Resident Identifier _____ Numeric Identifier _____

P1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS

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

	DAYS (A)	MIN (B)
a. Speech - language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		

P3. NURSING REHABILITATION/ RESTORATIVE CARE

*Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was **provided to the residents for more than or equal to 15 minutes per day in the last 7 days** (ENTER 0 if none or less than15 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	

P4. DEVICES AND RESTRAINTS

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

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

P7. PHYSICIAN VISITS

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

P8. PHYSICIAN ORDERS

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

Q1. DISCHARGE POTENTIAL

a. Resident expresses/indicates preference to return to the community
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

Q2. OVERALL CHANGE IN CARE NEEDS

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

R2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)
b. Date RN Assessment Coordinator signed as complete ☐☐ — ☐☐ — ☐☐☐☐ (Month — Day — Year)

T1. SPECIAL TREATMENTS AND PROCEDURES

Skip unless this is a Medicare 5 day or Medicare readmission/return assessment

b. ORDERED THERAPIES—*Has physician ordered any of the following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service?*
0. No 1. Yes

c. Through day15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered. ☐☐

d. Through day15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered. ☐☐☐☐☐

T3. CASE MIX GROUP

Medicare ☐☐☐☐☐ State ☐☐☐☐☐