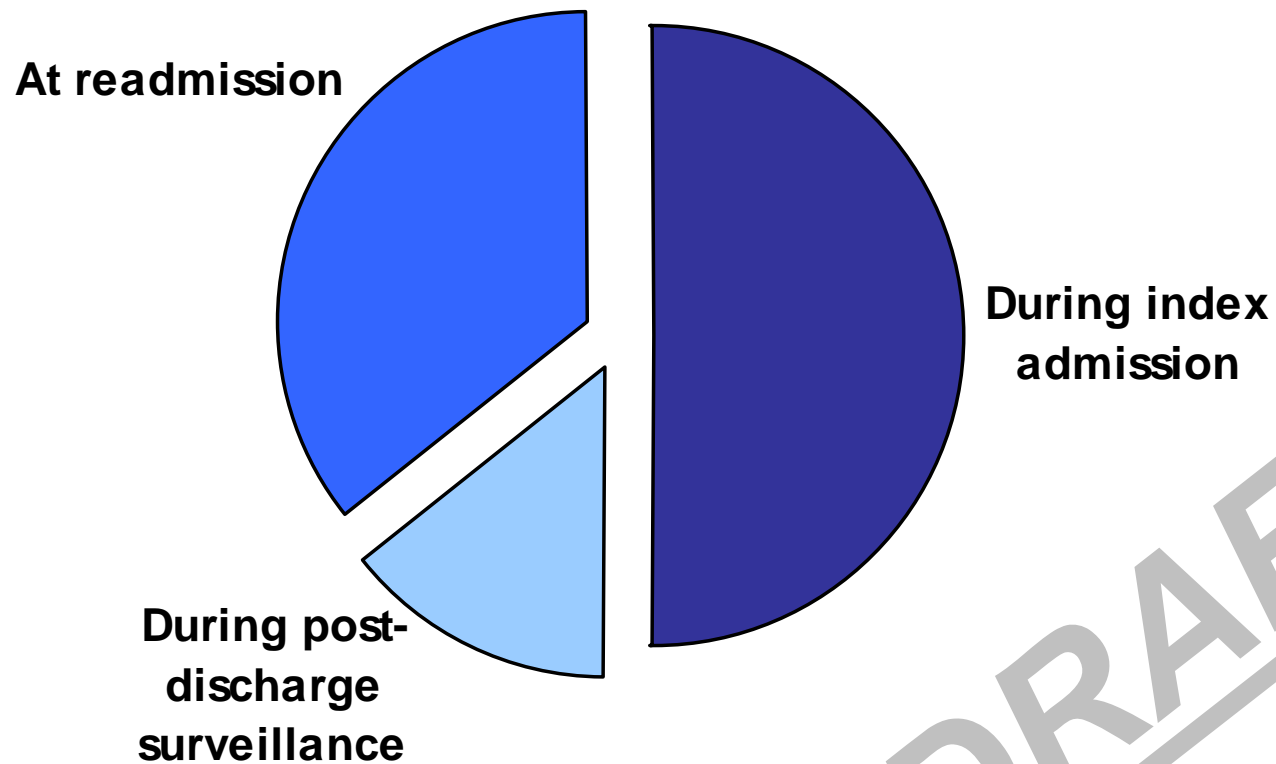
Risk	Procedures	Infections	Proportion
0	542	1	0.2%
1	635	5	0.8%
2,3	172	3	1.7%

CBGB SSIs

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

Detecting SSIs

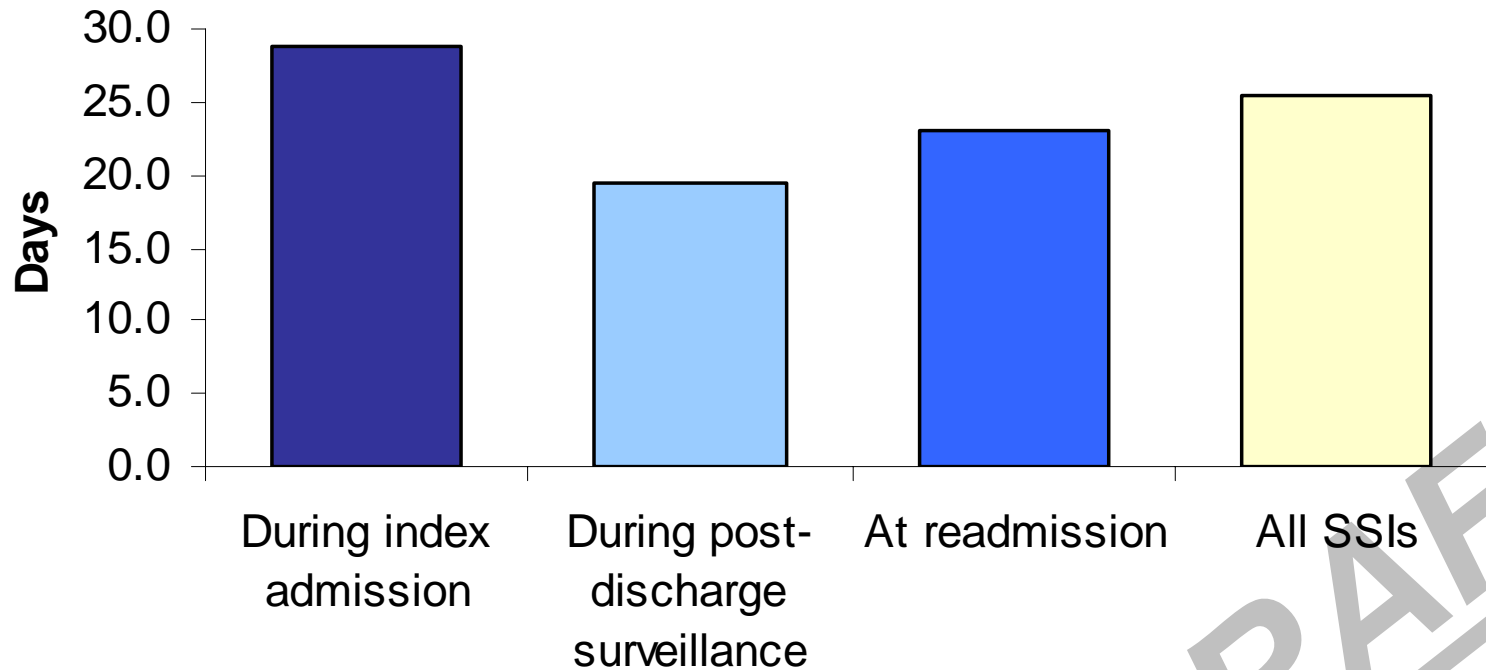
CBGB: How were SSIs detected?



DRAFT

Detecting SSIs

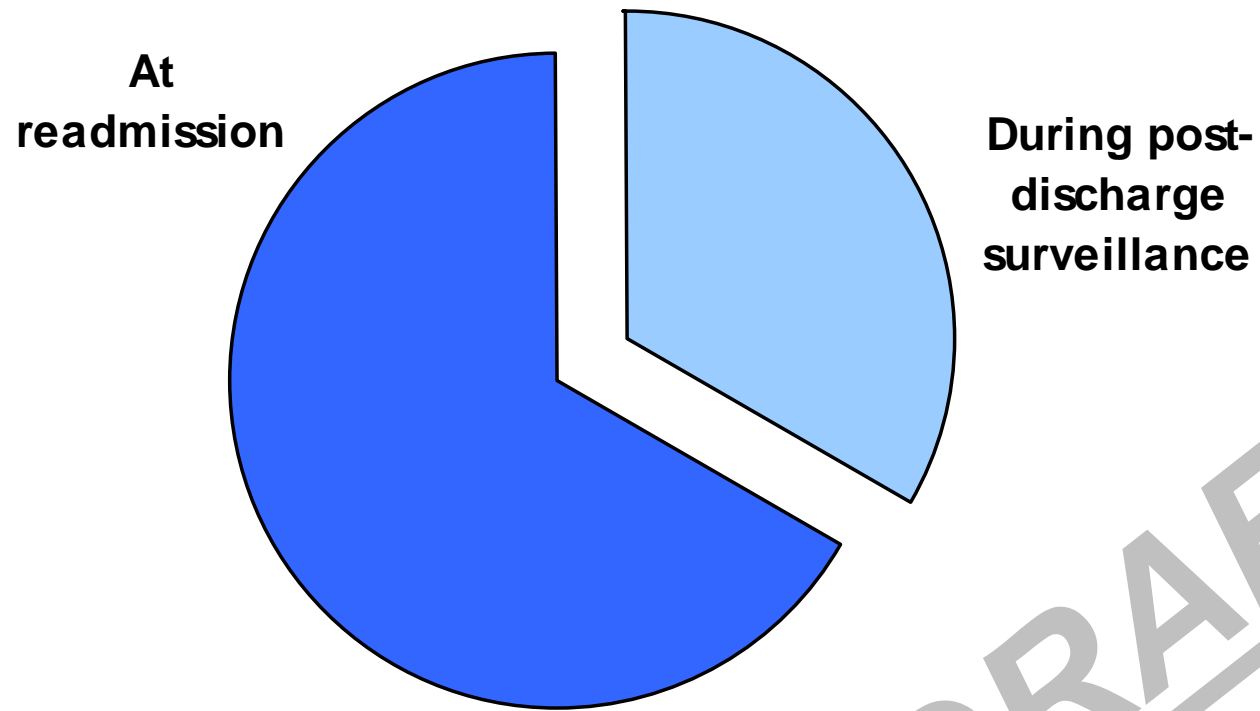
CBGB: Mean number of days from admission to SSI event



How were SSIs detected?

Detecting SSIs

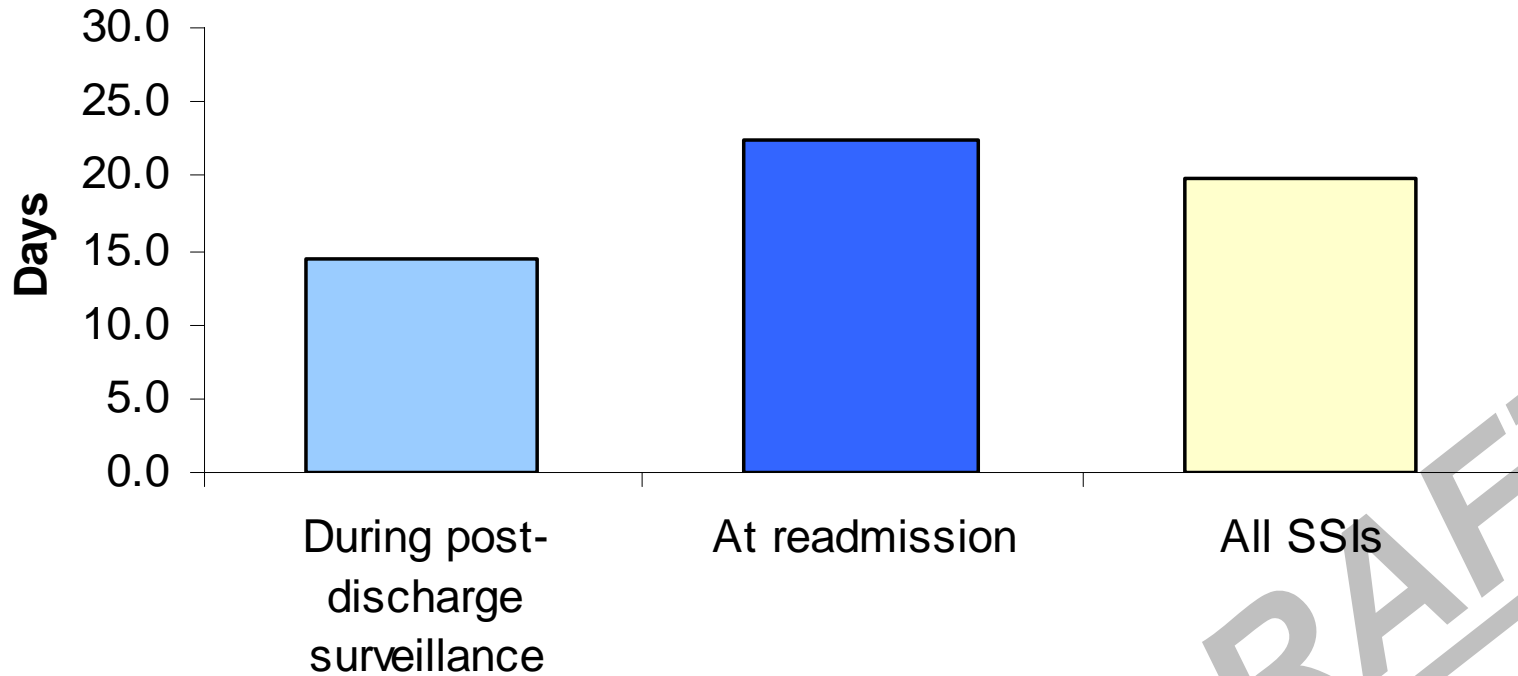
KPRO: How were SSIs detected?



DRAFT

Detecting SSIs

KPRO: Mean number of days from admission to SSI event



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

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 [Ⓞ]	<table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; text-align: center;">—</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; text-align: center;">—</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: none; text-align: center;">Year</td> </tr> <tr> <td style="text-align: center; font-size: small;">Month</td> <td style="text-align: center; font-size: small;">Day</td> <td></td> <td style="text-align: center; font-size: small;">Year</td> <td colspan="7"></td> </tr> </table>						—			—					Year	Month	Day		Year																													
		—			—					Year																																							
Month	Day		Year																																														
4.	RACE/ETHNICITY [Ⓞ]	<table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1. American Indian/Alaskan Native</td> <td style="width: 50%;">4. Hispanic</td> </tr> <tr> <td>2. Asian/Pacific Islander</td> <td>5. White, not of Hispanic origin</td> </tr> <tr> <td>3. Black, not of Hispanic origin</td> <td></td> </tr> </table>				1. American Indian/Alaskan Native	4. Hispanic	2. Asian/Pacific Islander	5. White, not of Hispanic origin	3. Black, not of Hispanic origin																																							
1. American Indian/Alaskan Native	4. Hispanic																																																
2. Asian/Pacific Islander	5. White, not of Hispanic origin																																																
3. Black, not of Hispanic origin																																																	
5.	SOCIAL SECURITY AND MEDICARE NUMBERS [Ⓞ] [C in 1 st box if non med. no.]	<table style="width: 100%; border: none;"> <tr> <td colspan="11">a. Social Security Number</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="11">b. Medicare number (or comparable railroad insurance number)</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>				a. Social Security Number																						b. Medicare number (or comparable railroad insurance number)																					
a. Social Security Number																																																	
b. Medicare number (or comparable railroad insurance number)																																																	
6.	FACILITY PROVIDER NO. [Ⓞ]	<table style="width: 100%; border: none;"> <tr> <td colspan="11">a. State No.</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="11">b. Federal No.</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>				a. State No.																						b. Federal No.																					
a. State No.																																																	
b. Federal No.																																																	
7.	MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] [Ⓞ]	<table style="width: 100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>																																															
8.	REASONS FOR ASSESSMENT	<p>[Note—Other codes do not apply to this form]</p> <p>a. Primary reason for assessment</p> <ol style="list-style-type: none"> 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 <p>b. Codes for assessments required for Medicare PPS or the State</p> <ol style="list-style-type: none"> 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

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	<i>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</i> <div style="text-align: center;"> <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> — <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> — <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <div style="text-align: center; font-size: small;"> Month Day Year </div>
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, MR/DD facility 7. Rehabilitation hospital 8. Other
3.	LIVED ALONE (PRIOR TO ENTRY)	0. No 1. Yes 2. In other facility
4.	ZIP CODE OF PRIOR PRIMARY RESIDENCE	<input style="width: 40px; height: 20px;" type="text"/>
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. MR/DD setting e. NONE OF ABOVE f.
6.	LIFETIME OCCUPATION(S) [Put "/" between two occupations]	<input style="width: 100%; height: 20px;" type="text"/>
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. Graduate degree
8.	LANGUAGE	(Code for correct response) a. Primary Language 0. English 1. Spanish 2. French 3. Other b. If other, specify <input style="width: 40px; height: 20px;" type="text"/>
9.	MENTAL HEALTH HISTORY	Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem? 0. No 1. Yes
10.	CONDITIONS RELATED TO MR/DD STATUS	(Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely) Not applicable—no MR/DD (Skip to AB11) a. MR/DD with organic condition b. Down's syndrome c. Autism d. Epilepsy e. Other organic condition related to MR/DD f. MR/DD with no organic condition
11.	DATE BACKGROUND INFORMATION COMPLETED	<div style="text-align: center;"> <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> — <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> — <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> <input style="width: 20px; height: 20px; margin-right: 5px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </div> <div style="text-align: center; font-size: small;"> Month Day Year </div>

SECTION AC. CUSTOMARY ROUTINE

1.	CUSTOMARY ROUTINE	(Check all that apply. If all information UNKNOWN, check last box only)
	(In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home)	
	CYCLE OF DAILY EVENTS	
	Stays up late at night (e.g., after 9 pm)	a.
	Naps regularly during day (at least 1 hour)	b.
	Goes 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.
	Use 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.
	Use 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.
	Usually 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.
	UNKNOWN—Resident/family unable to provide information	y.

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:		
a. Signature of RN Assessment Coordinator		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.		

SECTION D. VISION PATTERNS

1. VISION	(Ability to see in adequate light and with glasses if used) 0. ADEQUATE —sees fine detail, including regular print in newspapers/books 1. IMPAIRED —sees large print, but not regular print in newspapers/books 2. MODERATELY IMPAIRED —limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY IMPAIRED —object identification in question, but eyes appear to follow objects 4. SEVERELY IMPAIRED —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) Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes <i>NONE OF ABOVE</i>	a. b. c.
3. VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. 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) 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	
2. 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		
3. CHANGE IN MOOD	Resident'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 OR behavior was easily altered 1. Behavior was not easily altered 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)	(A) (B)	

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

SECTION F. PSYCHOSOCIAL WELL-BEING

1. SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others At ease doing planned or structured activities At ease doing self-initiated activities Establishes own goals Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services) Accepts invitations into most group activities <i>NONE OF ABOVE</i>	a. b. c. d. e. f. g.
2. UNSETTLED RELATIONSHIPS	Covert/open conflict with or repeated criticism of staff Unhappy with roommate Unhappy with residents other than roommate Openly expresses conflict/anger with family/friends Absence of personal contact with family/friends Recent loss of close family member/friend Does not adjust easily to change in routines <i>NONE OF ABOVE</i>	a. b. c. d. e. f. g. h.
3. PAST ROLES	Strong identification with past roles and life status Expresses sadness/anger/empty feeling over lost roles/status Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community <i>NONE OF ABOVE</i>	a. b. c. d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (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 last 7 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	(A) (B)
(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	SELF-PERF 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)	
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)	

2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) Code for most dependent in self-performance and support. (A) BATHING SELF-PERFORMANCE codes appear below	(A) (B)
		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)	(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	
4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)	(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury)	
		(A) RANGE OF MOTION (B) VOLUNTARY MOVEMENT 0. No limitation 0. No loss 1. Limitation on one side 1. Partial loss 2. Limitation on both sides 2. Full loss 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	(A) (B)
5.	MODES OF LOCOMOTION	(Check all that apply during last 7 days)	
		Cane/walker/crutch a. Wheelchair primary mode of locomotion d. Wheeled self b. Other person wheeled e. Other person wheeled c. NONE OF ABOVE	
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 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	
8.	ADL FUNCTIONAL REHABILITATION POTENTIAL	Resident 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 Resident able to perform tasks/activity but is very slow Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings NONE OF ABOVE	b. c. d. e.
9.	CHANGE IN ADL FUNCTION	Resident'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.	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	
2.	BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days	a. Diarrhea c. b. Fecal impaction d. c. Constipation 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.	
4.	CHANGE IN URINARY CONTINENCE	External (condom) catheter	c.	Enemas/irrigation	h.	
		Indwelling catheter	d.	Ostomy present	i.	
		Intermittent catheter	e.	NONE OF ABOVE	j.	
		Resident'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.
		Diabetes mellitus a.		Multiple sclerosis	w.
2.	INFECTIONS (If none apply, CHECK the NONE OF ABOVE box)	Hypert thyroidism b.		Paraplegia	x.
		Hypothyroidism c.		Parkinson's disease	y.
		HEART/CIRCULATION		Quadruplegia	z.
		Arteriosclerotic heart disease (ASHD) d.		Seizure disorder	aa.
		Cardiac dysrhythmias e.		Transient ischemic attack (TIA)	bb.
		Congestive heart failure f.		Traumatic brain injury	cc.
		Deep vein thrombosis g.		PSYCHIATRIC/MOOD	
		Hypertension h.		Anxiety disorder	dd.
		Hypotension i.		Depression	ee.
		Peripheral vascular disease j.		Manic depression (bipolar disease)	ff.
		Other cardiovascular disease k.		Schizophrenia	gg.
		MUSCULOSKELETAL		PULMONARY	
		Arthritis l.		Asthma	hh.
		Hip fracture m.		Emphysema/COPD	ii.
		Missing limb (e.g., amputation) n.		SENSORY	
		Osteoporosis o.		Cataracts	jj.
		Pathological bone fracture p.		Diabetic retinopathy	kk.
		NEUROLOGICAL		Glaucoma	ll.
		Alzheimer's disease q.		Macular degeneration	mm.
		Aphasia r.		OTHER	
		Cerebral palsy s.		Allergies	nn.
		Cerebrovascular accident (stroke) t.		Anemia	oo.
Dementia other than Alzheimer's disease u.		Cancer	pp.		
3.	OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES	a. _____		Renal failure	qq.
		b. _____		NONE OF ABOVE	rr.
4.	OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES	a.		Septicemia	g.
		b.		Sexually transmitted diseases	h.
5.	OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES	c.		Tuberculosis	i.
		d.		Urinary tract infection in last 30 days	j.
		e.		Viral hepatitis	k.
				Wound infection	l.
				NONE OF ABOVE	m.

SECTION J. 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.
		Weight gain or loss of 3 or more pounds within a 7 day period	a.	Edema	g.
2.	PROBLEM CONDITIONS (Check all problems present in last 7 days unless other time frame is indicated)	Inability to lie flat due to shortness of breath	b.	Fever	h.
		Dehydrated; output exceeds input	c.	Hallucinations	i.
3.	PROBLEM CONDITIONS (Check all problems present in last 7 days unless other time frame is indicated)	Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days	d.	Internal bleeding	j.
		OTHER	e.	Recurrent lung aspirations in last 90 days	k.
4.	PROBLEM CONDITIONS (Check all problems present in last 7 days unless other time frame is indicated)	Delusions		Shortness of breath	l.
				Syncope (fainting)	m.
5.	PROBLEM CONDITIONS (Check all problems present in last 7 days unless other time frame is indicated)			Unsteady gait	n.
				Vomiting	o.
6.	PROBLEM CONDITIONS (Check all problems present in last 7 days unless other time frame is indicated)			NONE OF ABOVE	p.

SECTION M. SKIN CONDITION

2. 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 (<i>skip to J4</i>) 1. Pain less than daily 2. Pain daily b. INTENSITY of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating	
3. PAIN SITE	(If pain present, check all sites that apply in last 7 days) Back pain Bone pain Chest pain while doing usual activities Headache Hip pain	a. Incisional pain b. Joint pain (other than hip) c. Soft tissue pain (e.g., lesion, muscle) d. Stomach pain e. Other f. g. h. i. j.
4. ACCIDENTS	(Check all that apply) Fell in past 30 days Fell in past 31-180 days	a. Hip fracture in last 180 days b. Other fracture in last 180 days c. d. e. NONE OF ABOVE
5. STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating) Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem End-stage disease, 6 or fewer months to live NONE OF ABOVE	a. b. c. d.

SECTION K. ORAL/NUTRITIONAL STATUS

1. ORAL PROBLEMS	Chewing problem Swallowing problem Mouth pain NONE OF ABOVE	a. b. c. d.
2. 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.) <input type="text"/> <input type="text"/> <input type="text"/> b. WT (lb.) <input type="text"/> <input type="text"/> <input type="text"/>	
3. 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	
4. NUTRITIONAL PROBLEMS	Complains about the taste of many foods Regular or repetitive complaints of hunger	a. Leaves 25% or more of food uneaten at most meals b. NONE OF ABOVE c. d.
5. NUTRITIONAL APPROACHES	(Check all that apply in last 7 days) Parenteral/IV Feeding tube Mechanically altered diet Syringe (oral feeding) Therapeutic diet	a. Dietary supplement between meals b. Plate guard, stabilized built-up utensil, etc. c. On a planned weight change program d. NONE OF ABOVE e. f. g. h. i.
6. PARENTERAL OR ENTERAL INTAKE	(<i>Skip to Section L if neither 5a nor 5b is checked</i>) a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days 0. None 3. 51% to 75% 1. 1% to 25% 4. 76% to 100% 2. 26% to 50% b. Code the average fluid intake per day by IV or tube in last 7 days 0. None 3. 1001 to 1500 cc/day 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 Has dentures or removable bridge Some/all natural teeth lost—does not have or does not use dentures (or partial plates) Broken, loose, or carious teeth Inflamed gums (gingiva); swollen or bleeding gums; oral abscesses; ulcers or rashes Daily cleaning of teeth/dentures or daily mouth care—by resident or staff NONE OF ABOVE	a. b. c. d. e. f. g.
--	--	--

1. ULCERS (Due to any cause)	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during last 7 days . Code 9 = 9 or more.) [Requires full body exam.] a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when 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.	Number at Stage
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	Resident 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 Burns (second or third degree) Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions) Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster Skin desensitized to pain or pressure Skin tears or cuts (other than surgery) Surgical wounds NONE OF ABOVE	a. b. c. d. e. f. g. h.
5. SKIN TREATMENTS	(Check all that apply during last 7 days) Pressure relieving device(s) for chair Pressure relieving device(s) for bed Turning/repositioning program Nutrition or hydration intervention to manage skin problems Ulcer care Surgical wound care Application of dressings (with or without topical medications) other than to feet Application of ointments/medications (other than to feet) Other preventative or protective skin care (other than to feet) NONE OF ABOVE	a. b. c. d. e. f. g. h. i. j.
6. 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 Infection of the foot—e.g., cellulitis, purulent drainage Open lesions on the foot Nails/calluses trimmed during last 90 days Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators) Application of dressings (with or without topical medications) NONE OF ABOVE	a. b. c. d. e. f. g.

SECTION N. ACTIVITY PURSUIT PATTERNS

1. 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 <input type="text"/> Evening Afternoon <input type="text"/> NONE OF ABOVE	c. d.
(If resident is comatose, skip to Section O)		
2. AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care) 0. Most—more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None	
3. PREFERRED ACTIVITY SETTINGS	(Check all settings in which activities are preferred) Own room Day/activity room Inside NH/off unit	a. Outside facility b. NONE OF ABOVE c. d. e.
4. GENERAL ACTIVITY PREFERENCES (adapted to resident's current abilities)	(Check all PREFERENCES whether or not activity is currently available to resident) Cards/other games Crafts/arts Exercise/sports Music Reading/writing Spiritual/religious activities	a. Trips/shopping b. Walking/wheeling outdoors c. Watching TV d. Gardening or plants e. Talking or conversing f. Helping others g. h. i. j. k. l. m. NONE OF ABOVE

5. PREFERENCES CHANGE IN DAILY ROUTINE	Code 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. NEW MEDICATIONS	(Resident currently receiving medications that were initiated during the last 90 days) 0. No 1. Yes		
3. INJECTIONS	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)		
4. DAYS RECEIVED THE FOLLOWING MEDICATION	a. Antipsychotic		d. Hypnotic
	b. Antianxiety		e. Diuretic
	c. Antidepressant		

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	Ventilator or respirator	l.																																			
	Chemotherapy	a. PROGRAMS																																				
	Dialysis	b. Alcohol/drug treatment program	m.																																			
	IV medication	c. Alzheimer's/dementia special care unit	n.																																			
	Intake/output	d. Hospice care	o.																																			
	Monitoring acute medical condition	e. Pediatric unit	p.																																			
	Ostomy care	f. Respite care	q.																																			
	Oxygen therapy	g. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)	r.																																			
	Radiation	h. NONE OF ABOVE	s.																																			
Suctioning																																						
Tracheostomy care																																						
Transfusions																																						
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																																						
<table border="1"> <thead> <tr> <th></th> <th colspan="2">DAYS</th> <th colspan="2">MIN</th> </tr> <tr> <th></th> <th>(A)</th> <th>(B)</th> <th>(A)</th> <th>(B)</th> </tr> </thead> <tbody> <tr> <td>a. Speech - language pathology and audiology services</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>b. Occupational therapy</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>c. Physical therapy</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>d. Respiratory therapy</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>e. Psychological therapy (by any licensed mental health professional)</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>				DAYS		MIN			(A)	(B)	(A)	(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)					
	DAYS		MIN																																			
	(A)	(B)	(A)	(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)																																						
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.																																				
	Group therapy	c.																																				
	Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage	d.																																				
	Reorientation—e.g., cueing	e.																																				
	NONE OF ABOVE	f.																																				
3. NURSING REHABILITATION/ RESTORATIVE CARE	Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily.)																																					
	a. Range of motion (passive)		f. Walking																																			
	b. Range of motion (active)		g. Dressing or grooming																																			
	c. Splint or brace assistance		h. Eating or swallowing																																			
	TRAINING AND SKILL PRACTICE IN:		i. Amputation/prosthesis care																																			
	d. Bed mobility		j. Communication																																			
	e. Transfer		k. Other																																			

4. DEVICES AND RESTRAINTS	(Use the following codes for last 7 days:) 0. Not used 1. Used less than daily 2. Used daily		
	Bed rails		
	a.	— Full bed rails on all open sides of bed	
	b.	— Other types of side rails used (e.g., half rail, one side)	
	c.	Trunk restraint	
	d.	Limb restraint	
	e.	Chair prevents rising	
5. HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no hospital admissions)		
6. EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no ER visits)		
7. PHYSICIAN VISITS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter 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. Resident expresses/indicates preference to return to the community 0. No 1. Yes		
	b. Resident 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 1. Within 30 days 2. Within 31-90 days 3. Discharge status uncertain		
2. OVERALL CHANGE IN CARE NEEDS	Resident'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. Resident:	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 RN Assessment Coordinator (sign on above line)			
b. Date RN Assessment Coordinator signed as complete			
		Month	Day Year

SECTION T.THERAPY SUPPLEMENT FOR MEDICARE PPS

1.	SPECIAL TREATMENTS AND PROCEDURES	<p>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)</p> <table border="1"> <thead> <tr> <th colspan="2">DAYS</th> <th colspan="2">MIN</th> </tr> <tr> <th>(A)</th> <th>(B)</th> <th>(A)</th> <th>(B)</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table> <p>(A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in last 7 days</p> <p><i>Skip unless this is a Medicare 5 day or Medicare readmission/return assessment.</i></p> <p>b. ORDERED THERAPIES—Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service? 0. No 1. Yes</p> <p><i>If not ordered, skip to item 2</i></p> <p>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.</p> <p>d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?</p>	DAYS		MIN		(A)	(B)	(A)	(B)				
		DAYS		MIN										
(A)	(B)	(A)	(B)											
2.	WALKING WHEN MOST SELF SUFFICIENT	<p>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:</p> <ul style="list-style-type: none"> Resident received physical therapy involving gait training (P.1.b.c) Physical therapy was ordered for the resident involving gait training (T.1.b) Resident received nursing rehabilitation for walking (P.3.f) Physical therapy involving walking has been discontinued within the past 180 days <p><i>Skip to item 3 if resident did not walk in last 7 days</i></p> <p>(FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)</p> <p>a. Furthest distance walked without sitting down during this episode.</p> <table border="0"> <tr> <td>0. 150+ feet</td> <td>3. 10-25 feet</td> </tr> <tr> <td>1. 51-149 feet</td> <td>4. Less than 10 feet</td> </tr> <tr> <td>2. 26-50 feet</td> <td></td> </tr> </table> <p>b. Time walked without sitting down during this episode.</p> <table border="0"> <tr> <td>0. 1-2 minutes</td> <td>3. 11-15 minutes</td> </tr> <tr> <td>1. 3-4 minutes</td> <td>4. 16-30 minutes</td> </tr> <tr> <td>2. 5-10 minutes</td> <td>5. 31+ minutes</td> </tr> </table> <p>c. Self-Performance in walking during this episode.</p> <p>0. INDEPENDENT—No help or oversight 1. SUPERVISION—Oversight, encouragement or cueing provided 2. LIMITED ASSISTANCE—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3. EXTENSIVE ASSISTANCE—Resident received weight bearing assistance while walking</p> <p>d. Walking support provided associated with this episode (code regardless of resident's self-performance classification).</p> <p>0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+ persons physical assist</p> <p>e. Parallel bars used by resident in association with this episode.</p> <p>0. No 1. Yes</p>	0. 150+ feet	3. 10-25 feet	1. 51-149 feet	4. Less than 10 feet	2. 26-50 feet		0. 1-2 minutes	3. 11-15 minutes	1. 3-4 minutes	4. 16-30 minutes	2. 5-10 minutes	5. 31+ minutes
0. 150+ feet	3. 10-25 feet													
1. 51-149 feet	4. Less than 10 feet													
2. 26-50 feet														
0. 1-2 minutes	3. 11-15 minutes													
1. 3-4 minutes	4. 16-30 minutes													
2. 5-10 minutes	5. 31+ minutes													
3.	CASE MIX GROUP	<p>Medicare <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>State <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>												

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

SECTION W. SUPPLEMENTAL MDS ITEMS

1.	National Provider ID	Enter for all assessments and tracking forms, if available. <div style="border: 1px solid black; width: 100px; height: 15px; margin: 0 auto;"></div>	
		If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.	
2.	Influenza Vaccine	<p>a. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)?</p> <p style="margin-left: 20px;">0. No (If No, go to item W2b) 1. Yes (If Yes, go to item W3)</p> <p>b. If Influenza vaccine not received, state reason:</p> <p style="margin-left: 20px;">1. Not in facility during this year's flu season 2. Received outside of this facility 3. Not eligible 4. Offered and declined 5. Not offered 6. Inability to obtain vaccine</p>	
3.	Pneumo- coccal Vaccine	<p>a. Is the resident's PPV status up to date?</p> <p style="margin-left: 20px;">0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b)</p> <p>b. If PPV not received, state reason:</p> <p style="margin-left: 20px;">1. Not eligible 2. Offered and declined 3. Not offered</p>	

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

Numeric Identifier _____

Resident's Name:	Medical Record No.:
------------------	---------------------

1. Check if RAP is triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
 - Describe:
 - Nature of the condition (may include presence or lack of objective data and subjective complaints).
 - Complications and risk factors that affect your decision to proceed to care planning.
 - Factors that must be considered in developing individualized care plan interventions.
 - Need for referrals/further evaluation by appropriate health professionals.
 - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
 - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

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	<input type="checkbox"/>		<input type="checkbox"/>
2. COGNITIVE LOSS	<input type="checkbox"/>		<input type="checkbox"/>
3. VISUAL FUNCTION	<input type="checkbox"/>		<input type="checkbox"/>
4. COMMUNICATION	<input type="checkbox"/>		<input type="checkbox"/>
5. ADL FUNCTIONAL/ REHABILITATION POTENTIAL	<input type="checkbox"/>		<input type="checkbox"/>
6. URINARY INCONTINENCE AND INDWELLING CATHETER	<input type="checkbox"/>		<input type="checkbox"/>
7. PSYCHOSOCIAL WELL-BEING	<input type="checkbox"/>		<input type="checkbox"/>
8. MOOD STATE	<input type="checkbox"/>		<input type="checkbox"/>
9. BEHAVIORAL SYMPTOMS	<input type="checkbox"/>		<input type="checkbox"/>
10. ACTIVITIES	<input type="checkbox"/>		<input type="checkbox"/>
11. FALLS	<input type="checkbox"/>		<input type="checkbox"/>
12. NUTRITIONAL STATUS	<input type="checkbox"/>		<input type="checkbox"/>
13. FEEDING TUBES	<input type="checkbox"/>		<input type="checkbox"/>
14. DEHYDRATION/FLUID MAINTENANCE	<input type="checkbox"/>		<input type="checkbox"/>
15. DENTAL CARE	<input type="checkbox"/>		<input type="checkbox"/>
16. PRESSURE ULCERS	<input type="checkbox"/>		<input type="checkbox"/>
17. PSYCHOTROPIC DRUG USE	<input type="checkbox"/>		<input type="checkbox"/>
18. PHYSICAL RESTRAINTS	<input type="checkbox"/>		<input type="checkbox"/>

- B.** _____
1. Signature of RN Coordinator for RAP Assessment Process

 3. Signature of Person Completing Care Planning Decision

2. — —
Month Day Year

4. — —
Month Day Year

Health Care Acquire Infection Public Reporting

The Office for Oregon Health Policy & Research (OHPR) is proposing a partnership with the Oregon Healthcare Quality Corporation (QCorp) for public reporting of health care acquired infections through QCorp's quality website development.

Who would be involved in the partnership with QCorp?

The Office for Oregon Health Policy and Research administers the health care acquired infections reporting program established in July 2007. The Health Care Acquired Infections Advisory Committee (HCAIAC), co-chaired by Jim Dameron (Administrator, Patient Safety Commission) and Woody English, MD (Providence St Vincent's Medical Center), advises OHPR on all aspects of the reporting program and consists of a diverse group of experts in infection control, providers, purchasers, consumers and public health officials.

Why does this partnership make sense?

OHPR is required by statute to publicly reporting health care acquired infections with the first report due in January 2010. The HCAIAC has initially recommended the report be an interactive, consumer-centric website. OHPR has limited ability under current website protocols and restrictions to provide a website that would meet the recommendations of the HCAIAC. QCorp's development of its "quality website" provides a unique opportunity for a public-private partnership of quality reporting to include hospital infection outcome reporting. Using content expertise of OHPR and HCAIAC and consumer engagement expertise of QCorp, the public reporting of health care acquired infections will have a greater opportunity for impact on consumers so they can make informed and empowered health care decisions. Through an effective partnership, OHPR will be able to fulfill its statutorily obligated mission more effectively through the expertise at QCorp and QCorp will be able to supplement the public reporting of quality measures to include health care acquired infections, which only three other states currently publicly report.

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 use 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