

Resident Name _____

Numeric Identifier _____

24.	TOILETING PROGRAMS H3	Check any that apply during the last 14 days a. Any scheduled toileting plan b. Bladder retraining program	
25.	DISEASES I1	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. a. Diabetes mellitus (I1a) <input type="checkbox"/> d. Hemiplegia/hemiparesis (I1v) <input type="checkbox"/> b. Aphasia (I1r) <input type="checkbox"/> e. Multiple sclerosis (I1w) <input type="checkbox"/> c. Cerebral palsy (I1s) <input type="checkbox"/> f. Quadriplegia (I1z) <input type="checkbox"/>	
26.	INFECTIONS I2	Check any that apply a. Pneumonia (I2e) <input type="checkbox"/> b. Septicemia (I2g) <input type="checkbox"/>	
27.	PROBLEM CONDITIONS J1	Check all problems present in the last 7 days a. Dehydrated, output exceeds input (J1c) <input type="checkbox"/> d. Hallucinations (J1j) <input type="checkbox"/> b. Delusions (J1e) <input type="checkbox"/> e. Internal bleeding (J1j) <input type="checkbox"/> c. Fever (J1h) <input type="checkbox"/> f. Vomiting (J1o) <input type="checkbox"/>	
28.	WEIGHT LOSS K3a	Weight loss - 5% or more in last 30 days or 10% or more in the last 180 days 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/>	
29.	NUTRITIONAL APPROACHES K5	Check all that apply in last 7 days a. Parenteral/IV <input type="checkbox"/> b. Feeding tube <input type="checkbox"/>	
30.	PARENTERAL OR ENTERAL INTAKE K6	Skip to item 31 if neither 29a nor 29b is coded a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days 0. None <input type="checkbox"/> 3. 51% to 75% <input type="checkbox"/> 1. 1% to 25% <input type="checkbox"/> 4. 76% to 100% <input type="checkbox"/> 2. 26% to 50% <input type="checkbox"/> b. Code the average fluid intake per day by IV or tube feedings in last 7 days 0. None <input type="checkbox"/> 3. 1001 to 1500 cc/day <input type="checkbox"/> 1. 1 to 500 cc/day <input type="checkbox"/> 4. 1501 to 2000 cc/day <input type="checkbox"/> 2. 501 to 1000 cc/day <input type="checkbox"/> 5. 2001 or more cc/day <input type="checkbox"/>	
31.	ULCERS M1	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. a. Stage 1 A persistent area of skin redness 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 d. Stage 4 A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	
32.	PRESSURE ULCERS M2a	Code pressure ulcers for the highest stage in the last 7 days (0=None, stages =1, 2, 3, or 4)	
33.	OTHER SKIN PROBLEMS OR LESIONS M4	Check all that apply in last 7 days a. Burns (second or third degree) (M4b) b. Open lesions other than ulcers, rashes, cuts (M4c) c. Surgical Wounds (M4g)	
34.	SKIN TREATMENTS M5	Check all that apply in last 7 days a. Pressure relieving device(s) for chair b. Pressure relieving device(s) for bed c. Turning/repositioning program d. Nutrition or hydration intervention to manage skin problems e. Ulcer Care f. Surgical wound care g. Application of dressings (with or without topical medications) other than to feet. h. Application of ointments/medications (other than to feet)	
35.	FOOT CARE PROBLEMS M6	Check all that apply in last 7 days a. Infection of the foot – e.g., cellulitis, purulent drainage (M6b) b. Open lesions on the foot (M6c) c. Application of dressings (with or without topical medications) (M6f)	

36.	TIME AWAKE N1	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: a. Morning <input type="checkbox"/> c. Evening <input type="checkbox"/> b. Afternoon <input type="checkbox"/>																								
37.	INJECTIONS O3	Record the number of days injections of any type received in last 7 days . If none, enter "0".																								
38.	SPECIAL TREATMENTS AND PROCEDURES P1	a. SPECIAL CARE – Check treatments received during the last 14 days a. Chemotherapy (P1aa) <input type="checkbox"/> f. Suctioning (P1ai) <input type="checkbox"/> b. Dialysis (P1ab) <input type="checkbox"/> g. Tracheostomy care (P1aj) <input type="checkbox"/> c. IV medication (P1ac) <input type="checkbox"/> h. Transfusions (P1ak) <input type="checkbox"/> d. Oxygen therapy (P1ag) <input type="checkbox"/> i. Ventilator or respirator (P1al) <input type="checkbox"/> e. Radiation (P1ah) <input type="checkbox"/> 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 . Note: Count only therapies provided after admission for extended care swing bed services. (A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in the last 7 days <table border="1" style="float: right; margin-left: 20px;"><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><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr></tbody></table> a. Speech language pathology and audiology b. Occupational therapy c. Physical therapy d. Respiratory therapy	DAYS		MIN		(A)	(B)	(A)	(B)																
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(A)	(B)	(A)	(B)																							
39.	NURSING REHABILITATION/ RESTORATIVE CARE P3	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.) a. Range of motion(passive) <input type="checkbox"/> f. Walking <input type="checkbox"/> b. Range of motion(active) <input type="checkbox"/> g. Dressing or grooming <input type="checkbox"/> c. Splint/Brace assistance <input type="checkbox"/> h. Eating or swallowing <input type="checkbox"/> d. Bed mobility <input type="checkbox"/> i. Amputation/ Prosthesis Care <input type="checkbox"/> e. Transfer <input type="checkbox"/> j. Communication <input type="checkbox"/>																								
40.	PHYSICIAN VISITS P7	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.)																								
41.	PHYSICIAN ORDERS P8	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).																								
42.	ORDERED THERAPIES T1	Skip unless this is a PPS 5 day or PPS Readmission/Return assessment. 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) 0. No <input type="checkbox"/> 1. Yes <input type="checkbox"/> If No, skip to item 45. b. Through day 15 , provide an estimate of the number of days when at least 1 therapy can be expected to be delivered. (T1c) 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="text"/>																								
43.	CASE MIX GROUP T3	Medicare <input type="text"/> State <input type="text"/>																								
44.	HIPPS Code	<input type="text"/>																								
45.	SIGNATURE R2	a. Name/Signature of RN Coordinating Assessment _____ b. Date RN Assessment Coordinator signed as complete <input type="text"/> - <input type="text"/> - <input type="text"/>																								