

## RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare <span style="float: right;">F75</span>	Medicaid <span style="float: right;">F76</span>	Other <span style="float: right;">F77</span>	Total Residents <span style="float: right;">F78</span>
<b>ADL</b>	<b>Independent</b>	<b>Assist of One or Two Staff</b>		<b>Dependent</b>
Bathing	F79	F80		F81
Dressing	F82	F83		F84
Transferring	F85	F86		F87
Toilet Use	F88	F89		F90
Eating	F91	F92		F93

### A. Bowel/Bladder Status

- F94 \_\_\_ With indwelling or external catheter
- F95 Of total number of residents with catheters, \_\_\_ were present on admission.
- F96 \_\_\_ Occasionally or frequently incontinent of bladder
- F97 \_\_\_ Occasionally or frequently incontinent of bowel
- F98 \_\_\_ On individually written bladder training program
- F99 \_\_\_ On individually written bowel training program

### B. Mobility

- F100 \_\_\_ Bedfast all or most of time
- F101 \_\_\_ In chair all or most of time
- F102 \_\_\_ Independently ambulatory
- F103 \_\_\_ Ambulation with assistance or assistive device
- F104 \_\_\_ Physically restrained
- F105 Of total number of residents restrained, \_\_\_ were admitted with orders for restraints.
- F106 \_\_\_ With contractures
- F107 Of total number of residents with contractures, \_\_\_ had contractures on admission.

### C. Mental Status

- F108 \_\_\_ With mental retardation
- F109 \_\_\_ With documented signs and symptoms of depression
- F110 \_\_\_ With documented psychiatric diagnosis (exclude dementias and depression)
- F111 \_\_\_ Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type
- F112 \_\_\_ With behavioral symptoms
- F113 Of the total number of residents with behavioral symptoms, the total number receiving a behavior management program \_\_\_.
- F114 \_\_\_ Receiving health rehabilitative services for MI/MR

### D. Skin Integrity

- F115 \_\_\_ With pressure sores (exclude Stage I)
- F116 Of the total number of residents with pressure sores excluding Stage I, how many residents had pressure sores on admission? \_\_\_.
- F117 \_\_\_ Receiving preventive skin care
- F118 \_\_\_ With rashes

## RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

### E. Special Care

- F119 \_\_\_ Receiving hospice care benefit
- F120 \_\_\_ Receiving radiation therapy
- F121 \_\_\_ Receiving chemotherapy
- F122 \_\_\_ Receiving dialysis
- F123 \_\_\_ Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion
- F124 \_\_\_ Receiving respiratory treatment
- F125 \_\_\_ Receiving tracheostomy care
- F126 \_\_\_ Receiving ostomy care

- F127 \_\_\_ Receiving suctioning
- F128 \_\_\_ Receiving injections (exclude vitamin B12 injections)
- F129 \_\_\_ Receiving tube feedings
- F130 \_\_\_ Receiving mechanically altered diets including pureed and all chopped food (not only meat)
- F131 \_\_\_ Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy)
- F132 \_\_\_ Assistive devices while eating

### F. Medications

- F133 \_\_\_ Receiving any psychoactive medication
- F134 \_\_\_ Receiving antipsychotic medications
- F135 \_\_\_ Receiving antianxiety medications
- F136 \_\_\_ Receiving antidepressant medications
- F137 \_\_\_ Receiving hypnotic medications
- F138 \_\_\_ Receiving antibiotics
- F139 \_\_\_ On pain management program

### G. Other

- F140 \_\_\_ With unplanned significant weight loss/gain
- F141 \_\_\_ Who do not communicate in the dominant language of the facility (include those who use sign language)
- F142 \_\_\_ Who use non-oral communication devices
- F143 \_\_\_ With advance directives
- F144 \_\_\_ Received influenza immunization
- F145 \_\_\_ Received pneumococcal vaccine

**I certify that this information is accurate to the best of my knowledge.**

Signature of Person Completing the Form	Title	Date
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### TO BE COMPLETED BY SURVEY TEAM

- F146 Was ombudsman office notified prior to survey?      \_\_\_ Yes      \_\_\_ No
- F147 Was ombudsman present during any portion of the survey?      \_\_\_ Yes      \_\_\_ No
- F148 Medication error rate \_\_\_\_\_%

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# RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

## (use with Form CMS-672)

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### GENERAL INSTRUCTIONS:

#### THIS FORM IS TO BE COMPLETED BY THE FACILITY AND REPRESENTS THE CURRENT CONDITION OF RESIDENTS AT THE TIME OF COMPLETION

There is no federal requirement to automate the 672 form. This form may and in many instances will need to be completed manually. A facility may use its MDS data to assist in completing the entry fields for the 672 form, however, facilities should ensure that the MDS information is not simply counted and copied over into the form. The Resident Census and Conditions of Residents information is designed to be a representation of the facility during survey; it does not directly correspond to the MDS data in every field. **The information entered on this form must be reflective of all residents as of the day of survey; therefore all information entered must be independently verified.**

For the purpose of completing this form the terms: “facility” means certified beds (i.e., Medicare and/or Medicaid certified beds) and “residents” means residents in certified beds regardless of payer source.

Following the definition of certain entry fields, the related MDS 3.0 item(s) is noted. Remember, that although the MDS item(s) are noted for some entry fields, the field itself may need to be completed differently to reflect the current status of all residents as of the day of survey. The MDS items below are provided only as a reference point, but the form is to be completed using the time frames and other specific instructions as noted below.

Where a field refers to the “admission assessment,” use only the counts from the first assessment since the most recent admission/entry or reentry (OBRA or Scheduled PPS– i.e., A0310A = 01; A0310B = 01 or 06; A0310E = 1; for each resident).

### INSTRUCTIONS AND DEFINITIONS:

**Complete each field by specifying the number of residents in each category. If no residents fall into a category enter a “0”.**

**Provider Number:** Facility CMS certification provider number. A0100B; leave blank for initial certifications.

**Block F75:** Residents whose primary payer is Medicare.

**Block F76:** Residents whose primary payer is Medicaid.

**Block F77:** Residents whose primary payer is neither Medicare nor Medicaid.

**Block F78:** Residents for whom a bed is maintained on the day the survey begins, including those temporarily away in a hospital or on leave. This should be representative of residents in the nursing facility or those who have a bed-hold.

**ADLS (F79 – F93):** To determine resident status, unless otherwise noted, consider the resident’s condition for the 7 days prior to the survey. Horizontal totals across the three columns (Independent, Assist of One or Two Staff, and Dependent) must equal the number in Block F78. The ADL categories for each resident include Bathing, Dressing, Transferring, Toilet Use and Eating.

**Bathing (F79 – F81):** This includes a full-body bath/shower, sponge bath, and transfer into and out of tub or shower. G0120A = 0; F80: G0120A = 1, 2, or 3; G0120A = 4.

Facilities may provide “setup” assistance to residents such as drawing water for a tub bath or laying out clothes, bathing supplies/ toiletries, etc. Also, a resident may only need assistance with washing their back or shampooing their hair. If either of these are the case, and the resident requires no other assistance, count the resident as independent.

**Dressing (F82 – F84):** How the resident puts on, and takes off all items of clothing. May also include applying and/or removing elastic stockings or prostheses (e.g., braces and artificial limbs). G0110G1 = 0; G0110G1 = 1, 2, or 3; G0110G1 = 4.

Facilities may set out clothes for residents. If this is the case and this is the only assistance the resident receives, count the resident as independent. However, if a resident receives assistance, such as with dressing, donning a brace, elastic stocking, a prosthesis, or securing fasteners, etc. count the resident as needing the assistance of 1 or 2 staff, as appropriate.

**Transferring (F85 – F87):** How the resident moves between surfaces, including, to/from bed, chair, wheelchair, or standing position. (EXCLUDES transfers to/from the bath/toilet). G0110B1 = 0; G0110B1 = 1, 2, or 3; G0110B1 = 4.

Facilities may provide “setup” assistance to residents, such as handing equipment (e.g., quad cane) to the resident. If this is the case and is the only assistance required, count the resident as independent.

**Toilet Use (F88 – F90):** How the resident uses the toilet, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad(s); manages ostomy or catheter, and adjusts clothing. If all that is done for the resident is to open a package (e.g., a clean incontinence pad), count the resident as independent. G0110I1 = 0; G0110I1 = 1, 2, or 3; G0110I1 = 4.

**Eating (F91 – F93):** How a resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, includes IV fluids administered for nutrition or hydration). Facilities may provide “setup” activities, such as opening containers, buttering bread, and organizing the tray; if this is the case and is the only assistance a resident needs, count this resident as independent. G0110H1 = 0; G0110H1 = 1, 2, or 3; G0110H1 = 4.

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## RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form CMS-672)

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### A. BOWEL/BLADDER STATUS (F94 – F99)

#### **F94: With an indwelling or an external catheter:**

Residents whose urinary bladder is constantly drained by a catheter (e.g., an indwelling catheter, a suprapubic catheter or nephrostomy tube) or who wears an appliance that is applied over the penis and connected to a drainage bag to collect urine from the bladder (e.g., condom catheter or similar appliance). H0100A or B = checked.

#### **F95: Of the total number of residents with catheters:**

Number of residents who had a catheter present on admission/entry or reentry. H0100A or B = checked. To complete this field use only the counts from the first assessment since the most recent admission/entry or reentry (OBRA or Scheduled PPS), i.e., A0310A = 01, A0310B = 01 or 06; A0310E = 1 for each resident.

#### **F96: Occasionally or frequently incontinent of bladder:**

Residents who have an incontinent episode two or more times per week. Do not include residents with an indwelling or external catheter. H0100A and B = not checked **and** H0300 = 1, 2, or 3.

#### **F97: Occasionally or frequently incontinent of bowel:**

Residents who have a loss of bowel control two or more times per week. H0400 = 2 or 3.

**F98: On urinary training/toileting program:** Residents with a systematically implemented, individualized urinary training/toileting program (i.e. bladder rehabilitation/ retraining, prompted voiding, habit training/scheduled voiding) to decrease or prevent urinary incontinence or minimizing or avoiding the negative consequences of incontinence (e.g., pelvic floor exercises). Count all residents on urinary training programs including those who are incontinent. H0200A = 1; H200C = 1; H0300 = 1, 2 or 3.

**F99: On bowel toileting program:** Residents with a systematically implemented, individualized bowel toileting program to decrease or prevent bowel incontinence or minimizing or avoiding the negative consequences of incontinence (e.g., use of adequate fluid intake, fiber in the diet, exercise, and scheduled times to attempt bowel movement). Count all residents on toileting programs including those who are incontinent. H0400 = 2 or 3; H0500 = 1.

### B. MOBILITY (F100 – F107)

Total for F100 – F103 should = the number in Block F78, Total Residents. Algorithm to force mutual exclusivity: Test for each resident. If F100 = 1 then add 1 to F100, and go to the next resident; If F101 = 1 then add 1 to F101 and go to the next resident; If F103 = 1 then add 1 to F103 and go to the next resident; If F102 = 1 then add 1 and go to the next resident.

**F100: Bedfast all or most of time:** Residents who are bedfast all or most of the time (e.g., in bed or geriatric chair/recliner) includes bedfast with bathroom privileges.

**F101: In a chair all or most of time:** Residents who depend on a chair for mobility includes those residents who can stand with assistance to pivot from bed to wheelchair or to otherwise transfer. The resident cannot take steps without extensive or constant weight-bearing support from others and is not bedfast all or most of the time. G0300A or E = 2; G0600C = checked.

**F102: Independently ambulatory:** Residents who require no help or oversight; or help or oversight was provided only 1 or 2 times during the past 7 days. Do not include residents who use a cane, walker or crutch. G0110C1 or G0110D1 = 0 or 7 **and** G0110C2 or G0110D2 = 0 or 1; G0600A and G0600B = not checked.

#### **F103: Ambulation with assistance or assistive devices:**

Residents who require oversight, cueing, physical assistance or who use a cane, walker, or crutch. Count the use of lower leg splints, orthotics, and braces as assistive devices. G0110C1 or G0110D1 = 1, 2, or 3 **and** G0110C2 or G0110D2 = 1, 2 or 3; G0300B = 0; G0600A1 or G0600B1 = checked.

**F104: Physically restrained:** Residents for whom restraints were used. Restraints include any manual or physical method or mechanical device, material or equipment attached or adjacent to the resident's body in such a way that the individual cannot remove easily and it restricts freedom of movement or normal access to one's body. Do not include devices such as braces which are used for medical/clinical reasons. P0100A through H = 1 or 2.

**F105: Of total number of restrained residents:** Residents on admission/entry or reentry with an order for restraint(s). P0100A through H = 1 or 2. To complete this field use only the counts from the first assessment since the most recent admission/entry or reentry (OBRA or Scheduled PPS), i.e., A0310A = 01, A0310B = 01 or 06; A0310E = 1 for each resident.

**F106: With contractures:** Residents that have a restriction of full passive range of motion of any joint due to deformity, disuse, pain, etc., includes loss of range of motion in neck, fingers, wrists, elbows, shoulders, hips, knees and ankles. G0400A and/or B = 1 or 2.

**F107: Of the total of number with contractures, those who had a contracture(s) on admission:** To complete this field use only the counts from the first assessment since the most recent admission/entry or reentry (OBRA or Scheduled PPS), i.e., A0310A = 01, A0310B = 01 or 06; A0310E = 1 for each resident (although neck contractures not included in MDS data note if present).

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### C. MENTAL STATUS (F108 – F114)

**F108: With intellectual disability (mental retardation as defined at 483.45(a)) or developmental disability:** Residents in all of the categories of intellectual or developmental disability regardless of severity, as determined by the State Mental Health or State Mental Retardation Authorities. A1550A, B through E = checked.

**F109: With documented signs and symptoms of depression:** Residents with documented signs and symptoms of depression. Column D02001A through D = 1 for any indicator present; D02001I = 1; column D02002A through D = 2 or 3 for symptom frequency; D0300 = 05 - 27 or column D05001A through D = 1 for any indicator present; D05001I = 1; column D05002A through D = 2 or 3 for symptom frequency; D0600 = 05 – 30.

**F110: With documented psychiatric diagnosis (exclude dementias and depression):** Residents with primary or secondary psychiatric diagnosis including:

- Schizophrenia
- Schizo-affective disorder
- Schizophreniform disorder
- Delusional disorder
- Anxiety disorder
- Psychotic mood disorders (including mania and depression with psychotic features, acute psychotic episodes, brief reactive psychosis, and atypical psychosis). I5700, I5900, I5950, I6000 or I6100 = checked.

**F111: Dementia: Non-Alzheimer's Dementia (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases), or Alzheimer's Disease:** Residents with a primary or secondary diagnosis of dementia or organic mental syndrome including, Non-Alzheimer's Dementia (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases). I4200 or I4800 = checked.

**F112: With behavioral health care needs:** Residents with one or more of the following indicator(s): wandering, verbally abusive, physically abusive, socially inappropriate/ disruptive, and resistive to care. E0200A, B, C = 1, 2, or 3; E0500A, B, C = 1; E0600A, B, C = 1; E0300 = 1 or E0800 = 1, 2, or 3 or E0900 = 1, 2, or 3; E1000A, B = 1.

**F113: Of the total number with behavioral health care needs, those having an individualized care plan to support them:** Residents with behavior symptoms who are receiving an individualized care plan/program designed to support and manage behavioral needs (as noted in F112).

**F114: Receiving health rehabilitative services for MI and/or ID/DD:** Residents for whom the facility is providing health rehabilitative services for MI and/or ID/DD (mental retardation as defined at 483.45(a)).

### D. SKIN INTEGRITY (F115 – F118)

**F115: With pressure ulcers:** Residents with localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction (exclude Stage I); M0300B1, M0300C1, or M0300D1; M0300E1, M0300F1 and/or M0300G1 > 0. To complete this field, use only the counts from the first assessment since the most recent admission/ entry or reentry (OBRA or Scheduled PPS), i.e., A0310A = 01, A0310B = 01 or 06; A0310E = 1 for each resident.

**F116: Of the total number of residents with pressure ulcers (excluding Stage I), those who had pressure ulcers on admission/entry or reentry:** M0300B2, M0300C2, M0300D2, M0300E2, M0300F2 and/or M0300G2 > 0.

**F117: Receiving preventive skin care:** Residents receiving non-routine skin care ordered by a physician, and/or included in the resident's comprehensive plan of care (e.g., hydrocortisone ointment to areas of dermatitis three times a day, granulex sprays, etc.) M1200A through I = checked.

**F118: With rashes:** Residents who have rashes which may or may not be treated with any medication or special baths, etc. (e.g., may include but are not limited to antifungals, corticosteroids, emollients, diphenhydramines or scabicides).

### E. SPECIAL CARE (F119 – F132)

**F119: Receiving hospice care:** Residents who have elected or are currently receiving the hospice benefit. O0100K2 = checked.

**F120: Receiving radiation therapy:** Residents who are under a treatment plan involving radiation therapy. O0100B1 or O0100B2 = checked.

**F121: Receiving chemotherapy:** Residents under a specific treatment plan involving chemotherapy. O0100A1 or O0100A2 = checked.

**F122: Receiving dialysis:** Residents receiving hemodialysis or peritoneal dialysis either within the facility or offsite. O0100J1 or O0100J2 = checked.

**F123: Receiving intravenous therapy, IV nutrition and/or blood transfusion:** Residents receiving fluids, medications, all or most of their nutritional requirements and/or blood and blood products administered intravenously. K0510A2, O0100H2, or O0100I2 = checked.

**F124: Receiving respiratory treatment:** Residents receiving treatment by the use of respirators/ ventilators, oxygen, IPPB or other inhalation therapy, pulmonary toilet, humidifiers, and other methods to treat conditions of the respiratory tract. This does not include residents receiving tracheostomy care or respiratory suctioning. O0100C2, O0100F2, or O0100G2 = checked.

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**F125: Receiving tracheotomy care:** Residents receiving care involved in maintenance of the airway, the stoma and surrounding skin, and dressings/coverings for the stoma. O0100E2 = checked.

**F126: Receiving ostomy care:** Residents receiving care for a colostomy, ileostomy, uretostomy, or other ostomy of the intestinal and/or urinary tract. DO NOT include tracheostomy. H0100C = checked, identifies residents who use these appliances.

**F127: Receiving suctioning:** Residents that require use of a mechanical device which provides suction to remove secretions from the respiratory tract via the oral cavity, nasal passage, or tracheostomy. O0100D2 = checked (Note: O0100D2 does not include oral suctioning, so residents who receive oral suctioning will have to be counted separately).

**F128: Receiving injections:** Residents that have received one or more injections within the past 7 days. (Exclude injections of Vitamin B 12.) Review residents where N0300 = > 0. Omit from the count any resident whose only injection currently is B12.

**F129: Receiving tube feeding:** Residents who receive all or most of their nutritional requirements via a feeding tube that delivers food/nutritional substances directly into the GI system (e.g., nasogastric tube, gastrostomy tube). K0510B2 = checked.

**F130: Receiving mechanically altered diets:** Residents receiving a mechanically altered diet including pureed and/or chopped foods (not only meat). K0510C2 = checked.

**F131: Receiving rehabilitative services:** Residents receiving care designed to improve functional ability provided by, or under the direction of a rehabilitation professional (physical therapist, occupational therapist; speech-language pathologist). Exclude health rehabilitation for MI and/or ID/DD. Minutes entered > 0 for O0400A1, 2, or 3; O0400B1, 2, or 3; or O0400C1, 2, or 3.

**F132: Assistive devices with eating:** Residents who are using devices to maintain independence and to provide comfort when eating (i.e., plates with guards, large handled flatware, large handle mugs, extend hand flatware, etc.). O0500C or H = > 0.

### F. MEDICATIONS (F133 – F139)

**F133: Receiving psychoactive medications:** Residents that receive medications classified as antipsychotics, anxiolytics, antidepressants, and hypnotics. Days entered >0 for N0410A, B, C or D.

Use the following lists to assist you in determining the number of residents receiving psychoactive medications. These lists are not meant to be all inclusive; therefore, a resident receiving a psychoactive medication not on this list, should be counted under F133 and any other medication category that applies: F134, F135, F136, and/or F137.

**F134: Receiving antipsychotic medications:** N0410A = > 0

- Clozapine
- Haloperidol
- Haloperidol Deconate
- Droperidol
- Loxapine
- Thioridazine
- Molindone
- Theothixene
- Zyprexa
- Pimozide
- Fluphenazine Deconate
- Fluphenazine
- Quetiapine
- Risperidone
- Mesoridazine
- Promazine
- Trifluoperazine
- Chlorprothixene
- Chlorpromazine
- Acetophenazine
- Perphenazine

**F135: Receiving antianxiety medications (anxiolytics):**

N0410B = > 0

- Lorazepam
- Oxazepam
- Prazepam
- Diazepam
- Clonazepam
- Hydroxyzine
- Chlordiazepoxide
- Halazepam
- Alprazolam

**F136: Receiving antidepressant medications:** N0410C = > 0

- Aripiprazole
- Amoxapine
- Nortriptyline
- Wellbutrin
- Trazodone
- Venlafaxine
- Amtriptyline
- Lithium
- Maprotiline
- Isocarboxazid
- Phenelzine
- Serzone
- Desipramine
- Tranylcypromine
- Paroxetine
- Fluoxetine
- Sertraline
- Doxepin
- Imipramine
- Protriptyline

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**F137: Receiving hypnotic medications:** N0410D = > 0

- Flurazepam
- Quazepam
- Estazolam
- Temazepam
- Triazolam
- Zolpidem

**F138: Receiving antibiotics:** Residents receiving antibacterial sulfonamides, antibiotics, etc., either for prophylaxis or treatment. N0410F = > 0.

**F139: On a pain management program:** Residents with a specific plan for control of difficult to manage or intractable pain, which may include self medication pumps or regularly scheduled administration of medication alone or in combination with non-medication interventions (e.g., massages heat/cold, biofeedback, etc.). J0100A, B, or C = 1.

### G. OTHER RESIDENT CHARACTERISTICS (F140 – F146)

**F140: With unplanned significant weight loss/gain:** Residents who have experienced unplanned weight loss/gain of > 5% in one month or > 10% over six months. K0300 or K0310 = 2.

**F141: Who do not communicate in the dominant language at the facility?** Residents who do not speak in the dominant language of the facility; for example residents who speak only Spanish, but the majority of staff that care for the residents speak only English. A1100A = 1; A1100B = alternate language identified (e.g. Spanish, French, Portuguese, etc.).

**F142: Who use non-oral communication?** Residents who communicate via non-oral methods, including, picture boards, computers, etc. A1100B, Preferred Language (e.g. American Sign Language).

**F143: Who have advanced directives?** Residents who have advance directives, such as Physician's Orders for Life-Sustaining Treatment (POLST), a living will or durable power of attorney for health care, recognized under state law and relating to the provisions of care when the individual is incapacitated.

**F144: Received influenza immunization:** Residents known to have received the influenza immunization within the last 12 months. O0250A = 1.

**F145: Received pneumococcal vaccine:** Residents known to have received the pneumococcal vaccine. O0300A = 1.

### LEAVE BLANK (F146-F148) – To Be Completed By Survey Team

**F146: Ombudsman notice:** Indicate whether or not the State Ombudsman was notified prior to the survey.

**F147: Ombudsman presence:** Indicate whether or not the State Ombudsman was present at any time during the survey.

**F148: Medication error rate:** Calculate and enter the medication error percentage of the facility.



## ROSTER/SAMPLE MATRIX INSTRUCTIONS FOR PROVIDERS (use with Form CMS-802)

The Roster/Sample Matrix form (CMS-802) is used to list all current residents (including residents on bed-hold) and to note pertinent care categories. The facility completes the: resident name, resident room, and columns 6–31, which are described below. Columns 1–5 and blank columns are for Surveyor Use Only.

For the purpose of completing this form the terms: “facility” means certified beds (i.e., Medicare and/or Medicaid certified beds) and “residents” means residents in certified beds regardless of payer source.

There is no federal requirement to automate the 802 form. This form may and in many instances will need to be completed manually. A facility may use its MDS data to assist in completing the fields for the form; however, facilities should ensure that the MDS information is not simply copied over into the form. The Roster/Sample Matrix information is designed to be a representation of the facility during survey; it does not directly correspond to the MDS data in every field. **All information entered on this form by computer should be verified by a staff member knowledgeable about the resident population. Information must be reflective of all residents as of the day of survey.**

Following the definition of certain fields, the related MDS item(s) is noted. Remember, that although the MDS item(s) are noted for some fields, the field itself may need to be completed differently to reflect the current status of all residents as of the day of survey. The MDS items are provided only as a reference point, but the form is to be completed using the time frames and other specific instructions noted below. The information required on the Provider Instructions is not based on the Quality Measures.

*For each resident mark all columns that are pertinent*

### 1. – 5. Surveyor Use Only

- 6. Moderate/Severe Pain (constant or frequent):** needs pain medication, comfort measures or is on a pain management program. J0100A, B, or C = 1; J0300 = 1 or 9; J0400 = 1, 2, or 3; J0500A, B = 1; J0600A = 01- 10; J0600B = 1, 2, 3, or 4; J0700 = 1; J0800A, B, C, or D = checked; J0850 = 1, 2, or 3.
- 7. Hi-Risk Pressure Ulcers (Stage 2-4):** has a stage 2, 3 or 4 pressure ulcer(s) and/or unstageable pressure ulcer; M0300B1, M0300C1, or M0300D1; M0300E1, M0300F1, M0300G1 > 0.
- 8. New/Worsened Pressure Ulcers (Stage 2-4):** has a stage 2, 3 or 4 pressure ulcer(s) that are new or worsened; M0800A > 0 and M0800A <=M0300B1; OR M0800B > 0 and M0800B <=M0300C1; OR M0800C > 0 and M0800C <=M0300D1.
- 9. Physical Restraints:** has a physical restraint. Enter ‘N’ for non-side rail devices and ‘S’ for side rails. Enter the appropriate letter for all possible responses. P0100A = 1 or 2, enter S; P0100B, C, D, E, F, G, or H = 1 or 2, enter ‘N’.
- 10. Falls and/or Falls with Major Injury:** has fallen within the past 30 days and/or has fallen within the past 180 days and incurred a major injury. Enter ‘F’ if fall without injury or fracture; Enter ‘Fx’ if resident has had a fall with major injury (including fracture). Enter the appropriate letter for all possible responses. I3900 or I4000 = checked, enter Fx; J1700A = 1 enter F; J1700C = 1 enter Fx; J1800 = 1 enter F; J1900A and/or J1900B = 1 or 2 enter F; J1900C = 1 or 2 enter Fx.
- 11. Psychoactive Medications with Absence of Condition:** receives any psychoactive medications but has no psychiatric condition. Mark column if N0410A through N0410 D = 1 or > AND I5700 – I6100 = not checked. I8000 = no psychiatric/mood diagnoses.

- 12. Antianxiety/Hypnotic Medications:** receives anxiolytics and/or hypnotics. Enter ‘A’ for anti-anxiety, ‘H’ for hypnotic. Enter the appropriate letter for all possible responses. N04010B = 1 or >, enter A; N0410D = 1 or > enter H.
- 13. Behavioral Symptoms Affecting Others or Self:** has behavioral health care needs. E0200A, B, C = 1, 2 or 3; E0300 = 1; E0600A, B, C = 1 or 3 or E0900 = 1, 2, or 3, E1000A and/or B = 1.
- 14. Depressive Symptoms:** has symptoms of depression. I5800, I5900 = checked or column D02001A through D = 1 for any indicator present; D02001I = 1; column D02002A through D = 2 or 3 for symptom frequency; D02002I = 2 or 3; D0300 = 05 - 27; column D05001A through D = 1 for any indicator present; D05001I = 1; column D05002A through D = 2, or 3 for symptom frequency; D05002I = 1; D0600 = 05 – 30.
- 15. Urinary Tract Infection:** has an infection or is on antibiotics. I1700, I2000, I2100, I2200, I2300, I2400, or I2500 = checked. Also, any infections identified in I8000; M1040A = checked; N0410F = 1 or > days.
- 16. Indwelling Urinary Catheter:** has an indwelling urinary catheter. H0100A = checked.
- 17. Lo-Risk Resident Lose Bowel/Bladder Control– Incontinence/Toileting Programs:** incontinent of bladder/bowel, enter ‘I’. If the resident is on a bladder/bowel toileting program, enter ‘T’. Enter the appropriate letter for all possible responses. H0200A = 1; H0200C = 1 enter T; H0300 = 1, 2, or 3, enter I; H0400 = 2 or 3 enter I; H0500 = 1 enter T.

**18. Excessive Weight Loss/Gain:** had an unintended weight loss/gain of >5% in one month or >10% in six months, has had chronic insidious weight loss/gain or is at nutritional risk. Enter 'W' for weight change; K0300 or K0310 = 2, enter 'W'.

No crosswalk is available for chronic insidious weight loss or nutritional risk. Insidious weight loss is a slow, steady, and persistent weight loss over time that when reviewed in the aggregate is clinically significant. Enter 'W' for either condition.

**19. Need for Increased ADL Help:** has shown a decline in ADL areas.

**20. Hospice:** has elected or currently receiving hospice care. O0100K2 = checked.

**21. Dialysis:** is receiving hemodialysis or peritoneal dialysis either within the facility or offsite. O0100J1 or O0100J2 = checked.

**22. Admission/Transfer/Discharge:** enter the appropriate letter in this column if the resident was admitted within the past 30 days or is scheduled to be transferred or discharged within the next 30 days. A0310E = 1, enter 'A' for an admission. Enter for first assessment after initial admission/entry or reentry after discharge without expectation of return. A0310F = 11, enter 'T' for a transfer; and A0310F = 10 or 12, enter 'D' for a discharge. Enter the appropriate letter for all possible responses. If today's date minus A1600, Entry Date, is less than or equal to 30 days, enter 'A'.

**23. MI (Non-Dementia) or ID/DD:** if the resident has a diagnosis of mental illness or intellectual or developmental disability, mark this column. Enter 'ID' for intellectual disability, 'DD' for developmental disability, or 'MI' for mental illness not classified as dementia. A1500 = 1, A1510A = checked, enter 'MI'; A1510B = checked, enter 'ID'; A1550A, B, C, D, or E = checked, enter 'ID' and/or 'DD' as appropriate; I5700, I5800, I5900, I5950, I6000, I16100 = checked, enter 'MI'; I8000 psychiatric/mood disorder diagnosis listed, enter 'MI'.

**24. Language/Communication:** uses a language other than the dominant language of the facility or exhibits difficulty communicating his/her needs. This must be individually determined. In some facilities the predominant language is other than English, such as Spanish, Navajo, or French.

A1100A = 1; A1100B = alternate language identified] Enter 'L' if resident uses a language other than the dominant language of the facility. (If a resident uses American Sign Language, consider this a different language and enter 'L') B0100 = 1; B0600 = 1 or 2; B0700 = 2 or 3; B0800 = 2 or 3] Enter 'C' if the resident has communication difficulties.

**25. Vision/Hearing/Other Assistive Devices:** has significant impairment of vision or hearing, or uses devices to aid vision or hearing. Enter 'V' for visual impairment, 'H' for hearing impairment, and 'D' for use of devices (glasses or hearing aids). B0200 = 2 or 3, enter 'H'; B0300 = 1, enter 'D'; B1000 = 2, 3, or 4, enter 'V'; B1200 = 1, enter 'D'.

**Other Assistive Devices:** uses special devices to assist with eating or mobility (e.g., tables, utensils, hand splints, canes, crutches, etc.) and other assistive devices. O0500C or H; G0600A through D = checked.

**26. Fecal Impaction:** had fecal impaction within the last 90 days.

**27. ROM/Contractures/Positioning:** has functional limitations in range of motion. G0400A and/or B = 1 or 2; M1200C = checked.

**28. Special Care (Tube Feeding, Central Lines, Ventilators, O<sub>2</sub>):** has special treatments. I8000 = 38.93 (Puncture of vessel, venous catheterization, NEC); K0510B2 = checked; O0100F = checked.

**29. Hydration/Swallowing/Oral Health:** has nutrition, hydration or oral health issues. K0510A, C, D = checked, enter "H" for hydration; K0100A-D = checked, enter "S" for swallowing; L0200A-G = checked, enter "O" for oral health.

**30. Infections:** has infections or infectious disease. I1700 – I2500 = checked; I8000 = infection diagnosis; O0100M = checked.

**31. Specialized Rehab (OT, PT, Speech) or other Services:** has specialized therapy or nursing rehab services. O0400A, B, C, D, E, F = minutes > 0, O0500 A-J = > 1.

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## ROSTER/SAMPLE MATRIX INSTRUCTIONS FOR SURVEYORS

(use with Form CMS-802)

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The Roster/Sample Matrix form (CMS-802) is used to list all current residents (including residents on bed-hold) and to note pertinent care categories. The facility completes the: resident name, resident room, and columns 6-31, all remaining columns are for Surveyor Use Only.

For the purpose of completing this form the terms: “facility” means certified beds (i.e., Medicare and/or Medicaid certified beds) and “residents” means residents in certified beds regardless of payer source.

The Roster/Sample Matrix is a tool for selecting the resident sample and may be used for recording information acquired during the tour. When using the form to identify the resident sample, indicate by a check whether this CMS-802 is being used for the sample from Offsite, Phase 1 or Phase 2. The horizontal rows list residents chosen for review (or residents encountered during the tour) and indicate the characteristics/concerns identified for each resident. Use the resident sample selection table in Appendix P of the State Operations Manual (SOM) to identify the number of residents required in the sample.

In the vertical column under the heading *Interview: Individual/Family* mark the column with ‘I’ for each resident receiving an interview or with ‘F’ for any non-interviewable resident receiving a family interview and/or staff observation. Mark the *Closed Record/Comprehensive/Focused* column with ‘CL’ for a closed record review, ‘C’ for a resident chosen for a comprehensive review or ‘FO’ for a resident chosen for a focused review. Use the vertical columns numbered 1 through 31 to check the characteristics for each resident, as appropriate. During each portion of the survey (Offsite, Phase I, Phase 2) highlight the vertical columns for each characteristic identified.

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**Resident Number:** Number each line sequentially down the rows continuing the numbering sequence for any additional pages needed. These numbers may be used as resident identifiers for the sample.

**Resident Name:** List the name of the resident.

**Surveyor Assigned:** List initials or surveyor number of surveyor assigned to review each resident.

**Resident Room:** Identify room number for the resident.

**COLUMNS 6–31: Highlight each column that is an area of concern.** For each resident entered on the roster/sample matrix, check all columns that pertain to the resident according to the Offsite and Sample Selection Tasks of the Survey.

1. **Privacy/Dignity:** residents’ right to privacy (accommodations, written and telephone communication, visitation, personal care, etc.) or concerns that the facility does not maintain or enhance residents’ dignity.
2. **Social Services:** medically related or other social services; e.g., interpersonal relationships, grief, clothing, etc.
3. **Self-Determination/Accommodation of Needs:** residents’ ability to exercise their rights as citizens; freedom from coercion, discrimination or reprisal; self-determination and participation; choice of care and schedule, etc.
4. **Abuse/Neglect:** resident abuse, neglect or misappropriation of resident property or how the facility responds to allegations of abuse, neglect or misappropriation of resident property.
5. **Clean/Comfortable/Homelike:** facility environment including cleanliness, lighting levels, temperature, comfortable sound levels, or homelike environment and the residents’ ability to use their personal belongings and individualize their room to the extent possible.
6. **Moderate/Severe Pain (constant or frequent:** timely assessment and intervention with residents needing pain medications or measures to provide comfort, including non-medication interventions, or who are on a pain management program.
7. **Hi-Risk Pressure Ulcers (Stage 2-4):** risk assessment, clinical assessment, treatment, monitoring, evaluation, and prevention of pressure ulcers; or other necessary skin care. Concerns regarding residents identified as having stage 2, 3, or 4 pressure ulcers or unstageable pressure ulcers.
8. **New/Worsened Pressure Ulcers (Stage 2-4):** risk assessment, clinical assessment, treatment, monitoring, evaluation, and prevention of pressure ulcers; or other necessary skin care. Concerns regarding residents identified as having new or worsened stage 2, 3, or 4 pressure ulcers.
9. **Physical Restraints:** use of restraints or residents identified as physically restrained daily, including side rails.
10. **Falls and/or Falls with Major Injury:** residents that have fallen within the past 30 days and/or have fallen within the past 180 days and incurred a major injury.
11. **Psychoactive Medications with Absence of Condition:** residents identified as receiving any psychoactive medications in the absence of a psychiatric or mood related diagnoses or conditions.
12. **Antianxiety/Hypnotic Medications:** residents identified as anxiolytics and/or hypnotics.
13. **Behavioral Symptoms Affecting Others or Self:** residents with behavioral health care needs (e.g., verbal or physical outbursts, withdrawing/ isolation).

14. **Depressive Symptoms:** residents with symptoms of depression with or without antidepressant therapy.
15. **Urinary Tract Infections (UTI):** residents identified as having a UTI.
16. **Indwelling Urinary Catheter:** residents with an indwelling urinary catheter.
17. **Lo-Risk Resident Lose Bowel/Bladder Control–Incontinence/Toileting Programs:** resident bowel and/or bladder incontinence and facility toileting programs.
18. **Excessive Weight Loss/Gain:** residents with an unintended weight loss/gain of >5% in one month or >10% in six months, or has had an insidious weight loss/gain or is at nutritional risk.
19. **Need for Increased ADL Help:** residents receive appropriate treatment and services to maintain or improve ability or concerns about residents identified as having ADL decline.
20. **Hospice:** residents who have elected or are receiving hospice care.
21. **Dialysis:** care and coordination of services for residents receiving hemo or peritoneal dialysis either in the facility or offsite.
22. **Admission/Transfer/Discharge:** care/treatment for residents admitted within the past 30 days or is scheduled to be transferred or discharged within the next 30 days. Including but not limited to, resident preparation and procedures for transfer or discharge, such as:
  - Relevant clinical and psychosocial information provided to next care providers, (i.e., Home Health; Hospital, Primary Care Provider, etc.); and
  - Appropriate arrangements for necessary services to meet resident needs upon transfer and/or discharge.
23. **MI (Non-Dementia) or ID/DD:** care and treatment of residents with a diagnosis of mental illness, intellectual or developmental disabilities.
24. **Language/Communication:** facility assisting those residents with communication challenges to communicate at their highest practicable level, or residents identified as speaking other than the dominant language of the facility, or using non-oral communication such as, picture boards, computers, American Sign Language, etc.
25. **Vision/Hearing/Other Assistive Devices:** facility assisting those residents with visual or hearing impairments to function at their highest practicable level, including those residents who have glasses or hearing aids. Include residents needing special devices to assist with eating or mobility.
26. **Fecal Impaction:** management of constipation or residents having a fecal impaction.
27. **ROM/Contractures/Positioning:** occurrence, prevention or treatment of contractures, staff provision or lack of provision of appropriate application/use of splints, ROM exercises, or positioning. Concerns about residents identified as having a decline in ROM.
28. **Special Care (Tube Feeding, Central Lines, Ventilators, O<sub>2</sub>, etc.):** residents receiving nutrition via a feeding tube. Care provided to residents with tracheostomies or ventilators, residents needing suctioning, and residents receiving oxygen, IPPB or other inhalation therapy, pulmonary toilet, humidifiers, etc., or have special care areas, (e.g., prosthesis, ostomy, injection, IV's, including total parenteral nutrition, etc.), that may be of concern.
29. **Hydration/Swallowing/Oral Health:** residents, who show signs or symptoms, have risk factors for, or who are identified as having dehydration. Residents with chewing or swallowing problems. Provision or lack of provision for oral health care for residents.
30. **Infections:** presence or prevalence of resident infections, residents receiving antibiotics or have an infectious disease or residents under strict isolation precautions.
31. **Specialized Rehab:** facility's provision or lack of provision of specialized rehabilitative services including, but not limited to;
  - Physical therapy
  - Speech/language pathology
  - Occupational therapy
  - Nursing Rehabilitative services
  - Health rehabilitative services for MI and/or ID/DD
- 32.–34. Note any other concerns; e.g., residents who are comatose, have delirium, have special skin care needs other than pressure ulcers or observed to spend most of their time in bed or a chair, such as a geriatric chair, recliner, etc. If during offsite preparation, concerns arise about the accuracy of the MDS information, enter MDS accuracy as a concern.

**Nursing Home Discharge Planning Checklist  
MDS 3.0 Section Q**

*Disclaimer: Our facility is completing this information in accordance with MDS 3.0 Section Q regarding transition back into the community. We understand that the resident has a right to receive the needed long term care services in the least restrictive and most integrated setting. This information is true and correct to the best of our knowledge based in the information received from the resident during an interview.*

Date Section Q Interview Conducted: \_\_\_\_\_

Person Conducting Interview: \_\_\_\_\_

**Personal Information**

Resident Name:	Room Number:
Primary Contact Person:	Relationship to Resident:
Medicare #	Medicaid #

Has the resident been adjudicated incompetent by a court of law?    Yes     No

Has the resident been placed in the facility by DHR?    Yes     No

    If yes, was the placement by DHR:

        Court Ordered/Protective Placement    Yes     No

*Please attach a copy of the Court Order*

Has the resident been placed in the facility by a Court Order other than from DHR?

*Please attach a copy of the Court Order*    Yes     No

Is the discharge medically contraindicated by a physician?    Yes     No

*The physician progress note can be located:*

**If the discharge is medically contraindicated by a physician, please explain \_\_\_\_\_**

*If yes to any of the above questions, please stop the discharge planning process with respect to MDS 3.0 Section Q because it has been determined that discharge to the community is not feasible at this time. Before automatically stopping the discharge planning process, the nursing facility must document in the resident's medical record why it has been determined that discharge is not feasible at this time. If the resident persists and can feasibly be discharged, the discharge planning process should continue and include collaboration with the physician, guardian or court system.*

## Communication

Discharge Planning Start Date:	Local Contact Agency Assigned:
Has coordination been established with the Local Contact Agency?	When did the initial conversation occur with the Local Contact Agency?  Date:  Time:  Name of person contacted:  Title of person contacted:
Anticipated date and time of visit/call by Local Contact Agency:  Date:  Time:	Briefly describe the initial conversation with the Local Contact Agency:
What type of visit is expected from the Local Contact Agency. i.e., phone call, face-to-face?	Dates and times of additional follow-up contact made with the Local Contact Agency:  Date:  Time:  Date:  Time:  Date:  Time:

**Signature of Facility Representative:** \_\_\_\_\_

**Date Signed:** \_\_\_\_\_

**Printed Name and Title of Facility Representative:** \_\_\_\_\_

### **Housing – RAI Manual Q0400**

What type of residence has the resident indicated that they wish to be discharged, i.e., another nursing facility, assisted living facility, private home, etc.?	Anticipated New Address:
Have any barriers and/ or challenges been identified by the Local Contact Agency?	List the barriers and/or challenges identified by the Local Contact Agency:

### **Assistive Technology - RAI Manual Q0400**

Does the resident require assistive technology (Hardware and software that help people who are physically impaired)? Examples include, but are not limited to: eyeglasses, hearing aids, large print books, translating devices, TDD/TYY for phone service, etc. If so, what does the resident require? List all that apply	Has the facility communicated to the Local Contact Agency that the resident requires assistive technology:  Date:  Time:  Name of person contacted:
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### **Medical Needs/Referrals - RAI Manual Q0400**

Is the resident enrolled in a managed care plan?	Name of managed care plan:
Has the resident been referred for Hospice services?	Name of Hospice  Date of Referral
Has the resident been referred for Home Health services?	Name of Home Health  Date of Referral

Has the resident been referred for other services?	Name of Other Services
	Date of Referral
	Name of Other Services
	Date of Referral
	Name of Other Services
	Date of Referral

**Durable Medical Equipment - RAI Manual Q0400**

Does the resident require any durable medical equipment, i.e., hospital bed, wheelchair, walker, etc.? If so, what does the resident require? List all that apply	Has the facility communicated to the Local Contact Agency that the resident requires durable medical equipment:  Date:  Time:  Name of person contacted:
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**Medical Support - RAI Manual Q0400**

**On the day of transition, the following information has been communicated with the Local Contact Agency:**

Type of transportation used to transition into the community:	Name of transportation	Date Completed
	Date set up	
	Name of person contacted	

<p>Are medication orders written?</p>	<p>Medication orders requested and written</p>   <p>Date set up</p>  <p>Name of physician</p>	<p>Date Completed</p>
<p>Are treatment orders written?</p>	<p>Treatment orders requested and written</p>   <p>Date set up</p>  <p>Name of physician</p>	<p>Date Completed</p>
<p>Are special diet orders written?</p>	<p>Special Diet orders requested and written</p>   <p>Date set up</p>  <p>Name of physician</p>	<p>Date Completed</p>
<p>Does the resident have any allergies or reactions to medications?</p>	<p>Known allergies or reactions to medications</p>	<p>Date Completed</p>
<p>Are special nursing needs required?</p>	<p>Special nursing needs requested</p>   <p>Date set up</p>  <p>Name of Provider</p>	<p>Date Completed</p>

<p>Does the resident need Mental Health support?</p>	<p>Mental Health needs requested</p> <p>Date set up</p> <p>Name of Provider</p>	<p>Date Completed</p>
<p>Does the resident require assistance with Activities of Daily Living?</p>	<p>Activity of Daily Living needs requested</p> <p>Date set up</p> <p>Name of Provider</p>	<p>Date Completed</p>
<p>Does the resident require therapy?</p>	<p>Therapy needs requested</p> <p>Date set up</p> <p>Name of Provider</p>	<p>Date Completed</p>
<p>Have any medical or special appointments been pre-arranged for the resident upon discharge?</p>	<p>List of pre-arranged appointments</p> <p>Date set up</p> <p>Name of Provider</p> <p>Date set up</p> <p>Name of Provider</p>	<p>Date Completed</p>

	<p>Date set up</p> <p>Name of Provider</p> <p>Date set up</p> <p>Name of Provider</p>	
<p>Has the resident/responsible party received medication education?</p>	<p>Medication education provided for (list drugs):</p> <p>Date medication education provided</p> <p>Name and signature of Educator</p>	<p>Date Completed</p>
<p>Has the resident/responsible party received prevention and disease management education?</p>	<p>Prevention and disease management education provided for (list diseases):</p> <p>Date education provided</p> <p>Name and signature of Educator</p>	<p>Date Completed</p>

## Medical Support - RAI Manual Q0400

The following medications and/or scripts have been sent with the resident/responsible party upon discharge:

<b>Name of Medication and/or Script</b>	<b>Dosage Instructions</b>	<b>Amount of Medication Distributed</b>	<b>Certification and Signature of Receiving Party</b>
			Facility RN Signature  Receiving Party Signature
			Facility RN Signature  Receiving Party Signature
			Facility RN Signature  Receiving Party Signature
			Facility RN Signature  Receiving Party Signature
			Facility RN Signature  Receiving Party Signature

**Medical Support - RAI Manual Q0400****Attach a copy of the medical records release form dated and signed to this document!****The following documents have been sent with the resident/responsible party upon discharge:**

<b>Name of Document/Information</b>	<b>Certification and Signature of Receiving Party</b>
Advance Directive	Facility Signature and Date  Receiving Party Signature and Date
Brief Medical History	Facility Signature and Date  Receiving Party Signature and Date
Medication Education	Facility Signature and Date  Receiving Party Signature and Date
Post Discharge Plan of Care	Facility Signature and Date  Receiving Party Signature and Date
Prevention and Disease Management Education	Facility Signature and Date  Receiving Party Signature and Date
List of resident preferences and needs for care and supports	Facility Signature and Date  Receiving Party Signature and Date
Name and phone number of who to call in case of an emergency or if symptoms of decline occur	Facility Signature and Date  Receiving Party Signature and Date

	Facility Signature and Date  Receiving Party Signature and Date
	Facility Signature and Date  Receiving Party Signature and Date
	Facility Signature and Date  Receiving Party Signature and Date
	Facility Signature and Date  Receiving Party Signature and Date
	Facility Signature and Date  Receiving Party Signature and Date

**Date Discharge Completed:** \_\_\_\_\_

**Signature of Facility Representative:** \_\_\_\_\_

**Date Signed:** \_\_\_\_\_

**Printed Name and Title of Facility Representative:** \_\_\_\_\_

**Signature of Local Contact Agency Representative:** \_\_\_\_\_

**Date Signed:** \_\_\_\_\_

**Printed Name and Title of Local Contact Agency Representative:** \_\_\_\_\_

**Signature of Resident or Responsible Party:** \_\_\_\_\_

**Date Signed:** \_\_\_\_\_

# CASPER Report MDS 3.0 Resident Level Quality Measure Report

**Facility ID:** 111111  
**Facility Name:** 111111  
**CCN:** 111111  
**City/State:** 111111  
**Report Period:** 04/01/11-09/30/11  
**Run Date:** 12/16/11  
**Report Version Number:** 1.00

Data was calculated on: 12/01/2011

Note: S = short stay, L = long stay; X=triggered, (b) not triggered or excluded

Resident Name	Resident ID	A0310A/B/F	SR Moderate/Severe Pain (S)	SR Moderate/Severe Pain (L)	Hi-Risk Pressure Ulcer (L)	New/Worsened Pres. Ulcer (S)	Physical Restraints (L)	Falls (L)	Falls w/Major Injury (L)	Psychoactive Meds Without Condition (L)	Antianxiety/Hypnotic Med (L)	Behavior Symptoms Affecting Others (L)	Depressive Symptoms (L)	Urinary Tract Infection (L)	Catheter Inserted and Left in Bladder (L)	Lo-Risk Res Lose Bowel/Bladder Control (L)	Excessive Weight Loss (L)	Need for Increased ADL Help (L)	Quality Measure Count
<b>Active Residents</b>																			
DOE, JOHN	4566544	02/99/99	b	b	b	b	b	X	X	X	b	X	b	b	b	X	b	b	5
DOE, JOHN	3214789	02/99/99	b	X	b	b	b	X	X	X	b	b	X	b	b	b	b	b	5
DOE, JOHN	8765432	02/99/99	b	b	b	b	b	b	b	b	b	X	b	b	b	b	b	b	2
DOE, JOHN	4567891	99/99/11	b	b	b	b	b	b	b	b	X	b	b	b	b	b	b	b	1
DOE, JOHN	12343567	02/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	1
DOE, JOHN	7788997	03/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	0
DOE, JOHN	1231231	02/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	0
DOE, JOHN	9632147	02/99/99	b	b	b	b	b	b	b	X	b	b	b	X	b	b	b	b	2
DOE, JOHN	7654321	02/99/99	b	X	b	b	b	X	X	b	b	b	b	b	b	X	b	b	4
DOE, JOHN	8877665	03/99/99	b	b	b	b	b	b	b	X	b	X	b	b	b	b	b	b	2
DOE, JOHN	2345678	03/99/99	b	b	b	b	b	b	b	b	b	b	b	b	b	X	b	b	1
<b>Discharged Residents</b>																			
DOE, JOHN	7531595	04/99/99	b	b	b	b	b	X	X	b	X	b	X	b	b	b	X	b	5
DOE, JOHN	3456789	02/99/99	b	b	b	b	b	X	X	X	X	X	b	b	b	b	X	b	6
DOE, JOHN	7849516	99/99/10	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	b	0
DOE, JOHN	9876543	99/99/10	b	b	b	b	b	X	X	X	b	b	b	b	b	b	b	b	3

# Facility Characteristics Report

**Facility Name**  
**City/State**  
**Provider Number**  
**Login/Facility ID**  
 Data was calculated on 01/6/2012

**Run Date** 01/19/12 09:12:26  
**Report Period** 12/01/09 - 05/31/10  
**Comparison Group** 11/01/10 - 04/30/11  
**Report Version Number** 1.07

	Facility			Comparison Group	
	Num	Denom	Observed Percent	State Average	National Average
<b><u>Gender</u></b>					
Male	14	31	45.2%	40.1%	31.6%
Female	17	31	54.8%	59.9%	68.4%
<b><u>Age</u></b>					
<25 years old	0	31	0.0%	0.3%	0.5%
25-54 years old	2	31	6.5%	10.2%	5.7%
55-64 years old	3	31	9.7%	11.7%	6.8%
65-74 years old	7	31	22.6%	17.1%	13.3%
75-84 years old	14	31	45.2%	31.9%	32.6%
85+ years old	5	31	16.1%	28.8%	41.1%
<b><u>Payment Source (all that apply)</u></b>					
Medicare Part A	25	31	80.6%	13.0%	31.5%
Medicare Part A Non-Therapy	25	31	80.6%	16.0%	18.0%
State Medicaid	0	31	0.0%	6.4%	14.7%
Alternate State Medicaid					
Insurance	15	31	48.4%	4.5%	10.4%
<b><u>Diagnostic Characteristics</u></b>					
Psychiatric diagnosis	2	31	6.5%	7.5%	13.1%
Intellectual or Developmental Disability	0	31	0.0%	3.0%	2.7%
Hospice	1	31	3.2%	0.5%	3.3%
<b><u>Type of Assessment</u></b>					
Admission assessment	17	31	54.8%	24.4%	32.8%
Annual assessment	4	31	12.9%	12.6%	11.0%
Significant change in status assessment	0	31	0.0%	7.9%	8.9%
Significant correction to prior comprehensive assessment	0	31	0.0%	0.0%	0.0%
Quarterly review assessment	10	31	32.3%	55.0%	47.3%
Significant correction to prior quarterly assessment	0	31	0.0%	0.2%	0.0%
All other assessment types	0	31	0.0%	0.0%	0.0%
<b><u>Prognosis</u></b>					
Life expectancy of less than 6 months	1	31	3.2%	2.1%	2.8%
<b><u>Return to Community</u></b>					
Expects to be discharged to the community	8	31	25.8%	66.0%	64.7%
Expects to remain in this facility	5	31	16.1%	4.9%	11.0%
Expects to be discharged to another facility/institution	2	31	6.5%	10.7%	5.8%
Unknown or Uncertain	16	31	51.6%	17.9%	17.8%

*deleted again*

*120*

## CASPER Report MDS 3.0 Facility Quality Measure Report

Facility ID:  
CCN:  
Facility Name:  
City/State: MISSISSAUGA, ONTARIO  
Data was calculated on: 12/01/2011

Report Period: 04/01/11-09/30/11  
Comparison Group: 02/01/11-07/31/11  
Run Date: 12/16/11  
Report Version Number: 1.00

Note: Dashes represent a value that could not be computed  
Note: S = short stay, L = long stay  
Note: \* is an indicator used to identify that the measure is flagged

	Measure ID	Num	Denom	Facility Observed Percent	Facility Adjusted Percent	Comparison Group State Average	Comparison Group National Average	Comparison Group National Percentile
Self-Reported (SR) Moderate/Severe Pain (S)	0676	10	23	43.5%	43.5%	37.0%	22.9%	79*
Self-Reported (SR) Moderate/Severe Pain (L)	0677	8	52	15.4%	10.4%	31.7%	19.0%	38
High-Risk Residents with Pressure Ulcers (L)	0679	3	38	7.9%	7.9%	15.0%	10.5%	62
New/Worsened Pressure Ulcers (S)	0678	0	24	0.0%	0.0%	16.0%	4.3%	0
Physical Restraints (L)	0687	1	68	1.5%	1.5%	17.3%	5.7%	67
Falls (L)		25	68	36.8%	36.8%	36.5%	41.2%	48
Falls with Major Injury (L)	0674	1	68	1.5%	1.5%	39.2%	39.6%	19
Psychoactive Medication Use in Absence of Psychotic or Related Condition (L)		1	52	1.9%	1.9%	26.9%	24.8%	21
Antianxiety/Hypnotic Medication Use (L)		3	43	7.0%	7.0%	32.0%	32.8%	17
Behavior Symptoms Affecting Others (L)		18	64	28.1%	28.1%	28.6%	23.5%	63
Depressive Symptoms (L)	0690	2	65	3.1%	3.1%	21.2%	9.6%	41
Urinary Tract Infection (L)	0684	5	67	7.5%	7.5%	18.5%	10.3%	62
Catheter Inserted and Left in Bladder (L)	0686	1	54	1.9%	3.0%	16.4%	7.8%	29
Low-Risk Residents Who Lose Bowel/Bladder Control (L)	0685	6	16	37.5%	37.5%	30.6%	36.1%	41
Excessive Weight Loss (L)	0689	5	67	7.5%	7.5%	21.8%	11.2%	61
Need for Help with ADLs Has Increased (L)	0688	4	41	9.8%	9.8%	25.3%	18.1%	35

This report may contain privacy protected data and should not be released to the public.