

Resident Name _____

Numeric Identifier _____

24. TOILETING PROGRAMS H3	<p>Check any that apply during the last 14 days</p> <p>a. Any scheduled toileting plan</p> <p>b. Bladder retraining program</p>	<input type="checkbox"/>	<input type="checkbox"/>
25. DISEASES I1	<p>Check only those conditions/diseases that have a relationship to current ADL status, medical treatments, nursing monitoring or risk of death. Do not code inactive diagnoses.</p> <p>a. Diabetes mellitus (I1a) <input type="checkbox"/></p> <p>b. Aphasia (I1r) <input type="checkbox"/></p> <p>c. Cerebral palsy (I1s) <input type="checkbox"/></p> <p>d. Hemiplegia/hemiparesis (I1v) <input type="checkbox"/></p> <p>e. Multiple sclerosis (I1w) <input type="checkbox"/></p> <p>f. Quadriplegia (I1z) <input type="checkbox"/></p>	<input type="checkbox"/>	<input type="checkbox"/>
26. INFECTIONS I2	<p>Check any that apply</p> <p>a. Pneumonia (I2e) <input type="checkbox"/></p> <p>b. Septicemia (I2g) <input type="checkbox"/></p>	<input type="checkbox"/>	<input type="checkbox"/>
27. PROBLEM CONDITIONS J1	<p>Check all problems present in the last 7 days</p> <p>a. Dehydrated, output exceeds input (J1c) <input type="checkbox"/></p> <p>b. Delusions (J1e) <input type="checkbox"/></p> <p>c. Fever (J1h) <input type="checkbox"/></p> <p>d. Hallucinations (J1i) <input type="checkbox"/></p> <p>e. Internal bleeding (J1j) <input type="checkbox"/></p> <p>f. Vomiting (J1o) <input type="checkbox"/></p>	<input type="checkbox"/>	<input type="checkbox"/>
28. WEIGHT LOSS K3a	<p>Weight loss - 5% or more in last 30 days or 10% or more in the last 180 days</p> <p>0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/></p>	<input type="checkbox"/>	<input type="checkbox"/>
29. NUTRITIONAL APPROACHES K5	<p>Check all that apply in last 7 days</p> <p>a. Parenteral/IV <input type="checkbox"/></p> <p>b. Feeding tube <input type="checkbox"/></p>	<input type="checkbox"/>	<input type="checkbox"/>
30. PARENTERAL OR ENTERAL INTAKE K6	<p>Skip to item 31 if neither 29a nor 29b is coded</p> <p>a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days</p> <p>0. None <input type="checkbox"/> 3. 51% to 75% <input type="checkbox"/></p> <p>1. 1% to 25% <input type="checkbox"/> 4. 76% to 100% <input type="checkbox"/></p> <p>2. 26% to 50% <input type="checkbox"/></p> <p>b. Code the average fluid intake per day by IV or tube feedings in last 7 days</p> <p>0. None <input type="checkbox"/> 3. 1001 to 1500 cc/day <input type="checkbox"/></p> <p>1. 1 to 500 cc/day <input type="checkbox"/> 4. 1501 to 2000 cc/day <input type="checkbox"/></p> <p>2. 501 to 1000 cc/day <input type="checkbox"/> 5. 2001 or more cc/day <input type="checkbox"/></p>	<input type="checkbox"/>	<input type="checkbox"/>
31. ULCERS M1	<p>Record the number of ulcers at each ulcer stage — regardless of cause. If none present at a stage, record "0". Code all that apply during last 7 days. Code 9 for 9 or more.</p> <p>a. Stage 1 A persistent area of skin redness</p> <p>b. Stage 2 A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater</p> <p>c. Stage 3 A full thickness of skin is lost, exposing the subcutaneous tissues</p> <p>d. Stage 4 A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.</p>	<input type="checkbox"/>	<input type="checkbox"/>
32. PRESSURE ULCERS M2a	<p>Code pressure ulcers for the highest stage in the last 7 days (0=None, stages =1, 2, 3, or 4)</p>	<input type="checkbox"/>	<input type="checkbox"/>
33. OTHER SKIN PROBLEMS OR LESIONS M4	<p>Check all that apply in last 7 days</p> <p>a. Burns (second or third degree) (M4b) <input type="checkbox"/></p> <p>b. Open lesions other than ulcers, rashes, cuts (M4c) <input type="checkbox"/></p> <p>c. Surgical Wounds (M4g) <input type="checkbox"/></p>	<input type="checkbox"/>	<input type="checkbox"/>
34. SKIN TREATMENTS M5	<p>Check all that apply in last 7 days</p> <p>a. Pressure relieving device(s) for chair <input type="checkbox"/></p> <p>b. Pressure relieving device(s) for bed <input type="checkbox"/></p> <p>c. Turning/repositioning program <input type="checkbox"/></p> <p>d. Nutrition or hydration intervention to manage skin problems <input type="checkbox"/></p> <p>e. Ulcer Care <input type="checkbox"/></p> <p>f. Surgical wound care <input type="checkbox"/></p> <p>g. Application of dressings (with or without topical medications) other than to feet <input type="checkbox"/></p> <p>h. Application of ointments/medications (other than to feet) <input type="checkbox"/></p>	<input type="checkbox"/>	<input type="checkbox"/>
35. FOOT CARE PROBLEMS M6	<p>Check all that apply in last 7 days</p> <p>a. Infection of the foot – e.g., cellulitis, purulent drainage (M6b) <input type="checkbox"/></p> <p>b. Open lesions on the foot (M6c) <input type="checkbox"/></p> <p>c. Application of dressings (with or without topical medications) (M6f) <input type="checkbox"/></p>	<input type="checkbox"/>	<input type="checkbox"/>

36. TIME AWAKE N1	<p>Check appropriate time periods over the last 7 days the Resident was awake all or most of time (i.e., naps no more than one hour per time period) in the:</p> <p>a. Morning <input type="checkbox"/></p> <p>b. Afternoon <input type="checkbox"/></p> <p>c. Evening <input type="checkbox"/></p>	<input type="checkbox"/>	<input type="checkbox"/>																													
37. INJECTIONS O3	<p>Record the number of days injections of any type received in last 7 days. If none, enter "0".</p>	<input type="checkbox"/>	<input type="checkbox"/>																													
38. SPECIAL TREATMENTS AND PROCEDURES P1	<p>a. SPECIAL CARE – Check treatments received during the last 14 days</p> <p>a. Chemotherapy (P1aa) <input type="checkbox"/></p> <p>b. Dialysis (P1ab) <input type="checkbox"/></p> <p>c. IV medication (P1ac) <input type="checkbox"/></p> <p>d. Oxygen therapy (P1ag) <input type="checkbox"/></p> <p>e. Radiation (P1ah) <input type="checkbox"/></p> <p>f. Suctioning (P1ai) <input type="checkbox"/></p> <p>g. Tracheostomy care (P1aj) <input type="checkbox"/></p> <p>h. Transfusions (P1ak) <input type="checkbox"/></p> <p>i. Ventilator or respirator (P1al) <input type="checkbox"/></p> <p>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.</p> <p>Note: Count only therapies provided after admission for extended care swing bed services.</p> <p>(A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in the last 7 days</p> <table border="1"> <thead> <tr> <th rowspan="2"></th> <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>a. Speech language pathology and audiology</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>b. Occupational therapy</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>c. Physical therapy</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>d. Respiratory therapy</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>		DAYS		MIN		(A)	(B)	(A)	(B)	a. Speech language pathology and audiology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	b. Occupational therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	c. Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	d. Respiratory therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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39. NURSING REHABILITATION/ RESTORATIVE CARE P3	<p>Record the number of days each of the following 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 minutes per day.)</p> <p>a. Range of motion(passive) <input type="checkbox"/></p> <p>b. Range of motion(active) <input type="checkbox"/></p> <p>c. Splint/Brace assistance <input type="checkbox"/></p> <p>d. Bed mobility <input type="checkbox"/></p> <p>e. Transfer <input type="checkbox"/></p> <p>f. Walking <input type="checkbox"/></p> <p>g. Dressing or grooming <input type="checkbox"/></p> <p>h. Eating or swallowing <input type="checkbox"/></p> <p>i. Amputation/ Prosthesis Care <input type="checkbox"/></p> <p>j. Communication <input type="checkbox"/></p>	<input type="checkbox"/>	<input type="checkbox"/>																													
40. PHYSICIAN VISITS P7	<p>In the last 14 days (or since swing bed admission/readmission 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.)</p>	<input type="checkbox"/>	<input type="checkbox"/>																													
41. PHYSICIAN ORDERS P8	<p>In the last 14 days (or since swing bed admission/readmission 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).</p>	<input type="checkbox"/>	<input type="checkbox"/>																													
42. ORDERED THERAPIES T1	<p>Skip unless this is a PPS 5 day or PPS Readmission/Return assessment.</p> <p>a. Ordered Therapies: Has physician ordered any of the following therapy services to begin in the FIRST 14 days of stay — physical therapy, occupational therapy or speech pathology services. (T1b)</p> <p>0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/></p> <p>If No, skip to item 45.</p> <p>b. Through day 15, provide an estimate of the number of days when at least 1 therapy can be expected to be delivered. (T1c) <input type="checkbox"/></p> <p>c. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered. (T1d) <input type="checkbox"/></p>	<input type="checkbox"/>	<input type="checkbox"/>																													
43. CASE MIX GROUP T3	<p>Medicare <input type="checkbox"/></p> <p>State <input type="checkbox"/></p>	<input type="checkbox"/>	<input type="checkbox"/>																													
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45. SIGNATURE R2	<p>a. Name/Signature of RN Coordinating Assessment</p> <p>_____</p> <p>b. Date RN Assessment Coordinator signed as complete</p> <p><input type="checkbox"/> - <input type="checkbox"/> - <input type="checkbox"/></p>	<input type="checkbox"/>	<input type="checkbox"/>																													