

# Perfect SOC

On PC

# Step 1

Search your patient, click on their name and this should bring you to the patient's chart.

If the patient is still "Pending" status, then you will see this window and need to convert the patient to "Admitted":

Choose Edit

Choose Admission Status and select admit

Confirm the correct SOC date

Choose the correct Acuity Level

Choose the correct Emergency Triage

Choose Save on the top left

The screenshot displays the 'Admission Info' form in the Perspective Home Health, Inc. software. The patient's name is JOHN DOE. The form is currently in 'Edit' mode. Key fields and their values are as follows:

- Admission Status:** Pending
- Target SOC Date:** 04/25/2018
- Acuity:** [Select Acuity]
- Emergency Triage:** [Please Select Type Here]

Red circles highlight the 'Edit' button, the 'Admission Status' field, the 'Target SOC Date' field, the 'Acuity' dropdown, and the 'Emergency Triage' dropdown. Below these fields, there are sections for 'Special Instruction' and 'Admission Source'.

**Admission Source Section:**

- Admission Type:** Elective
- Admission Source Code:** 1 - Non-Health Care Facility Point of Origin
- Inpatient Discharged Date:** [Empty]
- Type:** [Please Select Admission Source Here]
- Name:** [Empty]
- Address:** [Empty]
- Market Source:** [Please Select Market Source Here]

**Other Fields:**

- F2F Visit:** [Empty]
- F2F Received:** [Empty]
- Code status:** [Select Full Code]
- Phone:** [Empty]
- Contact:** [Empty]

The footer of the software shows: Note-e-fied, Inc. © 2014. All rights reserved. Helpdesk No.: 1-855-825-7234. About Note-e-fied, Inc. Privacy Policy Support EULA web2wa

# Step 2

Next, you will create the admission order:

Choose the “Orders” section on the left

Choose the “Add New Order”

Choose “Type of Order” and select “Admission Order”

Enter your Discipline Name

Confirm the correct MD

Confirm the SOC date

Then SAVE

The screenshot shows the 'Perfect' software interface for 'Perspective Home Health, Inc.' The patient is identified as '01010-3 - DOE, JOHN'. The left-hand navigation menu is expanded to the 'Orders' section, with 'Add New Order' highlighted. The main form area is titled 'Add New Order' and contains several sections: 'Physician Order' with fields for 'Physician Name' (KELLEY, ASHLEY V NPI:1205929320) and 'Assigned Discipline'; 'Caller Information' with fields for 'Caller Name', 'Phone No.', 'Order Date' (04/25/2018), and 'Time' (1:54 PM); 'Type Of Order' dropdown menu set to 'Admission Order'; 'Reason/Notes' text area; 'Physician Orders' table; 'Goal' text area; 'Medications' section with a disclaimer and a table for medication management. The 'Save' button is circled in red at the top of the form.

Free Te	For Dru	New/Chan	Date	Medication	Strength	Dose	Frequency	Route	Classification	Lab Neede	Date of Dis	Profile
No data found												

# Step 3

Next, the admission order needs to be completed. Start by entering the Medications.

Enter medications by clicking on “Insert”  
This will create a field where you can enter the medication.

Start typing the medication name to bring forth a list of medications.

Choose the corresponding medication

Fill in the correct Strength, Dose, Frequency, and Route

To enter the next medication, click on the “insert” again

Save often

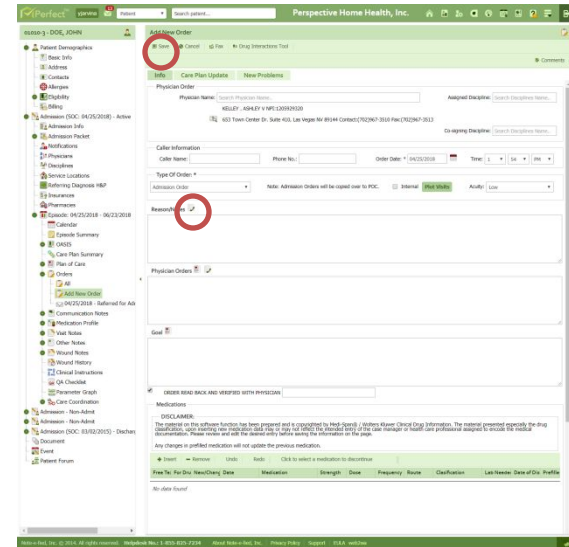
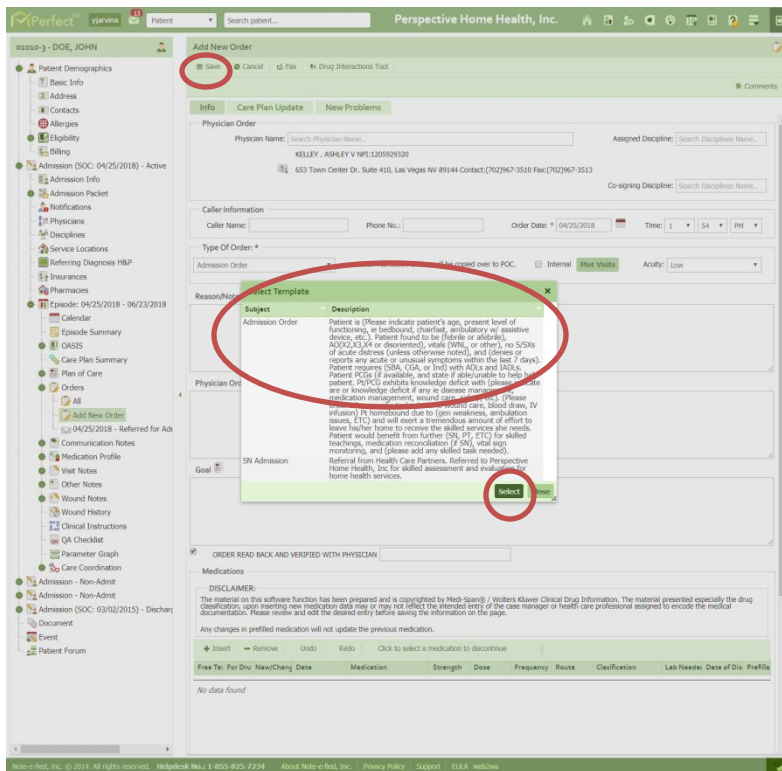
The screenshot shows the 'Perfect' software interface for 'Perspective Home Health, Inc.' The patient is identified as '01010-3 - DOE, JOHN'. The 'Add New Order' form is open, with the 'Save' button circled in red. The form includes sections for 'Physician Order', 'Caller Information', 'Type Of Order', and 'Medications'. The 'Medications' section is highlighted, and the 'Insert' button is also circled in red. The 'Medications' table is currently empty, showing 'No data found'.

Freeze	Order Dru	New/Chang	Date	Medication	Strength	Dose	Frequency	Route	Classification	Lab Neede	Date of Dis	Profile
No data found												

# Step 4

Complete the “Reason” section.

Choose the template icon located next to the “Reason/Notes”



Choose the “Admission Order” patient encounter template and click select.

Complete the narrative.

Feel free to amend the template to fit your patient.

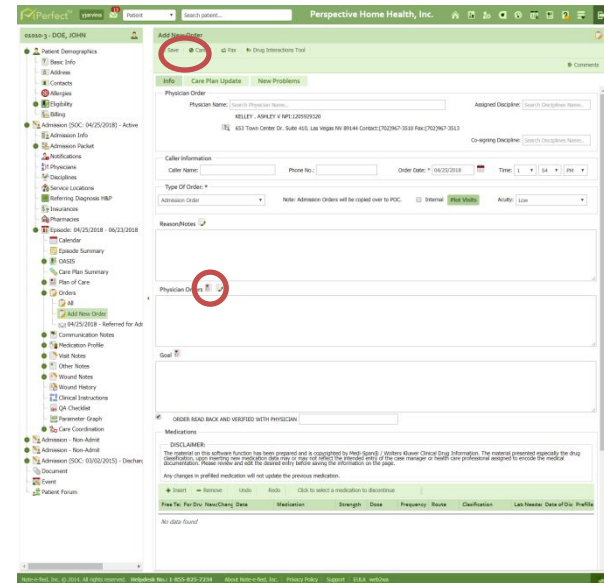
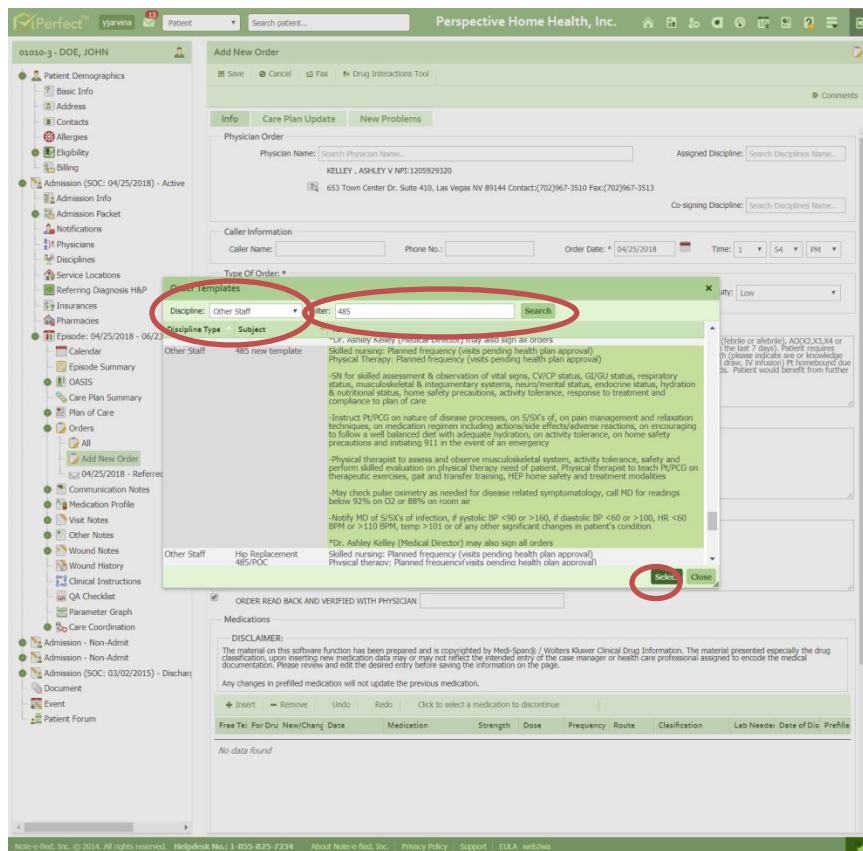
Your narrative should “paint” a clear picture of the Pt’s status, problems, skilled needs, and proposed solutions.

Save often

# Step 5

Next, complete the “Physician Orders” section.

Choose by clicking the template icon with the ‘heart’



For discipline, choose “Other Staff”

In filter, fist look for “485 new template”

Choose the 485 new template and click select

Then continue adding the diagnosis teachings by clicking repeating the earlier steps on this page.

Under filter, start typing in the diagnosis (ie ulcer, hypertension etc)

Choose the diagnosis and click select

Save often

# Step 6

Next, complete the “Goal” section.

Choose by clicking the template icon with the ‘heart’

The screenshot shows a medical software interface. At the top, there's a 'Physician Orders' section with a 'Goal' icon circled in red. Below it, a 'Select Template' dialog box is open, displaying a table of templates. The first row is circled in red, showing a template with a heart icon and the subject 'COPD goals'. The 'Select' button at the bottom of the dialog is also circled in red.

Subject	Description
COPD goals	Patient's respiratory condition will improve as evidenced by absence of productive cough, dyspnea on min. exertion, adventitious lung sounds (wheezing/rales), and will be able to demonstrate effective breathing and coughing exercises with no signs of superimposed respiratory infection within 4-5 weeks.
certification period	certification period
Constipation resolved in 5 days.	Constipation resolved in 5 days.
PT. WILL HAVE NO EVIDENCE OF CRF COMPLICATIONS LIKE HTN,DYSFUNCTION ON SKELETAL MUSCLES,POLYURIA,NOCTURIA, CELLULAR AND METABOLISM DYSFUNCTION, ELCTROLYTE EMBALANCE AND OTHER UNTOWARD COMPLICATIONS RELATED TO CRF AT THE END OF CERT. PERIOD.	PT. WILL HAVE NO EVIDENCE OF CRF COMPLICATIONS LIKE HTN,DYSFUNCTION ON SKELETAL MUSCLES,POLYURIA,NOCTURIA, CELLULAR AND METABOLISM DYSFUNCTION, ELCTROLYTE EMBALANCE AND OTHER UNTOWARD COMPLICATIONS RELATED TO CRF AT THE END OF CERT. PERIOD.
PT. WILL HAVE NO EVIDENCE OF CRF COMPLICATIONS LIKE HTN,DYSFUNCTION ON SKELETAL MUSCLES,POLYURIA,NOCTURIA, CELLULAR AND METABOLISM DYSFUNCTION,	PT. WILL HAVE NO EVIDENCE OF CRF COMPLICATIONS LIKE HTN,DYSFUNCTION ON SKELETAL MUSCLES,POLYURIA,NOCTURIA, CELLULAR AND METABOLISM DYSFUNCTION,

Click on the arrow to arrange the “subject” by alphabetical order.

Look for the diagnosis or reason that correlates to the main reason why skilled home health was needed

Choose the Goal description and click select.

Then continue adding the more goals the above steps.

Save often

# Step 7

Any changes in prefilled medication will not update the previous medication.

+ Insert   - Remove   Undo   Redo   Click to select a medication to discontinue

Free Tex	For Dru	New/Change	Date	Medication	Strength	Dose	Frequency	Route	Classification	Lab Needed	Date of Disc	Indicati	Prefilled
<input type="checkbox"/>	<input type="checkbox"/>	▼		MetFORMIN HCl	1000 Milligrar1 tab		Twice per Day	Oral	BIGUANIDES	<input type="checkbox"/>			<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	▼								<input type="checkbox"/>			<input type="checkbox"/>

## Medication Completion:

- Choose “Insert”
- Enter the “Date” of the prescription
- Start typing in the name of the medication under “Medication”
- Enter appropriate strength, dose, and frequency
- (Please note on Medications that have a finite prescribed period (ie Antibiotics), please enter length of the medication (ie x 4 days, 10-days, etc)
- Check “Lab Needed” box if labs are needed to monitor the medication.
- “Save” often
- When done, “Electronically Sign”

01010-6 - DOE, JOHN

03/26/2020 - Admission Order - In Progress

Save   Cancel   Delete   Mark as Sent   Electronically Sign   Print   Fax   0 File Attachment   Drug Interactions T

Info   Care Plan Update   New Problems

Physician Order

Physician Name:

KELLEY, ASHLEY NPI: 1205929320

653 Town Center Dr. Suite 410, Las Vegas NV 89144 Contact:(702)967-3510 Fax:(702)967-3513

Co



# Step 8

- OASIS Completion
- Choose the OASIS section and chose SOC OASIS

The screenshot displays a medical software interface. On the left is a navigation tree with various patient-related sections. The 'OASIS' section is highlighted with a green background, and a red arrow points to it. Below 'OASIS', there is a sub-section '03/26/2020 - SOC - Visits Plan' which is also highlighted. The right side of the interface shows a form with several sections: 'Physician Order' (with a 'Physician' field), 'Caller Information' (with a 'Caller Name' field), 'Type Of Order' (with a dropdown menu showing 'Admission Order'), 'Reason/Notes' (with a text area containing a note about patient safety), 'Physician Orders' (with a dropdown menu), and 'Goal' (with a dropdown menu). At the top right of the form, there are 'Save' and 'Cancel' buttons.

# Step 8 (cont)

Select the appropriate Race and  
Payment source

Select next to continue

03/26/2020 - SOC - Visits Planned (oo) - In Progress

Save Validate Clinical Validation Print Full OASIS Summary Only POC Pointers PDGM Worksheet File Attachment Download OASIS XML

Signature Pad ICD-10-CM Side by side compare View ICD-10 Version View QA Remarks In Pro

Section: PATIENT TRACKING SHEET Next >> Item: Search Zoom: Normal Exclusive Lock Activity Logs

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**PERSPECTIVE HOME HEALTH INC.**  
6045 S Fort Apache Rd, Suite 110, Las Vegas, NV 89148  
Phone: (702) 948 5095 / Fax: (702) 948 5115

**OASIS D1 - START OF CARE**

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**HOME HEALTH PATIENT TRACKING SHEET**

<p>(M0010) CMS Certification Number: 297100</p> <p>(M0014) Branch State: NV</p> <p>(M0016) Branch ID Number: N</p> <p>(M0018) National Provider Identifier (NPI) for the attending physician who has signed the plan of care: 1205929320 <input type="checkbox"/> UK - Unknown or Not Available</p> <p>Physician Name: KELLEY, ASHLEY V Phone: (702)967-3510 Address: 653 Town Center Dr., Suite 410 Las Vegas, NV 89144</p> <p>(M0020) Patient ID Number: 01010</p> <p>(M0030) Start of Care Date: 03/26/2020 (mm/dd/yyyy)</p> <p>(M0032) Resumption of Care Date: <input checked="" type="checkbox"/> NA - Not Applicable (mm/dd/yyyy)</p> <p>Certification Period: 03/26/2020 - 05/24/2020</p> <p>Marital Status: Single</p> <p>Religion: Adventists</p> <p>Primary Language: -- <input type="checkbox"/> Translator Needed</p> <p>(M0140) Race / Ethnicity: (Mark all that apply.) </p> <ul style="list-style-type: none"><li><input type="checkbox"/> 1 - American Indian or Alaska Native</li><li><input type="checkbox"/> 2 - Asian</li><li><input type="checkbox"/> 3 - Black or African-American</li><li><input type="checkbox"/> 4 - Hispanic or Latino</li><li><input type="checkbox"/> 5 - Native Hawaiian or Pacific Islander</li><li><input checked="" type="checkbox"/> 6 - White</li></ul>	<p>(M0040) Patient Name: JOHN DOE (First) (MI) (Last) (Suffix) Phone: (702)948-5095 Address: 6045 S Fort Apache Rd LAS VEGAS, NV 89148</p> <p>(M0050) Patient State of Residence: NV</p> <p>(M0060) Patient ZIP Code: 89148</p> <p>(M0063) Medicare Number: 123456789A <input type="checkbox"/> NA - No Medicare (including suffix)</p> <p>(M0064) Social Security Number: <input checked="" type="checkbox"/> UK - Unknown or Not Available</p> <p>(M0065) Medicaid Number: <input checked="" type="checkbox"/> NA - No Medicaid</p> <p>(M0066) Birth Date: 04/02/1977 (mm/dd/yyyy)</p> <p>(M0069) Gender: <input checked="" type="checkbox"/> 1 - Male <input type="checkbox"/> 2 - Female</p> <p>(M0150) Current Payment Sources for Home Care: (Mark all that apply.) </p> <ul style="list-style-type: none"><li><input type="checkbox"/> 0 - None; no charge for current services</li><li><input type="checkbox"/> 1 - Medicare (traditional fee-for-service)</li><li><input type="checkbox"/> 2 - Medicare (HMO/managed care/Advantage plan)</li><li><input type="checkbox"/> 3 - Medicaid (traditional fee-for-service)</li><li><input type="checkbox"/> 4 - Medicaid (HMO/managed care)</li><li><input type="checkbox"/> 5 - Workers' compensation</li><li><input type="checkbox"/> 6 - Title programs (for example, Title III, V, or XX)</li><li><input type="checkbox"/> 7 - Other government (for example, TriCare, VA)</li><li><input type="checkbox"/> 8 - Private insurance</li><li><input type="checkbox"/> 9 - Private HMO/managed care</li><li><input type="checkbox"/> 10 - Self-pay</li><li><input type="checkbox"/> 11 - Other (specify) _____</li><li><input type="checkbox"/> UK - Unknown</li></ul>
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# Step 8 (cont)

- Choose discipline type
- Enter staff name
- Confirm referral date or specified SOC date
- Choose “Next” when done

03/26/2020 - SOC - Visits Planned (00) - In Progress

Save Validate Clinical Validation Print Full OASIS Summary Only POC Pointers PDGM Worksheet 0 File Attachment Download OASIS XML

Signature Pad ICD-10-CM Side by side compare View ICD-10 Version View QA Remarks In Progress

Section: CLINICAL RECORD ITEMS << Previous Next >> Item: Search Zoom: Normal Exclusive Lock Activity Logs

### CLINICAL RECORD ITEMS

<p><b>(M0080) Discipline of Person Completing Assessment:</b> <a href="#">i</a> <input checked="" type="checkbox"/> 1 - RN   <input type="checkbox"/> 2 - PT   <input type="checkbox"/> 3 - SLP/ST   <input type="checkbox"/> 4 - OT <b>Care Staff Name:</b> LEE, NELIA B</p> <p><b>(M0090) Date Assessment Completed:</b> <a href="#">i</a> <input type="text" value="03/26/2020"/> (mm/dd/yyyy)</p> <p><b>Time In:</b> _____ <b>Time Out:</b> _____</p> <p><b>(M0100) This Assessment is Currently Being Completed for the Following Reason:</b> <a href="#">i</a> <b>Start / Resumption of Care</b> <input checked="" type="checkbox"/> 1 - Start of care - further visits planned <input type="checkbox"/> 3 - Resumption of care (after inpatient stay)</p> <p><b>(M0102) Date of Physician - ordered Start of Care (Resumption of Care):</b> If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified. <a href="#">i</a> <input type="text"/> [ <b>Go to M0110, if date entered</b> ] (mm/dd/yyyy) <input type="checkbox"/> NA - No specific SOC date ordered by physician</p>	<p><b>(M0104) Date of Referral:</b> Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA. <a href="#">i</a> <input type="text" value="03/26/2020"/> (mm/dd/yyyy)</p> <p><b>(M0110) \$ Episode Timing:</b> Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient's current sequence of adjacent Medicare home health payment episodes? <a href="#">i</a> <input checked="" type="checkbox"/> 1 - Early <input type="checkbox"/> 2 - Later <input type="checkbox"/> UK - Unknown <input type="checkbox"/> NA - Not Applicable: No Medicare case mix group to be defined by this assessment.</p>
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# Step 8 (cont)

- Complete all fields appropriately, and pay close attention to all fields labelled with “COP” (Conditions of Participation)
- ALL “COP” fields needs to be completed thoroughly
- Advance Directive information is needed, indicate if none
- If no advance directive, may place “Pt/PCG was educated on advance directives and was provided with educational materials and materials needed to enact a simple advance directive.”
- List POA
- Inpatient DC date must be entered if Pt was DC'd from an inpatient facility within 14-days of the SOC date.
- Primary reason for Home Health. ie “The patient was referred to skilled home health care for a skilled evaluation on home safety, medication management, knowledge deficit, to check vital signs, to provide wound care, to provide therapy, and to provide skilled teachings on observed knowledge deficits.”

03/26/2020 - SOC - Visits Planned (00) - In Progress

Save Validate Clinical Validation Print Full OASIS Summary Only POC Printers PGM Worksheet 0 File Attachment Download OASIS XML Signature Pad

Section: PATIENT HISTORY AND DIAGNOSES << Previous Next >> Item: Search Zoom: Normal Exclusive Lock Activity Logs

**COP** PATIENT HISTORY AND DIAGNOSES

**EMERGENCY PREPAREDNESS**

Emergency Triage: Category 4 Acuity: LOW

Does the patient have an Advance Directives order?  No  Yes

Emergency Contact:

Last Name: First Name: Relationship: --

Address: City:

State: Nevada Zip Code: Email Address:

Home Phone: Work Phone: Fax Number:

Mobile Phone:

Notes:

**COP** EMERGENCY PREPAREDNESS CARE PLANNING

Check all that apply

Emergency Priority Code: assigned to this patient is \_\_\_\_\_ based upon the comprehensive assessment of their functional, medical condition, psychosocial situation, cognitive, mental status and other significant care needs.

NOTE: Record the code on the front page of this form and other places per agency policy

Obtained the patient's emergency contact numbers for the medical record

Discussed the HHA's plans for supporting their patients during a natural or man-made disaster

Discussed patient specific emergency planning options

Discussed the development of the patient's individualized emergency preparedness plan of care, including self-care readiness and the procedure to follow up with the HHA in the event services are interrupted

If applicable,  local utility companies  local emergency offices notified of life supporting equipment being used

State and local emergency preparedness officials notified about the possible need for evacuation

List of recommended items to have prepared/ready and available in the event of an emergency

Educational materials provided to suggest/assist with emergency management/decision making priorities

List of local and state approved evacuation routes and community shelters relevant to the patient's specific geographic location

Written materials to restate/reinforce the emergency preparedness procedures given to the  Patient  Representative

Other: \_\_\_\_\_

Comments:

**ADVANCE DIRECTIVES**

Healthcare Representative  Living Will

Do Not Resuscitate  Conservator Assigned

Full Code  Organ Donor

Limited Cardiopulmonary Resuscitation  Funeral Arrangements Made

Power of Attorney

Comments:

Pt/PCG provided with teaching materials and materials needed to enact a simple advance directive.

Power of Attorney:

(M1000) From which of the following Inpatient Facilities was the patient discharged within the past 14 days? (Mark all that apply.)

1 - Long-term nursing facility (NF)

2 - Skilled nursing facility (SNF/TCU)

3 - Short-stay acute hospital (IPPS)

4 - Long-term care hospital (LTCH)

5 - Inpatient rehabilitation hospital or unit (IRF)

6 - Psychiatric hospital or unit

7 - Other (specify): \_\_\_\_\_

NA - Patient was not discharged from an inpatient facility [ Go to M1021 ]

(M1005) Inpatient Discharge Date (most recent):

(mm/dd/yyyy)  UK - Unknown

PHYSICIAN: Date of last communication: Date of last visit:

Primary Reason for Home Health:

# Step 8 (cont)

- Complete homebound status and patient medical history.

HOMEBOUND REASON				
<b>Criteria One:</b> Describe what assistance devices the patient is dependent on (if any) and specifically why the patient condition warrants the special transportation or the assistance of another person or describe the condition that makes leaving home medically contraindicated.				
<input type="checkbox"/>	Patient is unable to safely ambulate on uneven surfaces and is at high risk for fall. Patient requires the use of _____ for safety.			
<input type="checkbox"/>	Patient has the following limitation _____ and requires the assistance of another person when leaving place of residence.			
<input type="checkbox"/>	Patient is homebound due to _____ limiting ability to ambulate safely and independently. and is currently dependent on _____			
<input type="checkbox"/>	Patient is homebound due to shortness of breath when ambulating greater than 20 feet, unsteady gait and requires _____ which results in making a taxing effort to leave their home.			
<input type="checkbox"/>	Patient has had several recent fall in the home/IF requiring PT to evaluate for the assistive devices for safety and gait training.			
<input type="checkbox"/>	Other - Homebound reason due to _____			
<b>Criteria Two:</b> Describe why the patient has abnormal ability to leave home and why leaving home must require a considerable and taxing effort.				
<input type="checkbox"/>	Patient is homebound due to dementia, poor safety awareness and high risk for fall.			
<input type="checkbox"/>	Patient is homebound due to recent hospitalization for _____ and is shortness of breath when walking short distance, unsteady gait and unable to ambulate without assistance of another person.			
<input type="checkbox"/>	Patient just returned from the hospital stay involving surgery _____ and had the following limitation: _____			
<input type="checkbox"/>	Patient is homebound due to recent fall secondary to _____			
<input type="checkbox"/>	Other - Homebound reason due to _____			
<b>Immunizations</b>				
<input type="checkbox"/> Influenza	<input type="checkbox"/> Tetanus			
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Shingles (Herpes Zoster) Vaccine			
<input type="checkbox"/> Other				
<b>Prior Hospitalizations</b>				
<input type="checkbox"/> No				
<input type="checkbox"/> Yes	Number of times _____			
Reason _____				
<b>Pertinent History and/or Previous Outcomes (note dates of onset, exacerbation when known)</b>				
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Fractures	<input type="checkbox"/> Cardiac	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Open Wound
<input type="checkbox"/> Cancer site: _____	<input type="checkbox"/> Infections	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Immunosuppressed	
<input type="checkbox"/> Respiratory				
<input type="checkbox"/> Surgeries				
<input type="checkbox"/> Other (specify) _____				

# Step 8 (cont)

- Enter diagnosis. May enter by description or by code.

**(M1021 / 1023) Diagnoses and Symptom Control:** List each diagnosis for which the patient is receiving home care in Column 1, and enter its ICD-10-CM code at the level of highest specificity in Column 2 (diagnosis codes only - no surgical or procedure codes allowed). Diagnoses are listed in the order that best reflects the seriousness of each condition and supports the disciplines and services provided. Rate the degree of symptom control for each condition in Column 2. ICD-10-CM sequencing requirements must be followed if multiple coding is indicated for any diagnoses.

**Code each row according to the following directions for each column:**

**Column 1:** Enter the description of the diagnosis. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

**Column 2:** Enter the ICD-10-CM code for the condition described in Column 1 - no surgical or procedure codes allowed. Codes must be entered at the level of highest specificity and ICD-10-CM coding rules and sequencing requirements must be followed. Note that external cause codes (ICD-10-CM codes beginning with V, W, X, or Y) may not be reported in M1021 (Primary Diagnosis) but may be reported in M1023 (Secondary Diagnoses). Also note that when a Z-code is reported in Column 2, the code for the underlying condition can often be entered in Column 2, as long as it is an active on-going condition impacting home health care.

Rate the degree of symptom control for the condition listed in Column 1. Do not assign a symptom control rating if the diagnosis code is a V, W, X, Y or Z-code. Choose one value that represents the degree of symptom control appropriate for each diagnosis using the following scale:

- 0 - Asymptomatic, no treatment needed at this time
- 1 - Symptoms well controlled with current therapy
- 2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
- 3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring
- 4 - Symptoms poorly controlled; history of re-hospitalizations

Note that the rating for symptom control in Column 2 should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide.

(M1021) § Primary Diagnosis & (M1023) § Other Diagnoses	
Column 1	Column 2
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided)	ICD-10-CM and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses
Description	ICD-10-CM / Symptom Control Rating
<p><b>#11 (M1021) § Primary Diagnosis</b></p> <p>a. <input type="text" value=""/> </p> <p style="text-align: right;"><input type="checkbox"/> Onset</p> <p style="text-align: center;">(mm/dd/yyyy)</p>	<p>V, W, X, Y codes NOT allowed</p> <p>a. <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p>
<p><b>#13 (M1023) § Other Diagnoses</b></p> <p>b. <input type="text" value=""/> </p> <p style="text-align: right;"><input type="checkbox"/> Onset</p> <p style="text-align: center;">(mm/dd/yyyy)</p>	<p>All ICD-10-CM codes allowed</p> <p>b. <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 </p>
<p>c. <input type="text" value=""/> </p> <p style="text-align: right;"><input type="checkbox"/> Onset</p> <p style="text-align: center;">(mm/dd/yyyy)</p>	<p>c. <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 </p>
<p>d. <input type="text" value=""/> </p> <p style="text-align: right;"><input type="checkbox"/> Onset</p> <p style="text-align: center;">(mm/dd/yyyy)</p>	<p>d. <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 </p>
<p>e. <input type="text" value=""/> </p> <p style="text-align: right;"><input type="checkbox"/> Onset</p> <p style="text-align: center;">(mm/dd/yyyy)</p>	<p>e. <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 </p>
<p>f. <input type="text" value=""/> </p> <p style="text-align: right;"><input type="checkbox"/> Onset</p> <p style="text-align: center;">(mm/dd/yyyy)</p>	<p>f. <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 </p>

# Step 8 (cont)

- Continue to complete all "(MXXXX) questions

COP RISK FACTORS / HOSPITAL ADMISSION / EMERGENCY ROOM	
<input type="checkbox"/> Not Applicable Risk factors identified and followed up on by: <input type="checkbox"/> Training <input type="checkbox"/> Discussion <input type="checkbox"/> Education Literature given to: <input type="checkbox"/> Patient <input type="checkbox"/> Representative <input type="checkbox"/> Caregiver <input type="checkbox"/> Family <input type="checkbox"/> Other: _____ List identified risk factors the patient has related to an unplanned hospital admission or an emergency department visit: _____ _____ _____ Comments: <input type="checkbox"/> _____ _____ _____	
HOSPITALIZATION RISK ASSESSMENT	
Purpose: Screening tool to identify those at risk for hospitalization.	
Prior pattern: Check all that apply.	
<input type="checkbox"/> > 1 Hospitalizations or ER visits in the past 12 months (M1033)	<input type="checkbox"/> History of falls (M1033 and M1910)
Chronic conditions: Check all that apply (M1021/1023)	
<input type="checkbox"/> HF	<input type="checkbox"/> Chronic skin ulcers (Wound consult if indicated for any wounds)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> COPD	
Risk factors: Check all that apply.	
<input type="checkbox"/> Discharged from hospital or skilled nursing facility (M1000)	<input type="checkbox"/> Help with managing medications needed (M2020) ★
<input type="checkbox"/> More than 2 secondary diagnoses (M1023)	<input type="checkbox"/> Non-compliance with medication regimen ★★
<input type="checkbox"/> Low socioeconomic status or financial concerns ★	<input type="checkbox"/> Confusion (M1710) ★★
<input type="checkbox"/> Lives alone (M1100) ▶	<input type="checkbox"/> Pressure ulcer (M1306) ★
<input type="checkbox"/> Inadequate support network (M1100) ◆	<input type="checkbox"/> Stasis ulcer (M1330) ★
<input type="checkbox"/> ADL assistance needed (M2102) ▶	<input type="checkbox"/> Overall Poor Status/Prognosis ■
<input type="checkbox"/> Home safety risks ▶ ◆	<input type="checkbox"/> Low literacy level ◆
<input type="checkbox"/> Dyspnea (M1400) ▶ ★	<input type="checkbox"/> Depression (M1730) ◆
Total number of checked boxes is _____	
<input type="checkbox"/> Consider Therapy referral (PT, OT, ST)	<input type="checkbox"/> Consider MSW referral
<input type="checkbox"/> Consider Hospice referral	<input type="checkbox"/> Consider RN referral, if not ordered
Your agency may want to select a threshold score to target patients at high risk. (For example: 5 or greater risk factors may indicate that the patient is at risk for hospitalization. Note: This number is for convenience only and has not been tested or validated. The agency may modify the score based upon the needs of their patient population.)	
Carry out patient specific interventions as appropriate/ordered, if patient is at risk for hospitalization:	
Referrals: <input type="checkbox"/> SW <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> MSW <input type="checkbox"/> HHA <input type="checkbox"/> Dietary Consultant <input type="checkbox"/> Other: _____	<input type="checkbox"/> Medication Management <input type="checkbox"/> Medication Reconciliation <input type="checkbox"/> Assess patient's: knowledge, ability, resources and adherence <input type="checkbox"/> Education
<input type="checkbox"/> Hospice/Palliative Referral	<input type="checkbox"/> Phone Monitoring
<input type="checkbox"/> Individualized Patient Emergency Care Plan	<input type="checkbox"/> Front-loading Visits
<input type="checkbox"/> Fall Prevention Program	<input type="checkbox"/> Telemonitoring
<input type="checkbox"/> Patient/family education Enrollment into a disease management program (specify): _____	<input type="checkbox"/> Immunizations <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Care Coordination (physicians, hospitals, nursing homes ...)
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____
Notify the following, as appropriate, if patient is at risk for hospitalization:	
<input type="checkbox"/> Physician Correlate for physician notification of specific parameters/ interventions	<input type="checkbox"/> Interdisciplinary Team: _____
<input type="checkbox"/> Patient/family/caregiver	<input type="checkbox"/> On Call Staff
<input type="checkbox"/> Agency Case Manager	<input type="checkbox"/> Payer: (e.g. Managed Care Organizations)
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____

Clinician Name: \_\_\_\_\_

(M1028) Active Diagnoses - Comorbidities and Co-existing Conditions - Check all that apply  
See OASIS Guidance Manual for a complete list of relevant ICD-10 codes. (1)

1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)  
 Yes  No  Not assessed (no information)

2 - Diabetes Mellitus (DM)  
 Yes  No  Not assessed (no information)

3 - None of the above  
 Yes  No  Not assessed (no information)

(M1030) Therapies the patient receives at home. (Mark all that apply.) (1)

1 - Intravenous or infusion therapy (excludes TPN)  
 2 - Parenteral nutrition (TPN or lipids)  
 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)  
 4 - None of the above

(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.) (1)

1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)  
 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months  
 3 - Multiple hospitalizations (2 or more) in the past 6 months  
 4 - Multiple emergency department visits (2 or more) in the past 6 months  
 5 - Decline in mental, emotional, or behavioral status in the past 3 months  
 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months  
 7 - Currently taking 5 or more medications  
 8 - Currently reports exhaustion  
 9 - Other risk(s) not listed in 1 - 8  
 10 - None of the above

Complete hospitalization risk

Height and weight are mandatory  
Complete Safety Measures and Prognosis

Clinician Name: \_\_\_\_\_

(M1060) Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up (1)

a. Height (in inches). Record most recent height measure since the most recent SOC/ROC  
 \_\_\_\_\_ inches

b. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.)  
 \_\_\_\_\_ pounds

BMI \_\_\_\_\_

#15 SAFETY MEASURES

1 - Bleeding precautions  4 - Fall precautions  7 - Elevate head of bed  10 - Lock w/c with transfers  
 2 - O2 precautions  5 - Aspiration precautions  8 - 24 hr. supervision  11 - Infection control measures  
 3 - Seizure precautions  6 - Siderails up  9 - Clear pathways  12 - Walker/cane  
 13 - Other: \_\_\_\_\_


#20 PROGNOSIS

1 - Poor  2 - Guarded  3 - Fair  4 - Good  5 - Excellent

# Step 8 (cont)

## Living arrangement and PCG information needed

### LIVING ARRANGEMENTS

**(M1100) Patient Living Situation:** Which of the following best describes the patient's residential circumstance and availability of assistance? **(Check one box only.)** 

Living Arrangement	Availability of Assistance				
	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	<input type="checkbox"/> 01	<input type="checkbox"/> 02	<input type="checkbox"/> 03	<input type="checkbox"/> 04	<input type="checkbox"/> 05
b. Patient lives with other person(s) in the home	<input type="checkbox"/> 06	<input type="checkbox"/> 07	<input type="checkbox"/> 08	<input type="checkbox"/> 09	<input type="checkbox"/> 10
c. Patient lives in congregate situation (for example, assisted living, residential care home)	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> 13	<input type="checkbox"/> 14	<input type="checkbox"/> 15

Name of facility \_\_\_\_\_ Phone \_\_\_\_\_

Primary Caregiver \_\_\_\_\_

Phone Number \_\_\_\_\_ Relationship \_\_\_\_\_

List name/relationship of other caregiver(s):

Name: \_\_\_\_\_ Contact #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Contact #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Able to safely care for patient  Yes  No

### HOME SAFETY ASSESSMENT

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Architectural Barriers                    | <input type="checkbox"/> No fire extinguisher                             | <input type="checkbox"/> No emergency exit plan          |
| <input type="checkbox"/> Medications are properly stored           | <input type="checkbox"/> Inadequate electricity / cooling / heating       | <input type="checkbox"/> Rodent / insect infestation     |
| <input type="checkbox"/> No telephone                              | <input type="checkbox"/> Inadequate supply of water                       | <input type="checkbox"/> Unsafe electrical wiring        |
| <input type="checkbox"/> Cluttered surroundings / Obstructed Paths | <input type="checkbox"/> Inadequate sanitation / plumbing                 | <input type="checkbox"/> Nonworking stove / refrigerator |
| <input type="checkbox"/> Inadequate railing / grab bars            | <input type="checkbox"/> Inadequate smoke detectors on all levels of home | <input type="checkbox"/> Exposed flammables              |
| <input type="checkbox"/> Unsafe oxygen use / storage               | <input type="checkbox"/> Unsafe storage of equipments                     | <input type="checkbox"/> Inadequate Lighting             |
| <input type="checkbox"/> Other: _____                              |   |  |



# Step 8 (cont)

Complete the sensory status, make sure responses are based on both subjective and objective observation.

M1242 Question asks if and how often does the pain interfere with activities. NOT whether there is pain or not.

Complete the "PAIN" portion even if response to M1242 is "1-4"

Don't forget to indicate if the current pain measures is/are adequate

**SENSORY STATUS**

(M1200) Vision (with corrective lenses if the patient usually wears them):  0 Normal vision: sees adequately in most situations; can see medication labels, newspaper.  
 1 Partially impaired: cannot see medication labels or newspaper, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.  
 2 Severely impaired: cannot locate objects without hearing or touching them, or patient nonresponsive.

**EYES**  Glasses  Contact Lenses  Artificial Eye  Eye and Vision Conditions:   No Problems Identified

Comments:

**EARS**  Hearing Impairment  Signs/Symptoms  L  R  Both  Deaf  Hearing Aid   No Problems Identified

Comments:

**NOSE**  Congestion  Epistaxis  Loss of smell  Sinus problem  No Problems Identified

Comments:

**THROAT AND MOUTH**  Dysphagia  Gingivitis  Dentures:  Upper  Lower  Hoarseness  Ulcerations  Lesions  Toothache  Sore throat  Masses/Tumors  Partial  No Problems Identified

Comments:

(M1242) Frequency of Pain interfering with patient's activity or movement:  1  
 0 Patient has no pain  
 1 Patient has pain that does not interfere with activity or movement  
 2 Less often than daily  
 3 Often, but not constantly  
 4 All of the time

**PAIN**

Patient has no pain

Wong-Baker FACES Pain Rating Scale

0 NO HURT 1 HURTS LITTLE BIT 2 HURTS LITTLE MORE 3 HURTS EVEN MORE 4 HURTS WHOLE LOT 5 HURTS WORST 10 HURTS WORST

From Wong B.L., Henderson-Davis M., White D., Wilkinson M.L., Schwartz P.: *Essentials of Pediatric Nursing*, ed. 6. St. Louis, 2001, p. 1381. Copyrighted by Mosby, Inc.

Pain intensity:  Unknown due to self assessment  Patient unable to communicate  Collected using:  Other:  FACES Scale  Numerical Rating Scale (0-10)

Implications:

Explain the impact of patient's pain on his/her functional/activity level:

Pain Assessment	Site 1	Site 2	Site 3
Location			
Onset			
Present level (0-10)			
Worst pain gets (0-10)			
Best pain gets (0-10)			
Pain description			

Frequency/Duration:  Occasional  Intermittent  Acute Sudden  Continuous  Chronic Long Lasting  
 Other:

Aggravated with:  Movement  Position  Immobility  Ambulation  
 Other:

Relieved with:  Rest  Heat  Repositioning  Ice  Medication  Massage  Activity  
 Other:

Pain pattern (Indicate if any):

Need for prescription medication:  None  Less than daily  2-3 times daily  Greater than 3 times daily  
Pain radiates?  Occasionally  Continuously  Intermittently

Current pain control medication:  Adequate  Inadequate

Comments:

Care Plan Implications:

Physician notified by:  Patient  Staff

Outcome:

# Step 8 (cont)

Complete the endocrine/hematology portion if applies to the patient.

Complete the portion even if we are not treating the patient for any endocrine or hematology ailments.

Choose next when done

INTEGUMENTARY STATUS PRESSURE SORE RISK ASSESSMENT SCALE				
	≤ 9 : Severe Risk	10 - 12 : High Risk	13 - 14 : Moderate Risk	15 - 18 : Mild Risk
<b>SENSORY PERCEPTION</b> Ability to respond meaningfully to pressure-related discomfort	<b>1. COMPLETELY LIMITED</b> Unresponsive (does not moan, flinch or grasp) to painful stimuli, due to diminished level of consciousness or sedation, OR limited ability to feel pain over most of the body surface.	<b>2. VERY LIMITED</b> Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, OR has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	<b>3. SLIGHTLY LIMITED</b> Responds only to verbal commands but cannot always communicate discomfort or need to be turned, OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	<b>4. NO IMPAIRMENT</b> Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
<b>MOISTURE</b> Degree to which skin is exposed to moisture.	<b>1. CONSTANTLY MOIST</b> Skin is kept moist almost constantly by perspiration, urine etc. Dampness is detected every time patient is moved or turned.	<b>2. OFTEN MOIST</b> Skin is often but not always moist. Linen must be changed at least once a shift.	<b>3. OCCASIONALLY MOIST</b> Skin is occasionally moist, requiring an extra linen change approximately once a day.	<b>4. BARELY MOIST</b> Skin is usually dry; linen only requires changing at routine intervals.
<b>ACTIVITY</b> Degree of physical activity.	<b>1. BEDFAST</b> Confined to bed.	<b>2. CHAIRFAST</b> Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	<b>3. WALKS OCCASIONALLY</b> Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	<b>4. WALKS FREQUENTLY</b> Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.
<b>MOBILITY</b> Ability to change and control body position.	<b>1. COMPLETELY IMMOBILE</b> Does not make even slight changes in body or extremity position without assistance.	<b>2. VERY LIMITED</b> Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	<b>3. SLIGHTLY LIMITED</b> Makes frequent though slight changes in body or extremity position independently.	<b>4. NO LIMITATIONS</b> Makes major and frequent changes in position without assistance.
<b>NUTRITION</b> Usual food intake pattern.	<b>1. VERY POOR</b> Never eats a complete meal. Rarely eats more than 1/2 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement. OR is NPO and/or maintained on clear liquids or N2 for more than 5 days.	<b>2. PROBABLY INADEQUATE</b> Rarely eats a complete meal and generally eats only about 1/2 of food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	<b>3. ADEQUATE</b> Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally refuses a meal, but will eventually take a supplement if offered, OR is on tube feeding or TPN regimen, which probably meets most of nutritional needs.	<b>4. EXCELLENT</b> Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.
<b>RICTION AND SHEAR</b>	<b>1. PROBLEM</b> Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	<b>2. POTENTIAL PROBLEM</b> Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	<b>3. NO APPARENT PROBLEM</b> Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.	
<b>TOTAL SCORE:</b>				
<input type="checkbox"/> No Problems Identified <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Ash <input type="checkbox"/> Dry <input type="checkbox"/> Scaling <input type="checkbox"/> Redness <input type="checkbox"/> Bruises <input type="checkbox"/> Erythema <input type="checkbox"/> Pallor <input type="checkbox"/> Jaundice Comments:				

ENDOCRINE/HEMATOLOGY	
<input type="checkbox"/> No Problems Identified <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II    Date of onset: _____ <input type="checkbox"/> Diet/Oral control (specify) _____ <input type="checkbox"/> Insulin dose/frequency (specify) _____ On insulin since _____ Administered by: <input type="checkbox"/> Self <input type="checkbox"/> Caregiver <input type="checkbox"/> Nurse <input type="checkbox"/> Other: _____ <input type="checkbox"/> Disease Management Problems _____	
<input type="checkbox"/> Hyperglycemia: <input type="checkbox"/> Glycosuria <input type="checkbox"/> Polyuria <input type="checkbox"/> Polydipsia <input type="checkbox"/> Hypoglycemia: <input type="checkbox"/> Sweats <input type="checkbox"/> Polyphagia <input type="checkbox"/> Weak <input type="checkbox"/> Faint <input type="checkbox"/> Stupor <input type="checkbox"/> Fatigue <input type="checkbox"/> Intolerance to heat/cold	
<input type="checkbox"/> Enlarged thyroid <input type="checkbox"/> Other: _____	
<input type="checkbox"/> Anemia (specify if known) <input type="checkbox"/> GI <input type="checkbox"/> GU <input type="checkbox"/> GYN <input type="checkbox"/> Unknown <input type="checkbox"/> Hemophilia <input type="checkbox"/> Secondary bleed: <input type="checkbox"/> Other: _____	
DIABETIC FOOT EXAM	
<input type="checkbox"/> Not Applicable Diabetic foot exam done by: <input type="checkbox"/> Patient <input type="checkbox"/> RN/PT <input type="checkbox"/> Caregiver (name): _____ <input type="checkbox"/> Other: _____ Frequency: _____ Pedal pulses: <input type="checkbox"/> Present <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Absent <input type="checkbox"/> R <input type="checkbox"/> L Comments:	
<input type="checkbox"/> Loss of sense of: <input type="checkbox"/> Warm <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Cold <input type="checkbox"/> R <input type="checkbox"/> L Comments:	
<input type="checkbox"/> Neuropathy <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Burning <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Tingling <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Absent <input type="checkbox"/> R <input type="checkbox"/> L <input type="checkbox"/> Leg hair: <input type="checkbox"/> Present <input type="checkbox"/> R <input type="checkbox"/> L	
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Start completing the integumentary status page.

# Step 8 (cont)

- Continue completing the integumentary section.

<p><b>Definitions.</b></p> <p><b>Newly epithelialized:</b></p> <ul style="list-style-type: none"> <li>Wound bed completely covered with new epithelium; and</li> <li>no exudate; and</li> <li>no avascular tissue (eschar and/or slough); and</li> <li>no signs or symptoms of infection.</li> </ul> <p><b>Fully granulating:</b></p> <ul style="list-style-type: none"> <li>Wound bed filled with granulation tissue to the level of the surrounding skin; and</li> <li>no dead space; and</li> <li>no avascular tissue (eschar and/or slough); and</li> <li>no signs or symptoms of infection; and</li> <li>wound edges are open.</li> </ul> <p><b>Early/partial granulation:</b></p> <ul style="list-style-type: none"> <li>Wound bed covered with <math>\geq</math> 25% of granulation tissue; and</li> <li>wound bed covered with <math>&lt;</math> 25% of avascular tissue (eschar and/or slough); and</li> <li>no signs or symptoms of infection; and</li> <li>wound edges are open.</li> </ul>	<p><b>Not healing:</b></p> <ul style="list-style-type: none"> <li>Wound with <math>\geq</math> 25% avascular tissue (eschar and/or slough); or</li> <li>signs/symptoms of infection; or</li> <li>clean but nongranulating wound bed; or</li> <li>closed/hyperkeratotic wound edges; or</li> <li>persistent failure to improve despite appropriate and comprehensive wound management.</li> </ul> <p><b>Unhealed:</b> The absence of the skin's original integrity.</p> <p><b>Non-epithelialized:</b> The absence of the regeneration of the epidermis across a wound surface.</p> <p><b>Pressure Ulcer:</b> A <b>pressure ulcer</b> is 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. A number of contributing or confounding factors also are associated with pressure ulcers; the significance of these factors is yet to be elucidated.</p> <p><i>This guidance applies to surgical wounds closed by either primary intention (specifically approximated incisions) or secondary intention (specifically, open surgical wounds).</i></p>
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**(M1306)** Does this patient have at least one **Unhealed Pressure Ulcer/Injury at Stage 2 or Higher** or designated as Unstageable? [Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries]  1

0 - No [ Go to M1322 ]

1 - Yes

<b>(M1311)</b> $\S$ Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage <input type="checkbox"/> 1	Enter Number
<b>A1. Stage 2:</b> Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. Number of Stage 2 pressure ulcers	_____
<b>B1. Stage 3:</b> Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Number of Stage 3 pressure ulcers	_____
<b>C1. Stage 4:</b> Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. Number of Stage 4 pressure ulcers	_____
<b>D1. Unstageable: Non-removable dressing/device:</b> Known but not stageable due to non-removable dressing/device Number of unstageable pressure ulcers/injuries due to non-removable dressing/device	_____
<b>E1. Unstageable: Slough and/or eschar:</b> Known but not stageable due to coverage of wound bed by slough and/or eschar Number of unstageable pressure ulcers/injuries due to coverage of wound bed by slough and/or eschar	_____
<b>F1. Unstageable: Deep tissue injury</b> Number of unstageable pressure injuries presenting as deep tissue injury	_____

**Pressure Ulcer Stages (NPUAP):**

**Category/Stage I: Non-blanchable erythema.** Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage I may be difficult to detect in individuals with dark skin tones. May indicate "at risk" individuals (a heralding sign of risk).

**Category/Stage II: Partial thickness skin loss.** Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising." This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation. "Bruising indicates suspected deep tissue injury.

**Category/Stage III: Full thickness skin loss.** Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/Stage III pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage III pressure ulcers. Bone/tendon is not visible or directly palpable.

**Category/Stage IV: Full thickness tissue loss.** Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage IV pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/Stage IV ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.

**Unstageable: Depth unknown.** Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural (biological) cover and should not be removed.

**Suspected Deep Tissue Injury: Depth unknown.** Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid exposing additional layers of tissue even with optimal treatment.

**(M1322)** Current Number of Stage 1 Pressure Injuries: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.  1

0  1  2  3  4 or more

**(M1324)**  $\S$  Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable: [Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.]  1

1 - Stage 1

2 - Stage 2

3 - Stage 3

4 - Stage 4

NA - Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries

**(M1330)** Does this patient have a Stasis Ulcer?  1

0 - No [ Go to M1340 ]

1 - Yes, patient has BOTH observable and unobservable stasis ulcers

2 - Yes, patient has observable stasis ulcers ONLY

3 - Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) [ Go to M1340 ]

**(M1332)** Current Number of Stasis Ulcer(s) that are Observable:  1

1 - One

2 - Two

3 - Three

4 - Four or more

**(M1334)**  $\S$  Status of Most Problematic Stasis Ulcer that is Observable:  1

1 - Fully granulating

2 - Early / partial granulation

3 - Not healing

**(M1340)** Does this patient have a Surgical Wound?  1

0 - No [ Go to M1400 ]

1 - Yes, patient has at least one observable surgical wound

2 - Surgical wound known but not observable due to non-removable dressing/device [ Go to M1400 ]

**(M1342)**  $\S$  Status of Most Problematic Surgical Wound that is Observable:  1

0 - Newly epithelialized

1 - Fully granulating

2 - Early / partial granulation

3 - Not healing

# Step 8 (cont)

Complete the wound information thoroughly

Indicate why or why can't the Pt/PCG do the wound care but also mention potential to learn wound care

Indicate if the patient is going to a wound care clinic, has WoundTech seeing the patient and/or if SN is not needed for wound care under comments.

Signature Pad ICD-10-CM Side by side compare View ICD-10 V

Sections: INTEGUMENTARY STATUS << Previous Next >> Item: Search Zoom: Normal Exclusive Lock Activity Logs

[W134Z] Status of most problematic surgical wound that is observable:

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early / partial granulation
- 3 - Not healing

Not Applicable

WOUND	#1	#2	#3	#4
Type of Wound				
Location				
Wound Status				
Wound Measurements (L x W x D in cm)				
Pressure Injury Stage (Stage 1-4 per policy)				
Tunneling				
Undermining				
Drainage				
Amount of Drainage				
Odor				
Tissue of Wound Base				
Tissue of Surrounding Wound				
Level of Pain				
Comments				
Wound Treatment Procedure				
Onset Date				

Pt/CG willing to do wound care?  No  Yes  NA  
If No, explain why

**WOUND CARE:**  
Wound care done during this visit:  Yes  No  
Wound location: \_\_\_\_\_  
Soiled dressing removed:  Yes  No  
If yes, by:  Patient  Caregiver (name): \_\_\_\_\_  
 Carestaff  Other: \_\_\_\_\_  
Wound Care (indicate materials used):  
 Cleaned with: \_\_\_\_\_  
 Irrigated with: \_\_\_\_\_  
 Packed with: \_\_\_\_\_  
 Applied dressing: \_\_\_\_\_  
Technique:  Sterile  Clean  
Procedure tolerated well by patient:  Yes  No  
Comments: \_\_\_\_\_

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# Step 8 (cont)

Continue to answer the Respiratory Status

VITAL SIGNS are mandatory

Complete the CARDIOPULMONARY section

Please be consistent with your responses

Note the new COVID-19 screening question when asked about travel information

COVID-19 questioning mandate answering the presence of cough question

Please indicate on the bottom portion on other pertinent responses to COVID-19 questions.

The screenshot shows a medical assessment form with the following sections and fields:

- Section:** RESPIRATORY STATUS
- RESPIRATORY STATUS (M1400):** When is the patient dyspneic or noticeably Short of Breath? (1)
  - 0 - Patient is not short of breath
  - 1 - When walking more than 20 feet, climbing stairs
  - 2 - With moderate exertion (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)
  - 3 - With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation
  - 4 - At rest (during day or night)
- VITAL SIGNS:**
  - Blood Pressure: \_\_\_/\_\_\_ R  L
  - Temperature: \_\_\_
  - Pulse:  Apical \_\_\_  Radial \_\_\_
  - Respirations: \_\_\_
  - O2 saturation: \_\_\_% O2 @ \_\_\_ LPM via \_\_\_
  - Any recent travels?  Yes  No
  - Weight: \_\_\_
  - Reported Weight Changes:  Gain  Loss \_\_\_ lb. X \_\_\_
  - Height: \_\_\_
  - FBS: \_\_\_ RBS: \_\_\_ Blood Sugar Ranges: \_\_\_
  - Intermittent  Continuous
- When?** \_\_\_\_\_
- Where?** \_\_\_\_\_
- CARDIOPULMONARY:**
  - No Problems Identified
  - Breath Sounds:**
    - Anterior: Right: \_\_\_ Left: \_\_\_
    - Posterior: Right: Upper \_\_\_ Left: Lower \_\_\_
    - Right: \_\_\_ Left: \_\_\_
  - Deferred
  - Accessory muscles used
  - Trach size/type: \_\_\_\_\_
  - Managed by:  Self  Caregiver  Family  RN  Other: \_\_\_\_\_
  - Cough:**  No  Yes:  Productive  Non-productive
  - Describe: \_\_\_\_\_
  - Dyspnea:**  Rest  During ADL's
  - Comments:  \_\_\_\_\_
  - Is positioning needed to improve breathing?  No  Yes
  - If Yes, describe: \_\_\_\_\_
  - Tuberculosis Risk Factors:**  Yes  No  Immigrated Within Last 5 Years  Known Exposure
  - HIV Positive  Other (specify): \_\_\_\_\_
  - History of:**  Asthma  Bronchitis  Pneumonia  Pleurisy  Emphysema
  - Other: \_\_\_\_\_
  - Heart Sounds
  - Chest Pain:**  Ache  Radiating  Angular  Vise-like  Dull
  - Sharp  Substernal  Postural  Localized
  - Frequency/duration: \_\_\_\_\_
  - Associated with:  Shortness of breath  Activity  Sweats  Palpitations  Fatigue
  - Edema
  - Comments:  \_\_\_\_\_

# Step 8 (cont)

**ELIMINATION STATUS**

**[M1600]** Has this patient been treated for a Urinary Tract Infection in the past 14 days?  0 - No  1 - Yes  NA - Patient on prophylactic treatment  UK - Unknown

**[M1610]** Urinary Incontinence or Urinary Catheter Presence:  0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage)  1 - Patient is incontinent  2 - Patient requires a urinary catheter (specifically: external, indwelling, intermittent, or suprapubic)

**GENITOURINARY**

No Problems Identified

Urine Color:  Amber  Blood-tinged  Yellow/Straw  Other:  Brown/Gray

Consistency:  Clear  Sedimentary  Cloudy  Mucousy

Odor:  Normal  Mild/Strong Odor

Urgency:  Frequency  Hesitancy  Burning  Pain

Nocturia:  Hematuria  Oliguria  Anuria  Diapers

Incontinence:  Urostomy site (specify): \_\_\_\_\_

Ureterostomy  Nephrostomy  Ileal conduit

Urinary Catheter

Type:  Foley; Date Inserted: \_\_\_\_\_ with \_\_\_\_\_ Last Change: \_\_\_\_\_ French

Inflated balloon with: \_\_\_\_\_ ml  Without Difficulty  Suprapubic

Irrigation solution: Type: \_\_\_\_\_ Amount: \_\_\_\_\_ ml Frequency: \_\_\_\_\_ Patient tolerated procedure well:  Yes  No

Others: \_\_\_\_\_

Comments: \_\_\_\_\_

**GYNECO - URINARY**

No Problems Identified

Breast self-exam. frequency: \_\_\_\_\_

Lesions:  Blisters  Masses  Cysts  Inflammation

Surgical alteration:  Rectal Bleeding  Hemorrhoids  Hx Hysterectomy

Describe drainage / discharge: \_\_\_\_\_

Discharge:  Right  Left Date: \_\_\_\_\_

Vasectomy:  Right  Left Date: \_\_\_\_\_

Menopause Date of Last PAP: \_\_\_\_\_ Result: \_\_\_\_\_

Prostate Problem:  BPH  TURP Date: \_\_\_\_\_

Self-testicular exam Frequency: \_\_\_\_\_

Dialysis: Type:  Hemodialysis  Peritoneal  AV fistula (shunt)  Non-palpable thrill/no bruit

Catheter:  Catheter s/s of infection  Dialysis Treatment Schedule \_\_\_\_\_

Others: \_\_\_\_\_

**[M1620]** Bowel Incontinence Frequency:  0 - Very rarely or never has bowel incontinence  1 - Less than once weekly  2 - One to three times weekly  3 - Four to six times weekly  4 - On a daily basis  5 - More often than once daily  NA - Patient has ostomy for bowel elimination  UK - Unknown

**[M1630]** Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay; or b) necessitated a change in medical or treatment regimen?  0 - Patient does not have an ostomy for bowel elimination.  1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.  2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

Complete the GI section and Nutritional sections.

Mention if Patient is on dialysis and which days they go to dialysis center

Note Last Bowel Movement and frequency of elimination

Indicate appropriate diet

Complete enteral feedings if present; even if we are not providing enteral feeding care.

**GASTROINTESTINAL**

No Problems Identified

Bowel Sounds:  None  Normal  Hypo  Hyperactive  \_\_\_\_\_ quadrants

Others: \_\_\_\_\_

Date of Last Bowel Movement: \_\_\_\_\_ Frequency of BM: \_\_\_\_\_

Nausea:  Vomiting  Tenderness  Reflux  Constipation  Impaction

Heartburn:  Pain  Diarrhea  Indigestion  Ascites

Retention:  Hard  Soft

Abdominal Girth: \_\_\_\_\_ cm.

Bleeding: \_\_\_\_\_

Bowel program/regimen: \_\_\_\_\_

Enema/Laxative used: \_\_\_\_\_

Incontinence (describe): \_\_\_\_\_

Others/Diapers: \_\_\_\_\_

Ostomy care managed by:  Self  Caregiver  Other: \_\_\_\_\_

Describe skin around stoma for ileostomy/Colostomy site: \_\_\_\_\_

Comments: \_\_\_\_\_

**NUTRITION**

No Problems Identified

Appetite:  Good  Fair  Poor

Heartburn:  Anorexic  Sore throat  Dysphagia  Difficulty chewing

TPN or Lipids:  Poor hydration  Ill-fitting dentures

Nausea/Vomiting: Frequency \_\_\_\_\_ Amount \_\_\_\_\_

Comments: \_\_\_\_\_

**#16 Nutritional Requirements**

NPO  No Added Salt  Low Salt  Low Fat  Low Cholesterol  No Concentrated Sweets

Controlled Carbohydrates  Regular  Fluid Restriction: \_\_\_\_\_

Other: \_\_\_\_\_

Directions: Check each area with "yes" to assessment, then total score to determine additional risk.

	YES
Has an illness or condition that changed the kind and/or amount of food eaten.	<input type="checkbox"/> 2
Eats fewer than 2 meals per day.	<input type="checkbox"/> 3
Eats few fruits, vegetables or milk products.	<input type="checkbox"/> 2
Has 3 or more drinks of beer, liquor or wine almost every day.	<input type="checkbox"/> 2
Has tooth or mouth problems that make it hard to eat.	<input type="checkbox"/> 2
Does not always have enough money to buy the food needed.	<input type="checkbox"/> 4
Eats alone most of the time.	<input type="checkbox"/> 1
Takes 3 or more different prescribed or over-the-counter drugs a day.	<input type="checkbox"/> 2
Without wanting to, has lost or gained 10 pounds in the last 6 months.	<input type="checkbox"/> 2
Not always physically able to shop, cook and/or feed self.	<input type="checkbox"/> 2
<b>TOTAL</b>	<input type="checkbox"/> _____

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**INTERPRETATION**

0 - 2 Good. As appropriate reassess and/or provide information based on situation.

3 - 5 Moderate risk. Educate, refer, monitor and reevaluate based on patient situation and organization policy.

6 or more High Risk. Coordinate with physician, dietician, social service professional or nurse about how to improve nutritional health. Reassess nutritional status and educate based on plan of care.

Describe at risk intervention and plan: \_\_\_\_\_

**ENTERAL FEEDINGS**

Not Applicable

Type of Feeding:  Nasogastric  Jejunostomy  Gastrostomy/PEG  Other: \_\_\_\_\_

Date of Placement: \_\_\_\_\_

Pump Type:  Continuous Rate: \_\_\_\_\_

Bolus  Feeding: Type/Amt. \_\_\_\_\_

Flush Protocol: \_\_\_\_\_

Dressing Care (specify): \_\_\_\_\_

Performed by:  SN  Caregiver  RN  Other: \_\_\_\_\_

Comments: \_\_\_\_\_

# Step 8 (cont)

## NEURO / EMOTIONAL / BEHAVIORAL STATUS

- (M1700) Cognitive Functioning:** Patient's current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands. **1**
- 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
  - 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
  - 2 - Requires assistance and some direction in specific situations (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility.
  - 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
  - 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

- (M1710) When Confused (Reported or Observed Within the Last 14 Days):** **1**

- 0 - Never
- 1 - In new or complex situations only
- 2 - On awakening or at night only
- 3 - During the day and evening, but not constantly
- 4 - Constantly
- NA - Patient nonresponsive

- (M1720) When Anxious (Reported or Observed Within the Last 14 Days):** **1**

- 0 - None of the time
- 1 - Less often than daily
- 2 - Daily, but not constantly
- 3 - All of the time
- NA - Patient nonresponsive

- (M1730) Depression Screening:** Has the patient been screened for depression, using a standardized, validated depression screening tool? **1**

- 0 - No
- 1 - Yes, patient was screened using the PHQ-2@\* scale.

Instructions for this two-question tool: Ask patient:  
"Over the last two weeks, how often have you been bothered by any of the following problems?"

PHQ-2@*	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 - 11 days	Nearly every day 12 - 14 days	N/A Unable to respond
a) Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA
b) Feeling down, depressed, or hopeless?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> NA

- 2 - Yes, patient was screened with a different standardized, validated assessment and the patient meets criteria for further evaluation for depression.
- 3 - Yes, patient was screened with a different standardized, validated assessment and the patient does not meet criteria for further evaluation for depression.

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- (M1740) Cognitive, behavioral, and psychiatric symptoms** that are demonstrated at least once a week (Reported or Observed): (Mark all that apply) **1**

- 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- 4 - Physical aggression: aggressive or combative to self and others (for example, hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- 5 - Disruptive, infantile, or socially inappropriate behavior (excludes verbal actions)
- 6 - Delusional, hallucinatory, or paranoid behavior
- 7 - None of the above behaviors demonstrated

- (M1745) Frequency of Disruptive Behavior Symptoms (Reported or Observed):** Any physical, verbal, or other disruptive / dangerous symptoms that are injurious to self or others or jeopardize personal safety. **1**

- 0 - Never
- 1 - Less than once a month
- 2 - Once a month
- 3 - Several times each month
- 4 - Several times a week
- 5 - At least daily

Complete NEURO section

If patient has indicator of being slightly none compliant, make sure to check # 2 in M1740 and indicate "Inappropriate follow-through in past

Complete "COP" sections

**NEUROLOGICAL**

No Problems Identified

PERRLA

Hand Grips: Oriented to:  Person  Place  Time specify,  Strong  Weak  Equal  Unequal  Right  Left

Pupils: Location  Receptive  Expressive  Frequency

Aphasia:  Receptive  Expressive

Motor Change:  Fine  Gross  Site

Paralysis/Hemiplegia:  Right  Left  Dominant  Non-Dominant

Paralysis/Monoplegia:  RUE  RLE  LUE  LLE

Paresis/Weakness:  RUE  RLE  LUE  LLE

Tremors:  Fine  Gross  Paralysis Site

Hallucinations:  Auditory  Visual

Hallucinogenic Drug Used: Dose/Frequency: \_\_\_\_\_

Others: \_\_\_\_\_

Comments: \_\_\_\_\_

---

**COP** **PSYCHOSOCIAL**

Educational level \_\_\_\_\_ Unable to  read  write

Primary Language \_\_\_\_\_

Barriers:  Language  Needs interpreter  Physical  Psychosocial  Functional

Learning:  Mental  Discouraged  Withdrawn  Flat affect  Functional

Emotions reported:  Angry  Discouraged  Depressed:  Recent  Long term  Difficulty coping

Treatment:  Evidence of abuse/neglect/exploitation:  Potential  Actual  Verbal/Emotional  Physical  Financial

Unable to cope with altered health status, patient:  Lacks motivation  Has unrealistic expectations  Denies problems  Unable to recognize problems

Sleep/Rest:  Adequate  Inadequate No. of hours slept per night: \_\_\_\_\_

Comments: \_\_\_\_\_

Spiritual / Cultural implications that impact care

Comments: \_\_\_\_\_

Spiritual resource \_\_\_\_\_

Contact No. \_\_\_\_\_

Inappropriate responses to caregivers/clinician

Inappropriate follow-through in past

Others: \_\_\_\_\_

Did patient drive a vehicle before admission?  Yes  No  NA Did the patient have a job before admission?  Yes  No

If yes, do they want to drive post-discharge?  Yes  No If yes, do they want to return to work post-discharge?  Yes  No

---

**COP** **#19 MENTAL STATUS**

1 - Oriented  2 - Comatose  3 - Forgetful  4 - Depressed  5 - Disoriented  6 - Lethargic

7 - Agitated  8 - Alert  9 - Confused  10 - Demented  11 - Assaultive  12 - Delirious

13 - Wanders  14 - Other \_\_\_\_\_

Describe the patient's mental status. Include general appearance, behaviors, emotional responses, mental functioning, overall social interaction as well as both clinical objective observations and subjective descriptions reported during this visit.

Has there been a sudden/acute change in their mental status?  Yes  No Reported by: \_\_\_\_\_

If yes, did the change coincide with something else like medication change, fall, or loss of a loved one?  No  Yes

Comments: \_\_\_\_\_

# Step 8 (cont)

## ADL / IADLs

**(M1800) Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).

- 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
- 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
- 2 - Someone must assist the patient to groom self.
- 3 - Patient depends entirely upon someone else for grooming needs.

**(M1810) Current Ability to Dress /Lower Body safety** (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps.

- 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- 2 - Someone must help the patient put on upper-body clothing.
- 3 - Patient depends entirely upon another person to dress the upper body.

**(M1820) Current Ability to Dress /Lower Body safety** (with or without dressing aids) including undergarments, socks, shoes or nylons, shoes.

- 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- 2 - Someone must help the patient put on undergarments, socks, shoes or nylons, and shoes.
- 3 - Patient depends entirely upon another person to dress lower body.

**(M1830) Bathing:** Current ability to wash entire body safely. **Excludes** grooming (washing face, washing hands, and shampooing hair).

- 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
- 2 - Able to bathe in shower or tub with the intermittent assistance of another person:
  - (a) for intermittent supervision or encouragement or reminders,
  - (b) to get in and out of the shower or tub,
  - (c) for washing difficult to reach areas.
- 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
- 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person.
- 6 - Unable to participate effectively in bathing and is bathed totally by another person.

**(M1840) Toilet Transferring:** Current ability to get to and from the toilet or bedside commode safely **add** transfer on and off toilet / commode.

- 0 - Able to get to and from the toilet and transfer independently with or without a device.
- 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
- 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
- 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
- 4 - Is totally dependent in toileting.

**(M1845) Toileting Hygiene:** Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

- 0 - Able to manage toileting hygiene and clothing management without assistance.
- 1 - Able to manage toileting hygiene and clothing management without assistance if supplies / implements are laid out for the patient.
- 2 - Someone must help the patient to maintain toileting hygiene and/or adjust clothing.
- 3 - Patient depends entirely upon another person to maintain toileting hygiene.

**(M1850) Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- 0 - Able to independently transfer.
- 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
- 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- 5 - Bedfast, unable to transfer and is unable to turn and position self.
- 6 - Bedfast, unable to ambulate or be up in a chair.

**(M1860) Ambulation / Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (specifically: needs no human assistance or assistive device).
- 1 - With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- 2 - Requires use of a two-handed device (for example, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- 3 - Able to walk only with the supervision or assistance of another person at all times.
- 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- 5 - Chairfast, unable to ambulate and is unable to wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair.

**(M1870) Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- 0 - Able to independently feed self.
- 1 - Able to feed self independently but requires:
  - (a) meal set-up,
  - (b) intermittent assistance or supervision from another person,
  - (c) a liquid, puréed or ground meat diet.
- 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.
- 3 - Able to take in nutrients orally **add** receives supplemental nutrients through a nasogastric tube or gastrostomy.
- 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- 5 - Unable to take in nutrients orally or by tube feeding.

### MUSCULOSKELETAL

<input type="checkbox"/> No Problems Identified	<input type="checkbox"/> Shuffling/Wide-based gait	<input type="checkbox"/> High risk for falls	<input type="checkbox"/> Orthopedic aftercare
<input type="checkbox"/> Weakness	<input type="checkbox"/> Joint stiffness	<input type="checkbox"/> Weight bearing restriction	<input type="checkbox"/> Poor conditioning
<input type="checkbox"/> Poor balance	<input type="checkbox"/> Gout		
<input type="checkbox"/> Hx Arthritis		<input type="checkbox"/> Balance: _____	
<input type="checkbox"/> Coordination: _____		<input type="checkbox"/> Ambulation: _____	
<input type="checkbox"/> Muscle Strength: _____		<input type="checkbox"/> Joints Pain: _____	
<input type="checkbox"/> Fracture: _____		<input type="checkbox"/> Atrophy: _____	
<input type="checkbox"/> Contractures: Site _____			
<input type="checkbox"/> Limited ROM: _____		<input type="checkbox"/> Foot Drop: <input type="checkbox"/> Right <input type="checkbox"/> Left	
<input type="checkbox"/> Parasthesia: _____			
<input type="checkbox"/> Quadriplegia	<input type="checkbox"/> RUE	<input type="checkbox"/> RLE	<input type="checkbox"/> LUE
<input type="checkbox"/> Hemiplegia	<input type="checkbox"/> Paraplegia		
<input type="checkbox"/> Others: _____			

### MAHC 10® - FALL RISK ASSESSMENT TOOL

Required Core Elements  
Please check the appropriate box.

Information may be gathered from medical record, assessment and if applicable, the patient/caregiver. Beyond protocols listed below, scoring should be based on your clinical judgment.

<b>Age 65+</b>	<input type="checkbox"/> 0 - No	<input type="checkbox"/> 1 - Yes
<b>Diagnosis (3 or more co-existing)</b> Includes only documented medical diagnosis	<input type="checkbox"/> 0 - No	<input type="checkbox"/> 1 - Yes
<b>Prior history of falls within 3 months</b> An unintentional change in position resulting in coming to rest on the ground or at a lower level	<input type="checkbox"/> 0 - No	<input type="checkbox"/> 1 - Yes
<b>Incontinence</b> Inability to make it to the bathroom or commode in timely manner. Includes frequency, urgency, and/or nocturia.	<input type="checkbox"/> 0 - No	<input type="checkbox"/> 1 - Yes
<b>Visual impairment</b> Includes but not limited to, macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, accommodation, glare tolerance, depth perception, and night vision or not wearing prescribed glasses or having the correct prescription.	<input type="checkbox"/> 0 - No	<input type="checkbox"/> 1 - Yes
<b>Impaired functional mobility</b> May include patients who need help with IADLs or ADLs or have gait or transfer problems, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices.	<input type="checkbox"/> 0 - No	<input type="checkbox"/> 1 - Yes
<b>Environmental hazards</b> May include but not limited to, poor illumination, equipment tubing, inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered, or outdoor entry and exits.	<input type="checkbox"/> 0 - No	<input type="checkbox"/> 1 - Yes
<b>Poly Pharmacy (4 or more prescriptions - any type)</b> All PRESCRIPTIONS including prescriptions for OTC meds. Drugs highly associated with fall risk include but not limited to, sedatives, anti-depressants, tranquilizers, narcotics, antihypertensives, cardiac meds, corticosteroids, anti-anxiety drugs, anticholinergic drugs, and hypoglycemic drugs.	<input type="checkbox"/> 0 - No	<input type="checkbox"/> 1 - Yes
<b>Pain affecting level of function</b> Pain often affects an individual's desire or ability to move or pain can be a factor in depression or compliance with safety recommendations.	<input type="checkbox"/> 0 - No	<input type="checkbox"/> 1 - Yes
<b>Cognitive impairment</b> Could include patients with dementia, Alzheimer's or stroke patients or patients who are confused, use poor judgment, have decreased comprehension, impulsivity, memory deficits. Consider patients ability to adhere to the plan of care.	<input type="checkbox"/> 0 - No	<input type="checkbox"/> 1 - Yes
<b>A score of 4 or more is considered at risk for falling.</b>	<b>Total</b>	

\*MAHC 10 content by Missouri Alliance for HOME CARE

Click to assess TUG

### TIMED UP & GO (TUG) ASSESSMENT

**Purpose:** To assess patient's mobility.  
**Equipment:** A stopwatch.  
**Directions:** Patients wear their regular footwear and can use a walking aid, if needed. Begin by having the patient sit back in a standard arm chair and identify a line 3 meters, or 10 feet away, on the floor.

- Instruct the patient:
  - When I say "Go", I want you to:
    - Stand up from the chair.
    - Walk to the line on the floor at your normal pace.
    - Turn.
    - Walk back to the chair at your normal pace.
    - Sit down again.
- On the word "Go", begin timing.
- Stop timing after patient sits back down.
- Record time.

**Time in Seconds:** \_\_\_\_\_ sec. A patient who takes greater than 12 seconds to complete the TUG is at risk for falling.

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### OPTIONAL

**(M1910)** Has this patient had a multi-factor Falls Risk Assessment using a standardized, validated assessment tool?

- 0 - No
- 1 - Yes, and it does not indicate a risk for falls.
- 2 - Yes, and it does indicate a risk for falls.

### #18A FUNCTIONAL LIMITATIONS

<input type="checkbox"/> 1 - Amputation	<input type="checkbox"/> 4 - Hearing	<input type="checkbox"/> 7 - Ambulation	<input type="checkbox"/> A - Dyspnea with minimal exertion
<input type="checkbox"/> 2 - Bowel/Bladder (Incontinence)	<input type="checkbox"/> 5 - Paralysis	<input type="checkbox"/> 8 - Speech	
<input type="checkbox"/> 3 - Contracture	<input type="checkbox"/> 6 - Endurance	<input type="checkbox"/> 9 - Legally blind	
<input type="checkbox"/> B - Other (specify) _____			

### #18B ACTIVITIES PERMITTED

<input type="checkbox"/> 1 - Complete bedrest	<input type="checkbox"/> 4 - Transfer bed/chair	<input type="checkbox"/> 7 - Independent in home	<input type="checkbox"/> A - Wheelchair
<input type="checkbox"/> 2 - Bedrest/BRP	<input type="checkbox"/> 5 - Exercises prescribed	<input type="checkbox"/> 8 - Crutches	<input type="checkbox"/> B - Walker
<input type="checkbox"/> 3 - Up as tolerated	<input type="checkbox"/> 6 - Partial weight bearing	<input type="checkbox"/> 9 - Cane	<input type="checkbox"/> C - No restrictions
<input type="checkbox"/> D - Other (specify) _____			

### APPLIANCES / SPECIAL EQUIPMENTS

Brace/Orthotics (specify): \_\_\_\_\_

Transfer equipment:  Board  Lift  Bedside commode

Prostasia:  RUE  RLE  LUE  LLL  Other: \_\_\_\_\_

Grab bars:  Bathroom  Other: \_\_\_\_\_

Hospital bed:  Semi-elec.  Crank  Spec: \_\_\_\_\_

Medical Alert

Needs (specify): \_\_\_\_\_

Oxygen: \_\_\_\_\_ DME Co: \_\_\_\_\_ DME Rep: \_\_\_\_\_ Phone: \_\_\_\_\_

Comments:

Complete ADL/IADLs section using both subjective and objective observation.

“Can patients be safer?”

Please think “within the past 7-days” when answering questions

Must indicate Functional Limitation and Activities Permitted



# Step 8 (cont)

## SECTION GG: FUNCTIONAL ABILITIES AND GOALS

**(GG0100) Prior Functioning: Everyday Activities:** Indicate the patient's usual ability with everyday activities prior to the current illness, exacerbation, or injury. **(1)**

**A. Self-Care:** Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.

- 3. Independent - Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
- 2. Needed Some Help - Patient needed partial assistance from another person to complete activities.
- 1. Dependent - A helper completed the activities for the patient.
- 8. Unknown
- 9. Not Applicable
- . Not assessed (no information)

**B. Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as cane, crutch or walker) prior to the current illness, exacerbation, or injury.

- 3. Independent - Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
- 2. Needed Some Help - Patient needed partial assistance from another person to complete activities.
- 1. Dependent - A helper completed the activities for the patient.
- 8. Unknown
- 9. Not Applicable
- . Not assessed (no information)

**C. Stairs:** Code the patient's need for assistance with internal or external stairs (with or without a device such as cane, crutch, or walker) prior to the current illness, exacerbation or injury.

- 3. Independent - Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
- 2. Needed Some Help - Patient needed partial assistance from another person to complete activities.
- 1. Dependent - A helper completed the activities for the patient.
- 8. Unknown
- 9. Not Applicable
- . Not assessed (no information)

**D. Functional Cognition:** Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation, or injury.

- 3. Independent - Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper.
- 2. Needed Some Help - Patient needed partial assistance from another person to complete activities.
- 1. Dependent - A helper completed the activities for the patient.
- 8. Unknown
- 9. Not Applicable
- . Not assessed (no information)

**(GG0110) Prior Device Uses:** Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury. **(1)**

Check all that apply:

- A. Manual wheelchair**
  - Yes  No  Not assessed (no information)
- B. Motorized wheelchair and/or scooter**
  - Yes  No  Not assessed (no information)
- C. Mechanical lift**
  - Yes  No  Not assessed (no information)
- D. Walker**
  - Yes  No  Not assessed (no information)
- E. Orthotics/Prosthetics**
  - Yes  No  Not assessed (no information)
- Z. None of the above**
  - Yes  No  Not assessed (no information)

**(GG0130) Self-Care:** Code the patient's usual performance at SOC/ROC for each activity using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. Code the patient's discharge goal(s) using the 6-point scale. Use of codes 07, 09, 10 or 88 is permissible to code discharge goal(s). **(1)**

**Coding:**  
**Safety and Quality of Performance -** If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided.

- Activities may be completed with or without assistive devices.
  - 06. Independent - Patient completes the activity by him/herself with no assistance from a helper.
  - 05. Setup or clean-up assistance - Helper sets up or cleans up, patient completes activity. Helper assists only prior to or following the activity.
  - 04. Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
  - 03. Partial / moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
  - 02. Substantial / maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
  - 01. Dependent - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.
- If activity was not attempted, code reason:
- 07. Patient refused
  - 09. Not applicable - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
  - 10. Not attempted due to environmental limitations (e.g., lack of equipment, weather constraints)
  - 88. Not attempted due to medical condition or safety concerns
  - . Not assessed (no information)

## 1. SOC/ROC Performance

**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial / moderate assistance
- 02. Substantial / maximal assistance
- 01. Dependent
- 07. Patient refused
- 09. Not applicable
- 10. Not attempted due to environmental limitations
- 88. Not attempted due to medical condition or safety concerns
- . Not assessed (no information)

**B. Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial / moderate assistance
- 02. Substantial / maximal assistance
- 01. Dependent
- 07. Patient refused
- 09. Not applicable
- 10. Not attempted due to environmental limitations
- 88. Not attempted due to medical condition or safety concerns
- . Not assessed (no information)

**C. Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial / moderate assistance
- 02. Substantial / maximal assistance
- 01. Dependent
- 07. Patient refused
- 09. Not applicable
- 10. Not attempted due to environmental limitations
- 88. Not attempted due to medical condition or safety concerns
- . Not assessed (no information)

**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial / moderate assistance
- 02. Substantial / maximal assistance
- 01. Dependent
- 07. Patient refused
- 09. Not applicable
- 10. Not attempted due to environmental limitations
- 88. Not attempted due to medical condition or safety concerns
- . Not assessed (no information)

**F. Upper body dressing:** The ability to dress and undress above the waist, including fasteners, if applicable.

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial / moderate assistance
- 02. Substantial / maximal assistance
- 01. Dependent
- 07. Patient refused
- 09. Not applicable
- 10. Not attempted due to environmental limitations
- 88. Not attempted due to medical condition or safety concerns
- . Not assessed (no information)

**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance

## 2. Discharge Goal

08. Not attempted due to medical condition or safety concerns  
 -. Not assessed (no information)

**N. 4 steps:** The ability to go up and down four steps with or without a rail. If SOC/ROC performance is coded 07, 08, 10 or 88, skip to GG0709. Picking up object.

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial / moderate assistance
- 02. Substantial / maximal assistance
- 01. Dependent
- 07. Patient refused
- 09. Not applicable
- 10. Not attempted due to environmental limitations
- 88. Not attempted due to medical condition or safety concerns
- . Not assessed (no information)

**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial / moderate assistance
- 02. Substantial / maximal assistance
- 01. Dependent
- 07. Patient refused
- 09. Not applicable
- 10. Not attempted due to environmental limitations
- 88. Not attempted due to medical condition or safety concerns
- . Not assessed (no information)

**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial / moderate assistance
- 02. Substantial / maximal assistance
- 01. Dependent
- 07. Patient refused
- 09. Not applicable
- 10. Not attempted due to environmental limitations
- 88. Not attempted due to medical condition or safety concerns
- . Not assessed (no information)

**Q. Does patient use a wheelchair and/or scooter?**

- 0. No
- 1. Yes
- . Not assessed (no information)

**R. Wheel 50 feet with two turns:** Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial / moderate assistance
- 02. Substantial / maximal assistance
- 01. Dependent
- 07. Patient refused
- 09. Not applicable
- 10. Not attempted due to environmental limitations
- 88. Not attempted due to medical condition or safety concerns
- . Not assessed (no information)

**RR1. Indicate the type of wheelchair or scooter used.**

- 1. Manual
- 2. Motorized
- . Not assessed (no information)

**S. Wheel 150 feet:** Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.

- 06. Independent
- 05. Setup or clean-up assistance
- 04. Supervision or touching assistance
- 03. Partial / moderate assistance
- 02. Substantial / maximal assistance
- 01. Dependent
- 07. Patient refused
- 09. Not applicable
- 10. Not attempted due to environmental limitations
- 88. Not attempted due to medical condition or safety concerns
- . Not assessed (no information)

**SS1. Indicate the type of wheelchair or scooter used.**

- 1. Manual
- 2. Motorized
- . Not assessed (no information)

Under Functional Status, please assess the tasks if possible. If not, use subjective and objective observation to answer.

Please refrain from answering “Not assessed”.

# Step 8 (cont)

Medications should populate under Medication section if it was properly entered in the Admission Order

Please indicate under comments on Patient compliance/none compliance, etc with medication

If patient has IV ABX, please indicate route (PIV, PIC, Port-A-Cath), where IV is located, capacity for Pt/PCG to learn and take over IV, and/or if specialty pharmacy nurse is managing IV instead of us

Enter all known ALLERGIES

**MEDICATIONS**

Free Text	For Dr	New/CI	Date	Medication	Strength	Dose	Route	Frequency	Classificati	Laboratory	Date of Disc	Indicati
				MetFORMIN HCl	1000 Milligr	1 tab	Oral	Twice per D	BIGUANIDE			

Comments:

(M2001) **Drug Regimen Review:** Did a complete drug regimen review identify potential clinically significant medication issues?  0 - No - No issues found during review [ Go to M2010 ]  
 1 - Yes - Issues found during review  
 9 - NA - Patient is not taking any medications [ Go to M2102 ]  
 Not assessed (no information)

(M2003) **Medication Follow-up:** Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?  0 - No  1 - Yes  Not assessed (no information)

(M2010) **Patient / Caregiver High-Risk Drug Education:** Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?  0 - No  1 - Yes  NA - Patient not taking any high-risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

(M2020) **Management of Oral Medications:** Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)  0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.  
 1 - Able to take medication(s) at the correct times if:  
(a) individual dosages are prepared in advance by another person; OR  
(b) another person develops a drug diary or chart.  
 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times.  
 3 - Unable to take medication unless administered by another person.  
 NA - No oral medications prescribed.

(M2030) **Management of Injectable Medications:** Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. Excludes IV medications.  0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.  
 1 - Able to take injectable medication(s) at the correct times if:  
(a) individual syringes are prepared in advance by another person; OR  
(b) another person develops a drug diary or chart.  
 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection  
 3 - Unable to take injectable medication unless administered by another person.  
 NA - No injectable medications prescribed.

**COP** Was psychotropic drug used?  No  Yes (see med sheet) **Able to pay for medications:**  Yes  No  
If no, was MSW referral made?  Yes  No/comment:

**#17 ALLERGIES**

None known  
 Aspirin  Penicillin  Sulfa  Pollen  Eggs  Milk products  Insect bites  
 Other:

# Step 8 (cont)

Complete the whole section, especially the “COP” sections

Proper completion will help “paint” a better picture of the care and other circumstances that may hamper care and goals.

CARE MANAGEMENT	
(M2102)	<p><b>Types and Sources of Assistance:</b> Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff. <b>11</b></p> <p>f. <b>Supervision and safety</b> (for example, due to cognitive impairment)</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 0 - No assistance needed - patient is independent or does not have needs in this area</li> <li><input type="checkbox"/> 1 - Non-agency caregiver(s) currently provide assistance</li> <li><input type="checkbox"/> 2 - Non-agency caregiver(s) need training/supportive services to provide assistance</li> <li><input type="checkbox"/> 3 - Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance</li> <li><input type="checkbox"/> 4 - Assistance needed, but no non-agency caregiver(s) available</li> </ul>
COP CARE PREFERENCES / PATIENT'S PERSONAL GOALS	
Did the <input type="checkbox"/> Patient <input type="checkbox"/> Representative <input type="checkbox"/> Other: _____ specify preferences involving home health provided services? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, specify:	<div style="border: 1px dashed black; height: 40px;"></div>
Did the <input type="checkbox"/> Patient <input type="checkbox"/> Representative <input type="checkbox"/> Other: _____ specify any personal goal(s) he/she would like to achieve from this home health admission? <input type="checkbox"/> No <input type="checkbox"/> Yes	
If yes, <input type="checkbox"/> Patient <input type="checkbox"/> Representative <input type="checkbox"/> Other: _____ discussed the goals with the assessing clinician and:	
<input type="checkbox"/> Agreed their personal goals were realistic based on the patient's health status.	
<input type="checkbox"/> Agreed their personal goals needed to be modified based on the patient's health status.	
<input type="checkbox"/> Agreed to and identified actions/interventions the patient is willing to safely implement, so the patient will be able to meet their goals by the anticipated discharge date	
<input type="checkbox"/> Patient <input type="checkbox"/> Representative <input type="checkbox"/> Other: _____ helped write a measurable goals, understandable to all stakeholders.	
<input type="checkbox"/> Patient <input type="checkbox"/> Representative <input type="checkbox"/> Other: _____ was informed, appeared to understand and agreed the personal goals would be added to the patient's individualized plan of care and submitted to the physician responsible for reviewing and signing the plan of care.	
<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Other: _____	
COP REFUSED CARES	
<input type="checkbox"/> Patient <input type="checkbox"/> Representative <input type="checkbox"/> Other: _____ refuse <input type="checkbox"/> Cares <input type="checkbox"/> Services in advance?	
<input type="checkbox"/> No <input type="checkbox"/> Yes, explain	
Could the <input type="checkbox"/> cares <input type="checkbox"/> services they refused significantly affect the recommended plan of care? <input type="checkbox"/> No <input type="checkbox"/> Yes, explain how	
	<div style="border: 1px dashed black; height: 40px;"></div>
COP STRENGTHS / LIMITATIONS	
Based upon the patient's Physical, Psychosocial, Cognitive and Mental Status:	
Patient's Strengths:	
<input type="checkbox"/> Patient optimism that change can occur	<input type="checkbox"/> Vocational interests, i.e. hobbies
<input type="checkbox"/> Motivation and readiness for change	<input type="checkbox"/> Interpersonal relationships and supports i.e., family, friends, peers
<input type="checkbox"/> Setting and pursuing goals	<input type="checkbox"/> Cultural/spiritual/religious and community involvement
<input type="checkbox"/> Attempting to realize one's potential	<input type="checkbox"/> Access to housing/residential stability
<input type="checkbox"/> Managing surrounding demands and opportunities	<input type="checkbox"/> Financial stability
<input type="checkbox"/> Exercising self-direction	<input type="checkbox"/> Knowledge of health conditions and medications
Others:	<div style="border: 1px dashed black; height: 20px;"></div>
List the patient's limitations that might challenge progress toward their goals, both personal and the HHA measurable goal.	
<div style="border: 1px dashed black; height: 40px;"></div>	
How might the patient's limitations affect their safety and/or progress?	
<div style="border: 1px dashed black; height: 40px;"></div>	

# Step 8 (cont)

Enter anticipated amount of therapy visit

Enter all DME (both present and to be ordered)

Under PATIENT/PRIMARY CAREGIVER EDUCATION... you may enter the following template:

Pt/PCG educated on on disease process, S/SX's of exacerbation and reportable S/SXs. Instructed Pt/PCG on proper medication management and monitoring of effectiveness. Instructed patient on home safety and when to call MD, SN, and/or EMS. Instructed patient about Patient's Rights & Responsibilities, and Complaint Procedure and State Hotline #. Informed patient of Agency's hours of operation and after-hours/weekends on-call contact information. Patient/PCG expresses understanding

Under SKILLED CARE PROVIDED... enter the following template:

SN observation and assessment of all systems, medication compliance/efficacy/knowledge, pain levels/management. With patient input prepared a POC. SN provided skilled education on proper disease management, medication management, home safety, and EMS protocol. MD notified of findings and further plans. (Please add other skilled services provided (ie wound care))

Under PATIENT SUMMARY, :

Please "Copy and Paste" the narrative you created in the "Reason" section in the Admission Order

THERAPY NEED AND PLAN OF CARE	
<p>(M2200) § <b>Therapy Need:</b> In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? (Enter zero ["0000"] if no therapy visits indicated.) (1)</p> <p>( ) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).</p> <p><input type="checkbox"/> NA - Not Applicable: No case mix group defined by this assessment.</p>	
#14 DME SUPPLIES	
<p><b>WOUND CARE:</b></p> <p><input type="checkbox"/> 2x2's <input type="checkbox"/> 4x4's <input type="checkbox"/> ABD's <input type="checkbox"/> Cotton tipped applicators <input type="checkbox"/> Wound cleanser <input type="checkbox"/> Wound gel <input type="checkbox"/> Gloves: <input type="checkbox"/> Sterile <input type="checkbox"/> Non-sterile</p> <p><input type="checkbox"/> Kerlix size _____ <input type="checkbox"/> Transparent dressings <input type="checkbox"/> Drain sponges <input type="checkbox"/> Hydrocolloids <input type="checkbox"/> Nu-gauze <input type="checkbox"/> Tape <input type="checkbox"/> Saline</p> <p>Other: _____</p>	
<p><b>DIABETIC:</b></p> <p><input type="checkbox"/> Chemstrips <input type="checkbox"/> Syringes <input type="checkbox"/> Other: _____</p>	
<p><b>IV SUPPLIES:</b></p> <p><input type="checkbox"/> IV start kit <input type="checkbox"/> IV tubing <input type="checkbox"/> IV pole <input type="checkbox"/> Alcohol swabs <input type="checkbox"/> Extension tubings <input type="checkbox"/> Central line dressing <input type="checkbox"/> Injection caps</p> <p><input type="checkbox"/> Angiocatheter size _____ <input type="checkbox"/> Tape <input type="checkbox"/> Infusion pump <input type="checkbox"/> Batteries size _____ <input type="checkbox"/> Syringes size _____</p> <p>Other: _____</p>	
<p><b>MISCELLANEOUS:</b></p> <p><input type="checkbox"/> Enema supplies <input type="checkbox"/> Suture removal kit <input type="checkbox"/> Staple removal kit <input type="checkbox"/> Steri strips <input type="checkbox"/> Feeding tube: Type _____ size _____</p> <p>Other: _____</p>	
<p><b>URINARY/OSTOMY:</b></p> <p><input type="checkbox"/> Underpads <input type="checkbox"/> Urinary bag/pouch <input type="checkbox"/> External catheters <input type="checkbox"/> Skin protectant <input type="checkbox"/> Stoma adhesive tape</p> <p><input type="checkbox"/> Ostomy pouch (brand, size) _____ <input type="checkbox"/> Ostomy wafer (brand, size) _____</p> <p>Other: _____</p>	
<p><b>FOLEY SUPPLIES:</b></p> <p><input type="checkbox"/> _____ Fr catheter kit <input type="checkbox"/> Straight catheter <input type="checkbox"/> Irrigation tray <input type="checkbox"/> Saline <input type="checkbox"/> Acetic acid</p> <p>Other: _____</p>	
<p><b>SUPPLIES/EQUIPMENT:</b></p> <p><input type="checkbox"/> Bath bench <input type="checkbox"/> Cane <input type="checkbox"/> Commode <input type="checkbox"/> Suction machine <input type="checkbox"/> Hospital bed <input type="checkbox"/> Hoyer lift <input type="checkbox"/> Enteral feeding pump</p> <p><input type="checkbox"/> Nebulizer <input type="checkbox"/> Eggcrate <input type="checkbox"/> Ventilator <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Tens unit <input type="checkbox"/> Oxygen concentrator</p> <p><input type="checkbox"/> Special mattress overlay _____ <input type="checkbox"/> Pressure relieving device _____</p> <p>Other: _____</p>	
COP	
<p>PATIENT / PRIMARY CAREGIVER EDUCATION AND TRAINING AND THEIR RESPONSE</p> <p>_____</p> <p>_____</p> <p>_____</p>	
SKILLED CARE PROVIDED THIS VISIT	
<p>_____</p> <p>_____</p> <p>_____</p>	
PATIENT SUMMARY	
<p>Frequency: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>	

# Step 8 (cont)

Complete the rest of the section with DC plans and Rehab potential

When done, proceed "Next" to setup the Care Plan Summary/Ongoing Plan of Care under the "CARE PLAN POINTERS" page.

SUMMARY CHECKLIST	
<input type="checkbox"/> Care Plan has been reviewed	
<b>Care Coordination:</b> <input type="checkbox"/> Physician <input type="checkbox"/> SN <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> MSW <input type="checkbox"/> Aide <input type="checkbox"/> Other: _____	
<b>Medication Status:</b> <input type="checkbox"/> No change <input type="checkbox"/> Order obtained	
Check if any of the following were identified:	
<input type="checkbox"/> Significant side effects	<input type="checkbox"/> Potential adverse effects/drug reaction
<input type="checkbox"/> Ineffective drug therapy	<input type="checkbox"/> Non-compliance with drug therapy
	<input type="checkbox"/> Significant drug interactions
	<input type="checkbox"/> Duplicate drug therapy
#21 PROFESSIONAL SERVICES	
<b>Skilled Nursing</b>	Frequency and Duration: _____
<b>Physical Therapy</b>	Frequency and Duration: _____
<b>Occupational Therapy</b>	Frequency and Duration: _____
<b>Speech Therapy</b>	Frequency and Duration: _____
<b>Home Health Aide</b>	Frequency and Duration: _____
<b>Homemaker</b>	Frequency and Duration: _____
<b>Medical Social Worker</b>	Frequency and Duration: _____
	Frequency and Duration: _____
#22 DISCHARGE PLANS AND REHABILITATION POTENTIAL	
<b>DISCHARGE PLANS</b>	
<input type="checkbox"/> When goals are met	
<input type="checkbox"/> Medical condition is stable	
<input type="checkbox"/> When patient no longer in need of skilled services	
<input type="checkbox"/> Able to return to an independent level of care	
<input type="checkbox"/> Able to stay in residence with primary caregiver's assistance or community agency's support	
<input type="checkbox"/> When patient knows when to notify physician	
<input type="checkbox"/> Able to understand medication regime and care related to diagnoses	
<input type="checkbox"/> When patient reaches maximum functional potential	
<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Discharge plans were discussed with patient	
<b>REHABILITATION POTENTIAL</b>	
<input type="checkbox"/> Rehabilitation potential is poor	<input type="checkbox"/> Rehabilitation potential is good
<input type="checkbox"/> Rehabilitation potential is fair	<input type="checkbox"/> Rehabilitation potential is excellent
I have personally reviewed all of the above information and hereby, certify, affirm, and declare that the above information is complete, true, accurate, and correct.	
_____	_____
[ Signature above / Printed name below ]	Date
The Outcome and Assessment Information Set (OASIS) is the intellectual property of the Center for Health Services and Policy Research, Denver, Colorado. It is used with permission.	
Patient Name: DOE, JOHN	MR #: 01010

# Step 9

- Completing the CARE PLAN POINTER will populate the “Ongoing Care Plan/Care Plan Summary” that will help create a road-map of care and intervention you can provide one every visit.
- Suggestions will automatically populate depending on your responses and diagnosis you entered in the OASIS.
- If you cannot find the appropriate Care Plan Pointer, you can add your own Care Plan Pointer.
- To add suggested pointers, choose the “Domain 14: Diagnosis” by clicking on the “Circle w/ a triangle” inside Icon to expand and reveal your choices
- You can expand the specific diagnosis by clicking on the same icon as above
- Click on the box to check them and add them as part of your Care Plan Pointers.
- Save when you are done choosing.

The screenshot displays the OASIS software interface for 'CARE PLAN POINTERS'. At the top, there is a search bar and navigation buttons. Below this, a list of diagnoses is shown. Two diagnosis boxes are expanded to show their respective 'Goals' and 'Interventions'.

**Diagnosis 1: ENCOUNTER FOR ADJUSTMENT AND MANAGEMENT OF VASCULAR ACCESS DEVICE (PICC/CENTRAL LINE)**

**Goals:**

- ✓ Patient/caregiver will verbalize understanding on infection control and intravenous infusion management principles by second week. Patient/caregiver will competently and independently perform intravenous infusion by second week. Patient's intravenous access will be free from newly acquired infection during the entire episode of care.
- ✓ Patient/caregiver will verbalize understanding on the importance of intravenous therapy and demonstrate willingness to cooperate with the care management of PICC/Central line by second week. Patient's PICC line on (site) will have no signs/symptoms of infection and patient will demonstrate resolution of disease condition necessitating intravenous therapy as evidence by no signs and symptoms of infection throughout the certification period.
- ✓ Patient/caregiver will report if intravenous lines rundry, be certain that the PICC line will be flush before and after medication to prevent clogging from drug precipitates, and ensure dressing is not applied tightly within certification period. Patient will verbalized understanding on signs/symptoms of infection by second week. Patient will report presence or excessive bleeding/leaking from the insertion site and monitor pain intensity within 24 hours.

**Interventions:**

- ✓ Skilled nurse to assess intravenous infusion access for signs of infection and change dressings weekly. Educate and train patient/caregiver on home intravenous infusion safety principles and on the importance of infection control. Instruct patient/caregiver to notify SN/MD for signs/symptoms of infection such as fever, chills, swelling, and redness on line site. Instruct patient/caregiver on infection control techniques in IV infusion like proper handwashing, use of gloves, and proper handling and disposal of waste. Evaluate patient/caregiver understanding on Home intravenous infusion administration principles. (SN, PT, OT, ST, M)
- ✓ Skilled nurse to educate patient/caregiver of the purpose, placement, insertion procedure and post insertion care including what to report to the SN/MD. Educate on necessary blood works to consider while patient is on PICC/Central line care. Reinforced infection control measures with PICC/central line. Evaluate effectiveness of teach-back technique. (SN, PT, OT, ST, M)
- ✓ Skilled nurse to assess intravenous tubing for occlusion of line such as kinks, clamps or if it is too tight. Assess for bleeding from the catheter insertion site and skin sensitivity at insertion site. Assess for pain during infusion as it signifies reduced blood flow and decreased hemodilution to these areas. Assess for leaking or broken catheters. (SN, PT, OT, ST, M)

**Diagnosis 2: ESSENTIAL (PRIMARY) HYPERTENSION**

**Goals:**

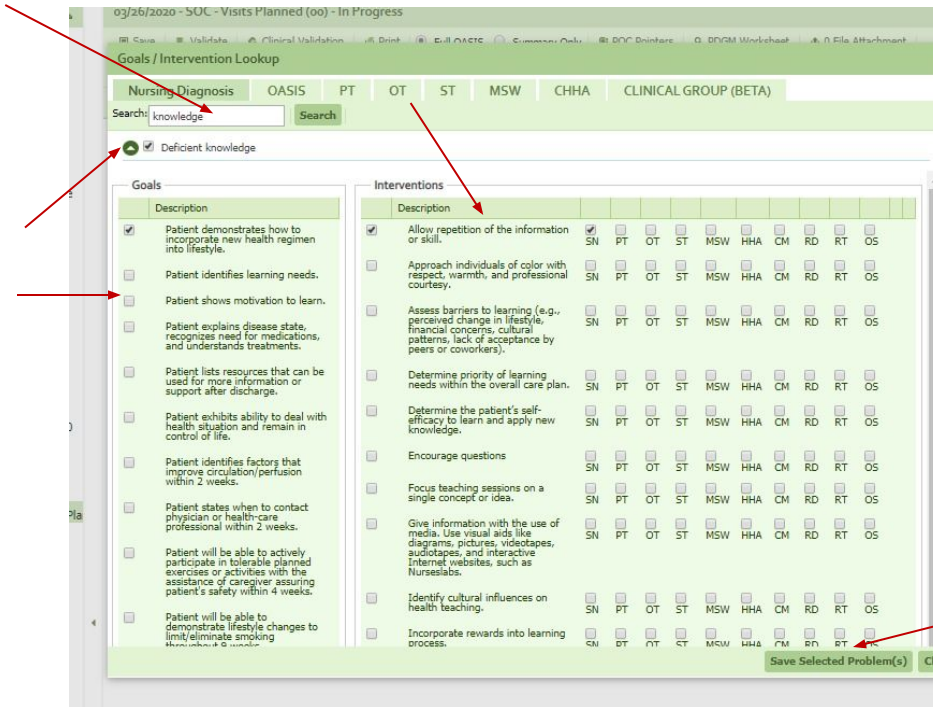
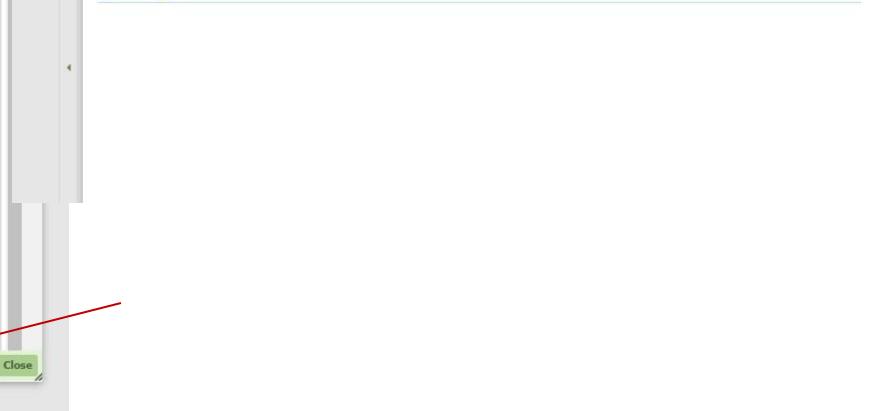
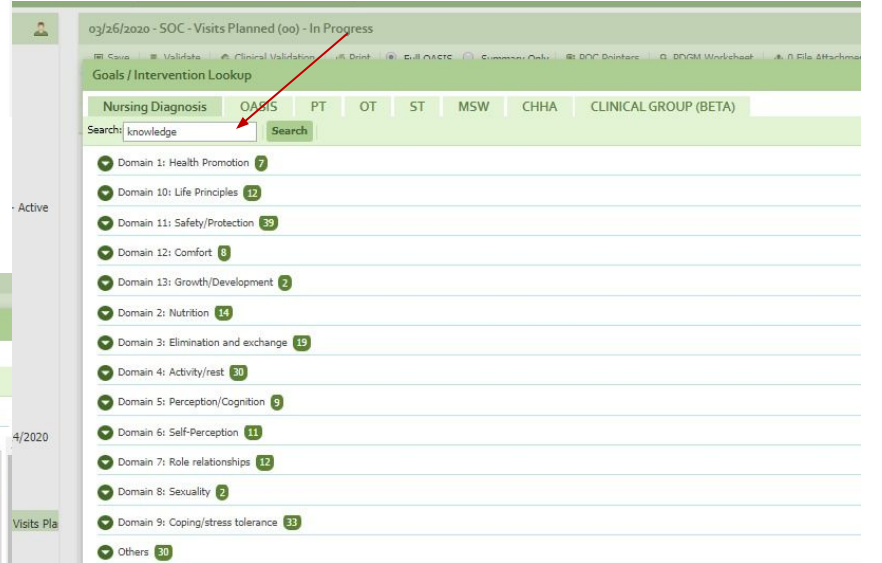
- ✓ During the certification period, the patient's vital signs will be within the normal limits: patient/caregiver will verbalize understanding of importance of reporting to the skilled nurse/physician when: heart/pulse rate is <60 and >100 beats per minute; Respiratory rate is <12 and >26 cycles per minute; Systolic blood pressure is <90 and >120 mmHg; Diastolic blood pressure is <60 and > 80 mmHg; and Temperature is >100.4 F. Patient/Caregiver will verbalize understanding of at least 3 signs/symptoms of hypertension and when to report to skilled nurse and physician within 1 to 2 weeks.
- ✓ Patient/Caregiver will demonstrate proper administration of anti-hypertensive medication and will verbalize understanding of the teaching given by the skilled nurse within 1 to 2 weeks. Patient/Caregiver will demonstrate compliance to the dietary and lifestyle changes during the certification period.
- ✓ During the certification period, the patient will not experience orthostatic hypotension, Patient will be able to demonstrate proper methods to prevent the occurrence of orthostatic hypotension within 1 to 2 weeks.

**Interventions:**

- ✓ Skilled nurse to monitor the patient's vital signs especially those pertaining to the cardiac functions such as blood pressure and heart rate to assess for presence of exacerbation of hypertension. Educate patient/caregiver on the signs/symptoms of hypertension such as nose pain, severe headache, light headedness, dizziness and nosebleeds, report to skilled nurse or physician if any of these are present. (SN, PT, OT, ST, M)
- ✓ Skilled nurse to instruct patient/caregiver on the proper administration, side effects and adverse effects of the anti-hypertensive drugs. Encourage patient to adhere to prescribed diet of sodium/fat limitation and to implement regular physical exercise. Stress the importance of avoiding alcohol consumption and use of tobacco products. (SN, PT, OT, ST, M)
- ✓ Skilled nurse to instruct patient to rise slowly from a lying to standing position, sitting for a few minutes before standing. Sleep with the head slightly elevated. (SN, PT, OT, ST, M)

# Step 9 (cont)

- You can add your own Care Plan Pointer if you don't see an appropriate Care Plan Pointer by choosing "Add Problem"
- You can search for a Care Plan Pointer by entering a key word under "Search"
- SUGGESTION: One of the best Care Plan Pointer to add to any patient is "Deficient Knowledge"
  - Choose the appropriate "Goals" and "Intervention"
  - When done, click on "Save Selected Problems"



# Step 9 (cont)

Save, wait for a couple of seconds, then Validate

Fix Errors and Problems as best as you can by choosing the item and it will bring you to the problem

Some Errors can only be fixed by us in the office due to their technical nature (ie incorrect ICD-10 code)

Save and re-Validate when done

Then go back to the patient calendar by clicking the calendar

The screenshot shows a medical software interface for a patient visit on 03/26/2020. The top navigation bar includes buttons for Save, Validate, Clinical Validation, Print, Full OASIS, Summary Only, and POC Pointer. Below this, the section is identified as 'CARE PLAN POINTERS'. The main content area displays 'Domain 14: Diagnosis' with a list of error/warning items. A red arrow points to the 'Validate' button in the top bar. Another red arrow points to the 'M1324' error item in the list. A third red arrow points to the 'M1324 STG\_PBLM\_ULCER' error item in the detailed error report on the right. The error report includes a table with columns for 'Item' and 'Error/Warning', listing various OASIS items and their associated warnings.

The screenshot shows a patient navigation menu with various options: Service Locations, Referring Diagnosis H&P, Medical Diagnoses, Insurances, Pharmacies, Episode: 03/26/2020 - 05/24/2020, Calendar, Episode Summary, OASIS, 03/26/2020 - SOC - Visits Pla, Care Plan Summary, Plan of Care, Orders, Communication Notes, Medication Profile, Visit Notes, and Other Notes. A red arrow points to the 'Calendar' option.

may include a thin blister rapid exposing addition.

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**(M1322) Current Nur**  
prominence.  
or purple hu  
 0

**(M1324) Stage of Mc**  
staged due t  
 1 - Stagi  
 2 - Stagi  
 3 - Stagi  
 4 - Stagi  
 NA - Patie

**(M1330) Does this pa**  
 0 - No [  
 1 - Yes,  
 2 - Yes,

**(M1324) Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stag**  
staged due to a non-removable dressing/device, coverage of wound bed b

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**(M1330) Does this patient have a Stasis Ulcer?**  
 0 - No [ Go to M1340 ]  
 1 - Yes, patient has BOTH observable and unobservable and unobservable stasis ulcers  
 2 - Yes, patient has observable stasis ulcers ONLY  
 3 - Yes, patient has unobservable stasis ulcers ONLY (known but not ob

**(M1332) Current Number of Stasis Ulcer(s) that are Observable:**  
 1 - One  
 2 - Two  
 3 - Three  
 4 - Four or more

**(M1334) Status of Most Problematic Stasis Ulcer that is Observable:**  
 1 - Fully granulating  
 2 - Early / partial granulation  
 3 - Not healing

**(M1340) Does this patient have a Surgical Wound?**  
 0 - No [ Go to M1400 ]  
 1 - Yes, patient has at least one observable surgical wound  
 2 - Surgical wound known but not observable due to non-removable c

**(M1342) Status of Most Problematic Surgical Wound that is Observable:**  
 0 - Non-healed

Item	Error/Warning
M0150_CPAY_NONE:	Only the value table of the De Report may be
M0150_CPAY_NONE:	Both M0150_C M0150_CPAY_1
M0150_CPAY_UK:	Both M0150_C M0150_CPAY_1
M0150_CPAY_MCARE_FFS:	Only the value table of the De Report may be
M0150_CPAY_MCARE_HMO:	Only the value table of the De Report may be
M0150_CPAY_MCAID_FFS:	Only the value table of the De Report may be
M0150_CPAY_MCAID_HMO:	Only the value table of the De Report may be
M0150_CPAY_WRKCOMP:	Only the value table of the De Report may be
M0150_CPAY_TITLEPGMS:	Only the value table of the De Report may be
M0150_CPAY_OTH_GOVTY:	Only the value table of the De Report may be
M0150_CPAY_PRIV_INS:	Only the value table of the De Report may be
M0150_CPAY_PRIV_HMO:	Only the value table of the De Report may be
M0150_CPAY_SELFPAY:	Only the value table of the De Report may be
M0150_CPAY_OTHER:	Only the value table of the De Report may be
M0150_CPAY_UK:	Only the value table of the De Report may be
M1324_STG_PBLM_ULCER:	IF M0100_ASS and M1322_NB IF M1311_NBR, M1311_NBR_P, M1311_NBR_P to 100, then must be equal
M0102_PHYSN_ORDRD_SOCROC_DT_NA:	IF M0102_PHYS (-) then if M0102_PHYS active it must e
M1000_DC LTC 14 DA:	Only the value table of the De Report may be
M1000_DC SNF 14 DA:	Only the value



# Step 10

- Complete the “Case Conference” form by clicking on the Case Conference Icon

Edit Visit Plan | Batch Post Visit | View Plan of Care | Visit Frequency Info | Technical Chart Audit | View Visits By Discipline | Legend | PDGM LUPA: 5 (1st 30-day), 2

**PERSPECTIVE HOME HEALTH INC. CASE CONFERENCE**  
6045 S Fort Apache Rd, Suite 110, Las Vegas, NV 89148  
Phone: (702) 948 5095 / Fax: (702) 948 5115

D.O.B.: 04/02/1977 SOC Date: 03/26/2020 Certification Period: 03/26/2020 - 05/24/2020  
Primary Diagnosis: AFTERCARE FOLLOWING JOINT REPLACEMENT SURGERY

Disciplines Involved:  SN  PT  OT  ST  HHA  MSW Case Manager:  
Type of Assessment:  SOC  ROC  RECERT  Follow-Up  Transfer  Discharge  DAH

**SERVICES PROVIDED**

**SKILLED NURSING**

- Significant change in general condition
- Questionable medication effectiveness
- Impaired wound healing process
- Symptoms of infection
- Inadequate nutrition/hydration
- Unreliable with meds/needs further instructions
- Pain management
- Unstable VS requiring frequent MD contact
- Slow to comprehend treatment
- Poor bowel/bladder management
- Dyspnea/Edema
- Cardiac/Lung/Circulatory Problem
- Vision/Hearing Impaired
- Diet Compliance
- Nausea/Vomiting/Weight problem
- Catheter care/incontinence problem
- Constipation/Diarrhea
- Ostomy care/Supplies
- No reliable caregiver
- Other: \_\_\_\_\_

**HOME HEALTH AIDE**

- Difficulty with self-care
- Unsafe in performing ADL's / IADL's
- Has need for light meal preparation/laundry/housework
- PT/OT/ST Assistance as instructed
- Observed changes in patient condition
- Other: \_\_\_\_\_

**SPEECH THERAPY**

- Dysphagia/Difficulty in swallowing
- Difficulty with receptive/expressive communication
- Voice Disorders/Speech articulation
- Facial /Tongue Mobility Deficit
- Patient cough and chokes
- Other: \_\_\_\_\_

**PHYSICAL THERAPY**

- Difficulty in transfer
- Decreased upright tolerance/endurance
- Poor safety balance
- Change in mental status
- Limited ROM/strength
- Pain
- Impaired bed mobility
- Need of therapeutic exercise
- Difficulty with gait
- Difficulty with equipment
- Modalities required
- Home safety problem
- Difficulty with pt family follow through
- Other: \_\_\_\_\_

**OCCUPATIONAL THERAPY**

- Difficulty with ADLs
- Decrease coordination with Fine/Gross Motor coordination
- Decrease upright tolerance/endurance
- Decrease ROM/strength
- Difficulty with cognitive/perceptual motor
- Pain
- Requires Splinting/Adaptive equipment
- Needs instruction in Energy Conservation/Self Pacing
- Difficulty with pt family follow through
- Other: \_\_\_\_\_

**MEDICAL SOCIAL WORKER**

- Behavioral/Psychological Problem
- Family unable to cope with situation
- Living arrangement unsafe/inadequate for level of care
- Patient having difficulty following medical treatment
- Patient needs financial assistance/placement
- Patient is socially isolated
- Patient is overwhelmed with condition
- Need for community resources
- Other: \_\_\_\_\_

Comments/Discussions/Recommendations:  
.....more

**PARTICIPANTS IN CASE CONFERENCE:**

SN Supervisor: \_\_\_\_\_ ST: \_\_\_\_\_  
Skilled Nursing: \_\_\_\_\_ MSW: \_\_\_\_\_  
PT / PTA: \_\_\_\_\_ CHHA: \_\_\_\_\_  
OT / OTA: \_\_\_\_\_ MD: \_\_\_\_\_  
Other: \_\_\_\_\_ Other: \_\_\_\_\_

Patient Name: DOE, JOHN MR#: 01010

Tuesday	Wednesday	Thursday	Friday
		Mar 26 Case Conference Coronavirus (CO...)	Mar 27
Mar 31	Apr 1	Apr 2	Apr 3
Apr 7	Apr 8	Apr 9	Apr 10

Write down Diagnosis if known

Choose identified SN problems being dealt with

“Copy & Past” the narrative you created in the Admission Order into the “Comment” section.

Enter your name in the “RN Supervisor” and/or Skilled Nursing

“Save” then “Review