Detailed Item by Item Guide
For Completing the
Pre-Admission Screening And Resident Review (PASARR) Screening Form
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The PASARR screening is designed to identify persons who may have indicators of mental illness, mental retardation or a related condition. Either a Registered Nurse or a Licensed Vocational Nurse may complete the screening form.

Procedure
The person being screened needs to be provided written notification that they are receiving a PASARR screening. The facility may use the DADS form letter to inform the individual or the facility may use a letter of their own.

When to Complete a PASARR Screening
The PASARR Screening form must be completed and submitted via the TMHP Long Term Care Portal prior to admission.

How to Complete a PASARR Screening
PASARR Screening forms can only be submitted on the TMHP’s LTC Online Portal. TMHP’s LTC Online Portal can be accessed via www.tmhp.com. Processing access is required to the portal and within the portal for submissions. Access details can be found on TMHP’s website.
The PASARR Screening form submission procedure:
- Transmit the PASARR Screening form to TMHP LTC Unit.
- Retain a copy of the PASARR Screening form with the appropriate original signatures on the form in the medical record.
- The PASARR Screening form must include the address of the individual/responsible party or the address where the individual/responsible party may be contacted.

Assessment Retention
Keep the electronic and/or handwritten assessment with appropriate original signatures in the individual’s records for 5 years after the individual's discharge or death. If the individual is a minor, records should be kept for 3 years past the date the individual reaches legal age under Texas law.

Coding Conventions
The following coding conventions should be used when preparing the PASARR Screening form:
- Use a check mark for white boxes with lower case letters in the box or before the item description, if specified condition is met; otherwise these boxes remain blank (e.g., P1, boxes a.-s).
- Use a numeric response (a number or pre-assigned value) for blank white boxes (e.g., H1a, Bowel Incontinence.)
- Darkly shaded areas remain blank.
- Dates - Where recording month, day, and year, enter two digits for the month and the day, and four digits for the year (mm.dd.yyyy). For example, July 6, 2008 is recorded: 07/06/2008.
- The convention of entering “0” - In assigning values for items that have an ordered set of responses (e.g., from independent to dependent), zero (“0”) is used universally to indicate the lack of a problem or that the individual is self-sufficient. For example, an individual whose ADL codes are almost all coded “0” is a self-sufficient individual; the individual whose ADLs have no “0” codes indicates an individual that receives help from others.
- None of the above - is a response item to several items (e.g., Item M6, Skin Conditions, box “g”). Check this item where none of the responses apply; it should not be used to signify lack of information about the item. If “None of above” is not present and none of the items apply, simply leave all boxes blank.
- “Skip” Patterns - There are a few instances where scoring on one item will govern how scoring is completed for one or more additional items. The instructions direct the assessor to “skip” over the next item (or several items) and go on to another (e.g., B1, Comatose, directs the assessor to “skip” to Section G. if B1 is answered “1” - “yes”. The intervening items from B2 - F3 would not be coded. If B1 were recorded as “0” - “no”, then the assessor would continue with Item B2).
- Infant – 0 – 1 years of age; Toddler – 1 – 2 years; Pre-School – 3 – 5 years; School age 6 – 10 years; Adolescence 11 – 18 years Young adult 18-21 years. Unless otherwise stated, the use of the term “child” refers to any of these ages.

Section AA Identification Information
1. Name - Enter the individual's first name, middle initial and last name. Use only formal names (no nicknames, commas, dashes, spaces, or apostrophes).
2. Gender - Enter the sex of the individual. 1 = Female, 2 = Male.
3. Date of Birth - Enter the month, day, and year of the individual's birth.
4. Omitted
5a Social Security Number - Enter the individual's social security number. If the individual has none, leave blank.
5b Medicare Number - Enter the individual's Medicare number. Leave blank if not known.
6a State facility provider number
6b Federal facility provider number
7. Medicaid Individual Number - Enter the individual's Medicaid number (nine digits). Leave blank if the Medicaid number is not known. If it is known the person is not Medicaid, put "n" in the left most box.

Section AB Demographic Information
1. Date of Assessment - Enter date the PASARR Screening form is actually completed. Use a month/day/year format. (Example: MM/DD/YYYY)
2. Admitted From (At entry) - Enter the code for the individual's location immediately before the current admission. If unknown, mark "other".
   1 = Private home/apt with no home health services
   2 = Private home/apt with home health services
   3 = Board and care/assisted living/group home
   4 = Nursing home
   5 = Acute care hospital
   6 = Psychiatric hospital/MR/DD facility
   7 = Rehabilitation hospital
   8 = Other

9. Mental Health History - Enter “0” if the person has no mental health history. Enter “1” (Yes) to MI if the individual meets the following criteria:
   • has a diagnosis of MI (a schizophrenic, mood, paranoid, panic, or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability)
   • has a level of impairment that results in functional limitations in major life activities within the past three to six months in the areas of interpersonal function concentration, persistence, pace, and/or adaptation to change, and
   • has received within the last two years more than one psychiatric treatment more intensive than outpatient care due to a mental disorder, or
   • experienced an episode of significant disruption to the normal living situation, for which supportive services were required

10. Conditions Related to MR/DD status - Check all conditions that are related to MR/DD status that were manifested before age 22, and are likely to continue indefinitely). Check the MR or RC condition if the individual meets at least one of the following criteria:
   • The person has a diagnosis of mental retardation as defined by significantly sub-average general intellectual functioning with deficits in adaptive behavior and manifested during the developmental period before age 18.
   • The person has a related condition that is a severe chronic disability manifested before age 22, which:
     o is attributable to cerebral palsy, epilepsy, or any other condition, including autism, but excluding mental illness, found to be closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with MR and requires treatment or services similar to those persons with MR;
     o is likely to continue indefinitely; and
     o results in substantial functional limitations in at least three of the following areas of major life activity:
       ▪ self-care
       ▪ understanding and use of language
       ▪ learning
       ▪ mobility
       ▪ self-direction
       ▪ the capacity for independent living
   • The individual has any history of mental retardation or developmental disability;
   • There is any presenting evidence (cognitive or behavior functions) that may indicate the person has mental retardation or a developmental disability.
• Check each that apply
  a. Not applicable—no MR/DD
     MR/DD with organic condition
  b. Down’s syndrome
  c. Autism
  d. Epilepsy
  e. Other organic condition related to MR/DD
  f. MR/DD with no organic condition

Section B Cognitive Patterns
B1. Comatose
Record whether the individual has had a persistent vegetative state or no discernible consciousness.
Enter
  0 = No
  1 = Yes
NOTE: If the response is 1 = Yes, then Skip to Section G.

B2. Memory
Do not complete B2. Memory if B1 is Yes -1. Skip to Section G.
Document the individual's functional capacity to remember both recent and long-past events (i.e., short-term and long-term memory). Identify the most representative level of function, not the highest. Judgment must be used to determine whether or not a single observation provides sufficient information on the individual's typical level of function. For individuals with limited communication skills, ask family about the individual's memory status.

• Short-term memory - Ask the individual to describe a recent (within the past several minutes) event that both of you had the opportunity to remember.
  1 = Memory problem
  If there is no positive indication of memory ability, enter “1”, Memory Problem. An individual with short-term memory problems 6 of 7 days should be coded as “1”.
  0 = Memory OK
  Individual has the capacity to recall short-term items.
  Leave blank if unable to assess

• Long-term memory – Engage in conversation that is meaningful to the individual. Ask questions for which you can validate the answers based on your general knowledge or the individual’s family.
  1 = Memory problem
  If there is no positive indication of memory ability, enter “1”, Memory Problem.
  0 = Memory OK
  Individual has the capacity to recall long-term items.
  Leave blank if unable to assess

CHILD: Ask the child to remember three items (e.g. cat, dog, bird) for a few minutes. After stating all three items, ask the child to repeat them to verify that you were heard and understood. Then proceed to talk about something else- do not be silent or leave the room. In a few minutes, ask the child to repeat the name of each item. For children with verbal communication deficits, non-verbal responses are acceptable. If the child has limited communication skills, ask the parents/ caregiver or staff about the child’s memory status. If the child is an infant or toddler and cannot be tested because of their age, leave B2 blank.

B3. Memory / Recall Ability
To determine the individual’s memory/recall performance.
CHECK ALL THOSE THAT APPLY:
  a. Current Season – Able to identify the current season (e.g., correctly refers to weather for the time of year, legal holidays, religious celebrations, etc.).
  f. Tell date – Able to tell the date
  g. Tell state – Able to say that they are in Texas.
  e. None of the above are recalled – Individual is unable to recall any of the items in B3a – B3c.
Enter the individual’s actual performance in making everyday decisions about tasks or activities of daily living. If the individual does not report participating in decision-making, whatever their level of capability may be, the individual should be considered to have impaired performance on decision-making.

CHILD: Assess the child to determine if he makes decisions about tasks or activities of daily living. Consult the parent, caregiver, or staff. If a child cannot be assessed because of the child’s age, leave blank.

Enter the number that corresponds to the appropriate response:
0. Independent. Individual’s decision in organizing daily routine and making decision were consistent, reasonable, and organized reflecting lifestyle, culture, values.
1. Modified Independence. Individual organized daily routine and made safe decisions in familiar situations, but had trouble in decision-making when faced with new tasks or situations.
2. Moderately Impaired. Individual’s decisions were poor; the individual required reminders, cues and supervision in planning, organizing and correcting daily routines. Individual attempts to make decisions, although poorly.
3. Severely Impaired. Individual’s decision-making was severely impaired; the Individual never (or rarely) made decisions, despite being provided with opportunities and appropriate cues.

B5. Indicators of Delirium – Periodic Disordered Thinking/Awareness
A record behavioral sign that may indicate that delirium is present. Frequently, delirium is caused by a treatable illness such as infections or reaction to medications.

INDICATORS:
a. Easily Distracted. Difficulty paying attention; is sidetracked.
b. Period of Altered Perception or Awareness of Surroundings. Moves lips or talks to someone not present; individual believes they are somewhere else; confuses night and day.
c. Episodes of Disorganized Speech. Speech slips from topic to topic, answers to questions are unrelated, or speech is so disorganized it is incomprehensible.
d. Periods of Restlessness. Difficulty paying attention; is sidetracked.
e. Period of Lethargy. Sluggishness, staring into space, difficult to arouse, little body movement.
f. Mental Function Varies Over the Course of the Day. Difficulty paying attention; is sidetracked.

Reply to a. – f. above using the options below.
0 = Behavior not present
1 = Behavior present, not of recent onset
2 = Behavior present over last 7 days appears different from usually functioning (e.g., new onset or worsening)

C1. Hearing
Enter the individual’s ability to hear (with environmental adjustments, if necessary). Environmental adjustments include reducing noise volume by lowering the sound on televisions or radios, and installing amplification devices on televisions.

Evaluate hearing ability after the individual has a hearing appliance in place, if the individual uses an appliance. Interview, observe, and ask about the hearing function. Consult with the individual’s family. Test the accuracy of your findings by observing the individual during your verbal interactions.

Be alert to what you have to do to communicate with the individual. For example, if you have to speak more clearly, use a louder tone, speak more slowly, or use more gestures, or if the individual needs to see your face to know what you are saying, or if you have to take the individual to a quieter area to conduct the interview. All of these are cues that there is a hearing problem, and should be so indicated in the coding.

0 = Hears Adequately. Individual hears all normal conversational speech, including when using the telephone, watching television, and engaged in activities.
1 = Minimal Difficulty. Individual hears speech at conversational levels but has difficulty hearing when not in quiet listening conditions or when not in one-on-one situations.
2 = Hears in Special Situations Only. Although hearing-deficient, the individual compensates when the speaker adjusts tonal quality and speaks distinctly; or the individual can hear only when the speaker’s face is clearly visible or requires the use of a hearing-enhanced telephone.
3 = Highly Impaired. Individual hears only some sounds and frequently fails to respond even when the speaker adjusts tonal quality, speaks distinctly, or is positioned face-to-face. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

C4. Making Self Understood
Enter the individual’s ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these.
Interact with the individual. Observe and listen to their efforts to communicate with you. Observe their interaction with others in different settings (e.g., one-on-one, groups) and different circumstances (e.g., when calm, when agitated). Consult with individual’s family or caregivers.

Choose the code that best describes the individual’s ability to be understood.

0 = Understood. Individual expresses ideas clearly.
1 = Usually Understood. Individual has difficulty finding the right words or finishing thoughts, resulting in delayed responses; or the individual requires some prompting to make self-understood.
2 = Sometimes Understood. Individual has limited ability, but is able to express concrete requests regarding at least basic needs (e.g., food, drink, sleep, and toilet).
3 = Rarely or Never Understood. At best, understanding is limited to staff interpretation of highly individual, individual-specific sounds or body language (e.g., indicated presence of pain or need to toilet).

CHILD: Assess the child to determine his ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these. Interact with the child. Observe and listen to the child’s efforts to communicate with you. Observe their interactions with others in different settings (e.g., one-on-one, groups) and different circumstances (e.g., when calm, when agitated). Consult with the parent/caregiver or staff to determine if the child makes his needs known or if the parent/caregiver or staff member is anticipating all of the child’s needs.

C6. Ability to Understand Others
Enter the individual’s ability to comprehend verbal information whether communicated to the individual orally, by writing, or in sign language or Braille. This item measures not only the individual’s ability to hear messages but also to process and understand language. This may be due to functional problems or that the individual uses a different language.

Interact with the individual. Consult with individual’s family or caregiver.

Enter the number that corresponds to the appropriate response:
0 = Understands. Individual clearly comprehends the speaker’s message(s) and demonstrates comprehension by words or actions/behaviors.
1 = Usually Understands. Individual may miss some part or intent of the message but comprehends most of it. The individual may have periodic difficulties integrating information but generally demonstrates comprehension by responding in words or actions.
2 = Sometimes Understands. Individual demonstrates frequent difficulties integrating information, and responds adequately only to simple and direct questions or directions. When staff rephrases or simplifies the message(s) and/or use gestures, the individual’s comprehension is enhanced.
3 = Rarely / Never Understands. At best, individual demonstrates very limited ability to understand communication. Alternatively, caregiver has difficulty determining whether or not the individual comprehends messages, based on verbal and non-verbal responses. Alternatively, the individual can hear sounds but does not understand messages.

D1. Vision
Enter the number that corresponds to the appropriate reported response:
0 = Adequate. Individual sees fine detail, including regular print in newspapers/books.
1 = Impaired. Individual sees large print, but not regular print in newspapers/books.
2 = Moderately Impaired. Individual has limited vision; not able to see newspaper headlines but can identify objects.
3 = Highly Impaired. Object identification in question, but eyes appear to follow objects.
4 = Severely Impaired. Individual has no vision or sees only light, colors, or shapes; eyes do not appear to follow objects.

E1. Indicators of Depression, Anxiety, Sad Mood
Code the indicators as follows based on direct observation, interview, or consultation with friends and family:
0 = Not exhibited during last 30 days.
1 = Exhibited up to 5 days a week.
2 = Exhibited daily or almost daily (6, 7 days a week).

VERBAL EXPRESSIONS OF DISTRESS.
a. Individual made negative statements. Examples include: “Nothing matters; Would rather be dead; What’s the use; Regrets having lived so long; Let me die.”
b. Repetitive questions. Examples include: “Where do I go; What do I do?”
c. Repetitive verbalizations. Examples include: Calling out for help. “God help me.”
d. Persistent anger with self or others. Examples include: Easily annoyed, anger at needing assistance, anger at care received.
e. Self deprecation. Examples include: “I am nothing; I am of no use to anyone.”
f. Expressions of what appear to be unrealistic fears. Examples include: Fear of being abandoned, left alone or fear of being with others.
g. Recurrent statements that something terrible is about to happen. Examples include: Believes they are about to die or have a heart attack.
h. Repetitive health complaints. Examples include: Persistently seeks medical attention, obsessive concern with body function.
i. Repetitive anxious complaints/concerns (non-health related). Examples include: Persistently seeks attention/reassurance regarding schedule, meals, laundry, clothing, relationship issues.

SLEEP-CYCLE ISSUES
j. Unpleasant mood in morning. Examples include: Angry, Irritable.
k. Insomnia/change in usual sleep pattern. Examples include: difficulty falling asleep, fewer or more hours of sleep than usual, waking up too early and unable to fall back to sleep.

SAD, APATHETIC, ANXIOUS APPEARANCE
l. Sad, pained, worried facial expressions. Example include: furrowed brows.
m. Crying, tearfulness. Examples include: tearful eyes.
n. Repetitive physical movements. Examples include: Pacing, hand wringing, restlessness, fidgeting, picking.

LOSS OF INTEREST
o. Withdrawal from activities of interest. Examples include: No interest in long standing activities or being with friends and family.
CHILD: If the child’s withdrawal from activities of interest persists over time, it should continue to be coded, regardless of the amount of time the child has withdrawn from activities of interest or has shown no interest in being with family/friends.
p. Reduced social interaction. Examples include: Less talkative, more isolated.
Initiate conversations with the individual. Observe carefully for any indicators. Consult with family and friends who may have direct knowledge.
CHILD: If possible, initiate a conversation with the child and observe for any of the above indicators. Consult with the caregivers, and family who have direct knowledge of the child’s behavior. INFANTS/TODDLERS: For infants or toddlers, who cannot be assessed due to their age, leave blank.
For each indicator listed above (a-f), think about whether or not it occurred at all.
For MOOD ITEMS code as follows:
0 = Not reported as exhibited during last 30 days.
1 = Exhibited up to 5 days a week (i.e., exhibited at least once during the last 30 days but less than 6 days a week)
2 = Exhibited daily, almost daily (6, 7 days a week), or multiple times daily.

For DEPRESSION ITEMS code as follows:
If reported as exhibited twice in the last 7 days it should be coded as “1” to indicate that the indicator of depression was exhibited up to 5 days a week (but less than 6 days a week). It does not need to occur in each week to be coded. If an indicator of depression occurs only in the beginning of the look back period, it should be coded as an indicator of depression occurring up to 5 days a week (but less than 6 days a week) in the last 30 days.

E2. Mood Persistence
Document if one or more indicators of depressed, sad or anxious mood were not easily altered by attempts to “cheer up”, console, or reassure the individual during the look back period.
Enter the number that corresponds to the appropriate response:
0 = No mood indicators.
1 = Indicators present, easily altered.
2 = Indicators present, not easily altered.
Observe the individual and discuss any concerning situations with friends and family.
E4. Behavioral Symptoms

Identify the (A) frequency, and (B) alterability of reported behavioral symptoms in the last 7 days that cause distress to the individual, or are distressing or disruptive to caregivers and friends and family. Such behaviors include those that are potentially harmful to the individual themselves or disruptive in the environment, even if others appear to have adjusted to them.

Code the indicators as follows based on direct observation or consultation with friends and family:

(A) Behavioral symptom frequency in last 7 days.
0 = Not exhibited in last 7 days.
1 = Exhibited 1 to 3 days in last 7 days.
2 = Exhibited 4 to 6 days, but less than daily.
3 = Exhibited daily.

(B) Behavioral symptom alterability in last 7 days.
0 = Behavior not present OR behavior was easily altered.
1 = Behavior was not easily altered.

INDICATORS

a. WANDERING. Moved with no rational purpose, seemingly oblivious to needs or safety. Locomotion with no discernible, rational purpose. A wandering individual may be oblivious to their physical or safety needs. Wandering behavior should be differentiated from purposeful movement (e.g., a hungry person moving about in search of food). Wandering may be manifested by walking or by wheelchair. Do not include pacing as wandering behavior. Pacing back and forth is not considered wandering, and if it occurs, it should be documented in Item E1 n. Repetitive physical movements.

b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS. Others were threatened, screamed at, and/or cursed.

c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS. Others were hit, shoved, scratched, and/or sexually abused.

d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS. Made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings.

e. RESISTS CARE. Resisted taking medications/injections, ADL assistance, or help with eating. This category does not include instances where the individual has made an informed choice not to follow a course of care (e.g., individual has exercised their right to refuse treatment, and reacts negatively as caregivers try to re-institute treatment). Observe the individual. Observe how the individual responds to caregivers' attempts to deliver care. Consult with friends and family.

CHIL: Focus on the child’s actual behavior rather than what the caregiver or staff believe to be the child’s reason for the behavior. Record those behaviors that are observed or documented through interviews with caregivers or staff. Consult with caregivers, staff and family regarding the frequency of the behavior within the last 30 days. Finally, review the medical record for documentation.

INFANTS/TODDLERS: For infants or toddlers who cannot be assessed due to their age, leave blank

A. Behavioral symptoms frequency in last 7 days.
0 = Not exhibited if the individual did not exhibit that type of symptom in the look back period. The code applies to individuals who have never exhibited the behavioral symptom or those who have previously exhibited the symptom but now no longer exhibit it, including those whose behavioral symptoms are fully managed by psychotropic drugs, restraints, or a behavior-management program.
1 = Exhibited 1 to 3 days in last 30 days.
2 = Exhibited 4 to 6 days, but less than daily.
3 = Occurred daily or more frequently (i.e., multiple times each day).

B. Behavioral symptoms alterability in last 7 days.
0 = The behavioral symptom was not present or the behavioral symptom was easily altered with current interventions.
1 = The behavioral symptom occurred with a degree of intensity that is not responsive to caregiver attempts to reduce the behavioral symptom through limit setting, diversion, adapting daily routines to the individual’s needs, environmental modification, activities programming, comfort measures, appropriate drug treatment, etc.

G1. ADL: Activities of Daily Living

Identify the ADL (A) SELF-PERFORMANCE, and (B) SUPPORT PROVIDED. Determines how much the individual did for themselves versus how much verbal or physical help was required. Code the indicators as follows based on direct observation or consultation with friends and family:

(A) ADL SELF-PERFORMANCE
Measures what the individual actually did (not what they are capable of doing) within each ADL category over the 30 day look back period according to a performance-based scale.

0 = INDEPENDENT.
1 = SUPERVISION.
2 = LIMITED ASSISTANCE.
3 = EXTENSIVE ASSISTANCE.
4 = TOTAL DEPENDENCE.
8 = ACTIVITY DID NOT OCCUR.

(B) ADL SUPPORT PROVIDED

0 = No setup of physical help from staff.
1 = Setup help only.
2 = One person physical assist.
3 = Two+ persons physical assist.
8 = ADL activity itself did not occur during the look back period.

INDICATORS

a. BED MOBILITY. How individual moves to and from lying position, turns side to side, and positions body while in bed, in a recliner, or other type of furniture the individual sleeps in, rather than a bed. CHILD: Observe how the child moves about in bed from one position to another and note if the child turns from lying on their back or abdomen to a side lying position. Observe the child to determine if he can change positions independently or if they require assistance. Interview the child, parent, caregiver, or staff member to determine if the child can move from on position to another independently or if assistance is needed.

b. TRANSFER. How individual moves between surfaces – to/from bed, chair, wheelchair, standing position, (EXCLUDE to/from bath/toilet which is covered under Toilet Use and Bathing). CHILD: Observe how the child moves between surfaces – i.e., to/from bed, chair, wheelchair, standing position. Observe the child to determine if they can transfer from bed to chair or wheelchair. Interview the child, parent, caregiver or staff member to determine if the child needs assistance with transferring from bed to a chair and if he is capable of doing any of the transfer alone.

c. WALKS. How individual walks between locations in a room.

e. WHEELCHAIR MOBILITY If in wheelchair, self-sufficiency once in chair. If no wheelchair is used, leave blank. DRESSING. How individual puts on, fastens, and take off all items of street clothing, including donning/removing a prosthesis. Dressing includes putting on and changing pajamas, and housedresses. h. EATING. How an individual eats and drinks (regardless of skill) including intake of nourishment by other means (e.g. tube feeding, total parenteral nutrition.) Even an individual who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment), and is not to be coded as an “8”. Code ‘0’ if the individual is receiving nourishment via tube feeding and manages the tube feeding independently. Code ‘4’ rather than ‘8’ for an individual who is receiving IV fluids or TPN. Code ‘4’ for an individual who is highly involved in giving themselves a tube feeding and not totally dependent on others. Code ‘8’ if the individual truly did not receive any nourishment which is a serious issue.

CHILD: Observe how the child eats and drinks and assess if the child can feed themselves independently or if they require assistance from the parent/caregiver/staff. Interview the parent/caregiver/staff to ascertain the level of assistance the child requires at meal time.

i. TOILET USE. How individual uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes. CHILD: Interview the parent/caregiver/staff pertaining to the child’s use of the bathroom, commode, bedpan, or urinal, whether the child wears diapers, of if the child has a colostomy or ileostomy. Ask if the child can transfer on and off toilet, cleanse herself, change pads, manage an ostomy or catheter if applicable, and adjust clothing after toilet use.

j. PERSONAL HYGIENE. How individual maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers which is covered under Bathing).

Enter, in column (A) labeled SELF-PERF, the number that corresponds to the appropriate response - the look back period is 7 days.

0 = INDEPENDENT. No help or oversight needed OR help/oversight provided only one or two times.
1 = SUPERVISION. Oversight, encouragement, or cueing provided 3+ times OR Supervision 3+ times and physical assistance provided, but only one or two times.
2 = LIMITED ASSISTANCE. Individual highly involved in activity, received physical help in guided maneuvering of limbs or other non weight-bearing assistance on 3+ occasions OR limited assistance 3+ and more weight-bearing support provided, but for only one or two times.
3 = EXTENSIVE ASSISTANCE. While the individual performed part of the activity, help of the following type(s) was provided 3+ times: a) weight-bearing support provided 3+ times or b) full caregiver performance of activity 3+ times.

4 = TOTAL DEPENDENCE. Full assistance of the activity during entire period. There is complete non-participation by the individual in all aspects of the ADL definition task. If the individual performs part of the activity themselves, it would not be coded as a 4.

8 = ACTIVITY DID NOT OCCUR. During the past 7 days, the ADL activity was not performed by the individual or caregiver. The particular activity did not occur at all.

G2. Bathing
How person takes full body bath/shower. Enter the corresponding code capturing the maximum amount of assistance the individual received during bathing episodes.

0 = Independent. No help provided
1 = Supervision. Oversight help only.
2 = Physical help limited to transfer only. Individual highly involved in activity, received physical help in guided maneuvering of limbs or other non weight-bearing assistance on 3+ occasions OR limited assistance 3+ and more weight-bearing support provided, but for only one or two times.
3 = Physical help in part of bathing activity. While the individual performed part of the activity, help of the following type(s) was provided 3+ times: a) weight-bearing support provided 3+ times or b) full caregiver performance of activity 3+ times
4 = Total dependence. Full assistance of the activity during entire period. There is complete non-participation by the individual in all aspects of the ADL definition task. If the individual performs part of the activity themselves, it would not be coded as a 4.

G4. Functional Limitation in Range of Motion
Coding for reported functional limitations that interfere with daily functioning, particularly with activities of daily living, or places the individual is at risk for injury.

(A) RANGE OF MOTION. To record the presence of limitation in range of joint motion.
Enter the number that corresponds to the appropriate reported response:
0 = No limitation. Individual has full function range of motion on the right and left sides.
1 = Limitation on one side. Individual has a limitation on one side, either right or left, that interferes with daily functioning or places the individual at risk of injury.
   Code ‘1’ if the individual has an amputation on one side of the body.
2 = Limitation on both sides. Individual has limitations on both sides that interferes with daily functioning or places the individual at risk of injury.
   Code ‘2’ if the individual has bilateral amputations.

(B) VOLUNTARY MOVEMENT. To record the impairment in purposeful, intentional, functional movement. This refers to range of impairments exhibited when an individual tries to perform a task and includes deficits such as uncoordinated movements, tremors, spasms, muscular rigidity, jerking as well as lack of initiation of movement. Impairments in voluntary movement are often due to injury or disease of muscles, bones, nerves, spinal cord or the brain and can place an individual at risk for functional disability and injury.
Enter the number that corresponds to the appropriate response:
0 = No loss. Individual moves body part to complete the required task. Movements are smooth and coordinated.
1 = Partial loss of voluntary movement. Individual is able to initiate and complete the required task but movements are slow, spastic, uncoordinated, rigid, choreiform, frozen, etc. on one or both sides. Individuals with full loss of voluntary movement on one side of the body and full range on the other would be coded ‘1’ partial loss. Individuals with partial loss on one side and full loss on the other would be coded ‘1’ partial loss. If a body part is missing on one side such as a left above knee amputation code ‘1’.
2 = Full loss of voluntary movement. Individual is not able to initiate the required task. There is no voluntary movement on either side.
   If missing bilaterally body parts due to amputation, code ‘2’.
   a. Neck
   b. Arm
   c. Hand
   d. Leg
   e. Foot
   f. Other limitations
G6. Modes of Transfer
To record the type(s) of appliances or assistive devices the individual uses for transferring in and out of bed or a chair and for bed mobility during last 7 days.

CHECK ALL THAT APPLY.

a. Bedfast all or most of time. Individual is in bed or in a recliner for 22+ hours per day. This definition includes individuals who are primarily bedfast but have bathroom privileges. Code this item when it occurs on at least one of the last 7 days.

b. Bed rails used for bed mobility or transfer. Refers to any type of side rail(s) attached to the bed USED by the individual as a means of support to facilitate turning and repositioning in bed, as well as for getting in and out of bed. Do NOT check this item if the individual did not use rails for this purpose.

When a bedrail is both a restraint and a transfer or mobility aid, it should be coded at Item P4 and at Item G6b.

f. None of above.

H1. Continence Self-Control Categories
Code for the individual's performance over 24 hours in the last 7 days. A five-point scale is used to describe continence patterns. Notice that in each category, different frequencies of incontinent episodes are specified for bladder and bowel. The differences are due to the fact that there are more episodes of urination per day and week whereas bowel movements typically occur less often.

Enter the number that corresponds to the most appropriate response

0 = CONTINENT. Complete control (includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool). Always dry.

1 = USUALLY CONTINENT.
BLADDER incontinent episodes once a week or less;
BOWEL, less than weekly

2 = OCCASIONALLY INCONTINENT.
BLADDER, 2 or more times a week but not daily;
BOWEL, once a week.

3 = FREQUENTLY INCONTINENT.
BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2 -3 times a week.

4 = INCONTINENT.
Had inadequate control of BLADDER, multiple daily episodes;
BOWEL, all (or almost all) of the time.

a. BOWEL CONTINENCE. Control of bowel movement with appliance or bowel continence programs, if employed.

b. BLADDER CONTINENCE. Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed.

Refers to control of urinary bladder function and/or bowel movement

H2. Bowel Elimination Pattern
CHECK ALL THOSE THAT APPLY

c. Diarrhea. Frequent elimination of watery stools from any etiology (e.g., diet, viral or bacterial infection).

d. Fecal Impaction. Presence of hard stool upon digital rectal exam. Fecal impaction may also be present if stool is seen on an abdominal x-ray in the sigmoid colon or higher, even with a negative digital exam or documentation in the medical record of daily bowel movement.

e. NONE OF THE ABOVE.

H3. Appliances and Programs
CHECK ALL THOSE THAT APPLY

a. Any schedule toileting plan. A plan for bowel and/or bladder elimination whereby caregivers at scheduled times each day either take the individual to the toilet room, or give the individual a urinal, or remind the individual to go to the toilet.

CHILD: Interview the parent/caregiver/staff about toileting. Ask if the parent/caregiver/staff take the child to the bathroom at certain times during the day. Or, if the parent/caregiver/staff prompts the child, ask how often the child has to be reminded to use the bathroom

b. Bladder retraining program. A retraining program where the individual is taught to consciously delay urinating (voiding) or resist the urgency to void. Individuals are encouraged to void on a schedule rather than according to their urge to void. This form of training is used to manage urinary incontinence due to bladder instability.

c. External (condom) catheter. A urinary collection appliance worn over the penis.
d. Indwelling catheter. A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. Includes catheters inserted through the urethra or by supra-public incision.

i. Ostomy present. Any type of excretory ostomy of the gastrointestinal or genitourinary tract. Do NOT code gastrostomies or other feeding "ostomies" here.

j. NONE OF ABOVE.

I DISEASES / DIAGNOSIS

Record those diseases or infections, which have a relationship to the individual's current ADL status, cognitive status, mood or behavior status, medical treatments, nursing monitoring or risk of death. The disease conditions in this section require a physician-documented diagnosis in the medical record. Conditions that have been resolved or no longer affect the individual's functioning should NOT be included.

11. Diseases
CHECK ALL THOSE THAT APPLY

ENDOCRINE/METABOLIC/NUTRITIONAL
a. Diabetes mellitus. Includes insulin-dependent diabetes mellitus (IDDM) and diet-controlled diabetes mellitus (NIDDM or AODM).
b. Hyperthyroidism.
c. Hypothyroidism.

HEART/CIRCULATION
d. Arteriosclerotic heart disease (ASHD).
e. Cardiac dysrhythmias. Disorder of heart rate or heart rhythm.
f. Congestive heart failure.
g. Deep vein thrombosis.
h. Hypertension.
i. Hypotension.
j. Peripheral vascular disease. Vascular disease of the lower extremities that can be of venous and/or arterial origin including diabetic PVD.
k. Other cardiovascular disease.

MUSCULOSKELETAL
l. Arthritis. Includes degenerative joint disease (DJD), osteoarthritis (OA), and rheumatoid arthritis (RA). Record more specific forms of arthritis (e.g., Sjogren’s syndrome; gouty arthritis) in Item I3 (with ICD-9-CM code)
m. Hip fracture. Includes any hip fracture that occurred at any time that continues to have a relationship to current status, treatments, monitoring, etc. Hip fracture diagnoses also include femoral neck fractures, fractures of the trochanter, and subcapital fractures.
n. Missing limb (e.g., amputation). Includes loss of any part of any upper or lower extremity. Missing digits should be coded in I3.
o. Osteoporosis.
p. Pathological bone fracture. Fracture of any bone due to weakening of the bone, usually as a result of a cancerous process.
ss. Spina Bifida.

NEUROLOGICAL
q. Alzheimer’s Disease.
r. Aphasia. A speech or language disorder caused by disease or injury to the brain resulting in difficulty expressing thoughts (i.e., speaking, writing), or understanding spoken or written language.
s. Cerebral Palsy. Paralysis related to developmental brain defects or birth trauma. Includes spastic quadriplegia secondary to cerebral palsy.
t. Cerebrovascular Accident. A vascular insult to the brain that may be caused by intracranial bleeding, cerebral thromboses, infarcts, and emboli.
u. Dementia other than Alzheimer’s Disease. Includes diagnoses of organic brain syndrome (OBS) or chronic brain syndrome (CBS), senility, senile dementia, multi-infarct dementia, and dementia related to neuralgic diseases other than Alzheimer’s (e.g., Picks, Creutzfeld-Jacob, Huntington’s disease, etc.)
tt. Hydrocephalus.
u. Hemiplegia/Hemiparesis. Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on one side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor.
w. Multiple sclerosis. Chronic disease affecting the central nervous system with remissions and relapses of weakness, incoordination, paresthesis, speech disturbances and visual disturbances.
x. Paraplegia. Paralysis (temporary or permanent impairment of sensation, function, motion) of the lower part of the body, including both legs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury.
y. Parkinson’s disease.
z. Quadriplegia. Paralysis (temporary or permanent impairment of sensation, function, motion) of all four limbs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury. Spastic quadriplegia, secondary to cerebral palsy, should not be coded as quadriplegia. Do not code quadriparesis here.

aa. Seizure Disorder/Epilepsy. Epilepsy is a chronic disorder with recurrent seizures.
bb. Transient ischemic attack (TIA). A sudden, temporary, inadequate supply of blood to a localized area of the brain. Often recurrent.
cc. Traumatic brain injury. Damage to the brain as a result of physical injury to the head.

PSYCHIATRIC/MOOD
dd. Anxiety disorder.
eed. Depression.
ff. Manic depression (bipolar disease). Includes documentation of clinical diagnoses of either manic depression or bipolar disorder. “bipolar disorder” is the current term for manic-depressive illness.
gg. Schizophrenia.

PULMONARY
hh. Asthma
ii. Emphysema/COPD. Includes COPD (chronic obstructive pulmonary disease) or COLD (chronic obstructive lung disease), and chronic restrictive lung diseases such as asbestosis and chronic bronchitis.

ww. Chronic Respiratory Failure.
xx. Cystic Fibrosis.

SENSORY
jj. Cataracts.
kk. Diabetic Retinopathy.
ll. Glaucoma
mm. Macular Degeneration

OTHER
nn. Allergies
oo. Anemia  Includes anemia of any etiology.
qq. Renal Failure.
yy. ADHD Syndrome.
zz. Developmental Delay.

uu. Mental Retardation.
vv. Down’s Syndrome.
rr. None of above.

I2. Infections
Check an item only if the infection has a relationship to current ADL status, cognitive status, mood and behavior status, medical treatment, nursing monitoring, or risk of death. Do not record any conditions that have been resolved and no longer affect the individual’s functional status or care plan.

CHECK ALL THAT APPLY
A Antibiotic resistant infection. (e.g., Methicillin Resistant Staphylococcus aureus (MRSA), Methicillin amnioglycocide Resistant Staphylococcus Aureus, and vancomycin Resistant Enterococcus (VRE), and Extended Spectrum Beta-Lactalase Organisms). An infection in which bacteria have developed a resistance to the effective actions of an antibiotic. Check this item only if there is supporting documentation in the medical record (including transmittal records of new admissions and recent transfers from other institutions).
b. Clostridium difficile (C.diff). Diarrheal infection caused by the Clostridium difficile bacteria. Check this item only if there is supporting documentation in the medical record.
c. Conjunctivitis. Inflammation of the mucous membranes lining the eyelids. Maybe of bacterial, viral, allergic, or traumatic origin.
e. Pneumonia. Inflammation of the lungs; most commonly of bacterial or viral origin.
f. Respiratory infection. Any upper or lower acute respiratory infection other than pneumonia.
g. Septicemia. Morbid condition associated with bacterial growth in the blood.
h. Sexually transmitted diseases. Check this item only if there is supporting documentation of a current diagnosis including but not limited to gonorrhea, or syphilis. DO NOT include HIV in this category.
i. Tuberculosis. Includes individuals with active tuberculosis or those who have converted to PPD positive tuberculin status and are currently receiving drug treatment (e.g., isoniazid (INH), ethambutol, rifampin, cycloserine) for tuberculosis.

j. Urinary tract infection in the last 90 days. Includes chronic and acute symptomatic infection(s) in the last 90 days

k. Viral hepatitis. Inflammation of the liver of viral origin. This category includes diagnoses of hepatitis A, hepatitis B, hepatitis non-A non-B, hepatitis C, and hepatitis E.

l. Wound infection. Infection of any type of wound (e.g., postoperative; traumatic; pressure) on any part of the body.

m. NONE OF ABOVE

CHILD: Observe the child, interview the parent/caregiver, and review the medical record to determine if the child has been receiving treatment for an acute infection or has been receiving treatment for a serious infection.

I3. Other Current or More Detailed Diagnoses and ICD-9 Codes

To identify additional conditions not listed in Item I1 and I2 that affect the individual’s current ADL status, mental health, developmental disability, mood and behavioral status, medical treatments, nursing monitoring, or risk of death. It is important to put all applicable psychiatric diagnoses on the PASARR Screening form.

J1. Problem Conditions

Record specific problems or symptoms that affect or could affect the individual’s health or functional status, and to identify risk factors for illness, accident, and functional decline.

CHECK ALL THAT APPLY

INDICATORS OF FLUID STATUS

a. Weight gain or loss of 3 or more pounds within a 7 day period for adults. Individual reported weight gain or loss in past week. When the individual does not know, leave this item blank.

b. Inability to lie flat due to shortness of breath. Individual is uncomfortable lying supine. Individual requires more than one pillow or having the head of the bed mechanically raised in order to get enough air (orthopnea). This symptom often occurs with fluid overload.

c. Dehydrated; output exceeds input. Check this item if the individual has two or more of the following indicators:
   • Individual usually takes in less than the recommended 1500 ml of fluids daily (water or liquids in beverages, and water in high fluid content foods such as gelatin and soups). Note: the recommended intake level has been changed from 2500 ml to 1500 ml to reflect current practice standards.
   • Individual has one or more clinical signs of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset or increased confusion, fever, abnormal laboratory values (e.g., elevated hemoglobin and hematocrit, potassium chloride, sodium albumin, blood urea nitrogen, or urine specific gravity). Individual’s fluid loss exceeds the amount of fluids they take in (e.g., loss from vomiting, fever, diarrhea that exceeds fluid replacement).
   d. Insufficient fluid; did not consume all/almost all liquids provided in the last 3 days. Liquids can include water, juices, coffee, gelatins, and soups. This item should be coded only when the individual is receiving, but not consuming, the proper amount of fluids to meet their daily minimum or assessed requirements. The item should not be coded for individuals who may request excessive amounts above and beyond what could reasonably be expected to be consumed.

CHILD: Observe the child, for clinical signs and symptoms of dehydration. Interview the parent/caregiver/staff to determine how they assess the child’s hydration, such as keeping intake and output records, routinely weighing the child, or counting diapers or pads in a 24-hour period. Review the medical record for documentation.

OTHER

e. Delusions. Fixed, false beliefs not shared by others that the individual holds even when there is obvious proof or evidence to the contrary (e.g., belief they are terminally ill; belief that spouse is having an affair; belief that food served is poisoned.)

f. Dizziness/Vertigo. The individual experiences the sensation of unsteadiness, that they are turning, or that their surroundings are whirling around

g. Edema. Excessive accumulation of fluid in tissues, either localized or systemic (generalized). Includes all types of edema (e.g., dependent, pulmonary, pitting).

h. Fever. A fever is present when the individual’s temperature is 2.4 degrees Fahrenheit greater than their baseline temperature.

i. Hallucinations. False sensory perceptions that occur in the absence of any real stimuli. An hallucination maybe auditory (e.g., hearing voices), visual (e.g., seeing people, animal), tactile (e.g., feeling bugs crawling over skin), olfactory (e.g., smelling poisonous fumes), or gustatory (e.g., having strange tastes)
j. Internal bleeding. Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting “coffee grounds,” hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing. However, nose bleeds that are easily controlled should not be coded as internal bleeding.

k. Recurrent lung aspirations in last 90 days. Note the extended time frame. Often occurs in individuals with swallowing difficulties or who receive tube feedings (i.e., esophageal reflux of stomach contents). Clinical indicators include productive cough, shortness of breath, wheezing. It is not necessary that there be X-ray evidence of lung aspiration for this item to be checked.

l. Shortness of breath. Difficulty breathing (dyspnea) occurring at rest, with activity, or in response to illness or anxiety. If the individual has shortness of breath while lying flat, also check item J1b – inability to lie flat due to shortness of breath.

m. Syncope (fainting). Transient loss of consciousness, characterized by unresponsiveness and loss of postural tone with spontaneous recovery.

n. Unsteady gait. A gait that places the individual at risk of falling. Unsteady gaits take many forms. The individual may appear unbalanced or walk with a sway. Other gaits may have uncoordinated or jerking movements. Examples of unsteady gaits may include fast gaits with large, careless movements; abnormally slow gaits with small shuffling steps; or wide-based gaits with halting, tentative steps.

o. Vomiting. Regurgitation of stomach contents; may be caused by any etiology (e.g., drug toxicity; influenza; psychogenic)

p. None of above

J2. Pain Symptoms
Record the highest level of pain frequency and intensity. Pain refers to any type of physical pain or discomfort in any part of the body. Pain may be localized to one area, or may be more generalized. It may be acute or chronic, continuous or intermittent, or occur at rest or with movement. The pain experience is very subjective; pain is whatever the individual says it is. Use your best judgment when coding.

a. FREQUENCY with which individual complains or shows evidence of pain. Frequency is defined as how often the individual complains or shows evidence of pain.
   Enter the number that corresponds to the appropriate response:
   0 = No pain (then skip to J4)
   1 = Pain less than daily
   2 = Pain daily

b. INTENSITY with which individual complains or shows evidence of pain. Intensity is the severity of pain as described or manifested by the individual.
   Enter the highest intensity of pain that occurred:
   1 = Mild pain. Individual is able to carry on with daily routines, socialization, or sleep.
   2 = Moderate pain. Individual experiences “a medium” amount of pain.
   3 = Times when pain is horrible or excruciating. Worst possible pain. Usually interferes with daily routines, socialization and sleep.

J4. Accidents
To determine the individual’s risk of future falls or injuries.
CHECK ALL THAT APPLY
a. Fell in past 30 days as reported.
b. Fell in past 31 – 180 days as reported.
c. Hip fracture in last 180 days as reported.
d. Other fracture in last 180 days as reported.
e. None of above.

J5. Stability of Conditions
To determine the individual’s disease or health conditions present over the last 7 days. Observe the individual, consult with family and physician and review the individual’s medical record.
CHECK ALL THAT APPLY:
a. Conditions/diseases make individual’s cognitive, ADL, mood or behavior status unstable - (fluctuating, precarious, or deteriorating) - Denotes the changing and variable nature of the individual’s condition. For example, an individual may experience a variable response to the intensity of pain and the analgesic effect of pain medications. On "good days" of the last 7 days, they participate in ADLs, are in a good mood, and enjoy preferred leisure activities. On "bad days," they will be dependent on others for care, be agitated, cry, etc. Likewise, this category reflects the degree of difficulty in achieving a balance between treatments for multiple conditions.
b. Individual experiencing an acute episode or a flare-up of a recurrent or chronic problem - Individual is symptomatic for an acute health condition (e.g., new myocardial infarction; adverse drug reaction; influenza), a recurrent (acute) condition (e.g., aspiration pneumonia; urinary tract infection) or an acute phase of a chronic disease (e.g., shortness of breath, edema, and confusion in an individual with congestive heart disease; acute joint pain and swelling in an individual who has had arthritis for many years). An acute episode is usually of sudden onset, has a time-limited course, and requires physician evaluation and a significant increase in licensed nursing monitoring.

c. End-Stage disease, 6 or fewer months to live - In one’s best clinical judgment, the individual with any end-stage disease has only 6 or fewer months to live. This judgment should be substantiated by a well documented disease diagnosis and deteriorating clinical course. A doctor’s certification that the individual has six months or less to live must be present in the record before coding the individual as terminal.

d. NONE OF ABOVE.

K1. Oral Problems
Interview the individual about any oral difficulties they might have. Observe the individual during meals. Review the individual’s medical record. Record any oral problems that have occurred in the last 7 days.

CHECK ALL THAT APPLY

a. Chewing problem. Inability to chew food easily and without pain or difficulties, regardless of cause (e.g., individual uses ill-fitting dentures, or has a neurologically impaired chewing mechanism, or has temporomandibular joint [TMJ] pain, or a painful tooth). Code chewing problem even when interventions have been successfully introduced.

b. Swallowing problem. Dysphagia. Clinical manifestations include frequent choking and coughing when eating or drinking, holding food in mouth for prolonged periods of time, or excessive drooling. Code swallowing problem even when interventions have been successfully introduced.

d. None of above.

K2. Height and Weight

a. HT (in). Record reported height in inches. Round up to the nearest whole inch. Measure height consistently over time (shoes off, etc.)

b. WT (lb). Record reported weight in pounds. Round weight upward to the nearest whole pound

K3. Weight Change
To track variations in weight over time.

a. Weight loss. 5% or more in last 30 days; or 10% or more in the last 180 days.
   - Enter the number corresponding to the most appropriate response.
   - 0 = No
   - 1 = Yes
   - Leave blank if there is no weight to compare to

b. Weight gain. 5% or more in last 30 days; or 10% or more in last 180 days. Record weight in pounds.
   - Enter the number corresponding to the most appropriate response.
   - 0 = No
   - 1 = Yes
   - Leave blank if there is no weight to compare to

CHILD: Ask the parent/caregiver/staff when the child was weighed last and if the child experienced a loss or gain during the Screening timeframes. If there is not a current weight, interview the parent/caregiver to determine if they suspect the child has experienced a weight change.

K5. Nutritional Approach
CHECK ALL THAT APPLY

a. Parenteral/IV. Include only fluids administered for nutrition of hydration such as:
   - IV fluids or hyper alimentation, including total parenteral nutrition (TPN), administered continuously or intermittently
   - IV Fluids running at KVO (Keep Vein Open)
   - IV Fluids administered via heparin locks
   - IV fluids contained in IC Piggybacks
   - IV fluids used to reconstitute medications for IV administration
   - DO NOT INCLUDE
   - IV medications
   - IV fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay
   - IV fluids administered solely as flushes
Parenteral/IV fluids administered during chemotherapy or dialysis.
b. Feeding tube. Presence of any type of tube that can deliver food/nutritional substances/fluids/medication directly into the gastrointestinal system. Included, but not limited to are the following:
Nasogastric tubes
Gastrostomy tubes
Jejunostomy tubes
Percutaneous endoscopic gastrostomy (PEG) tube.
h. On a planned weight change program,
i. None of the above

CHILD: Observe the child for the presence of a feeding tube or intravenous infusion device. Interview the parent/caregiver/staff to determine if the child is receiving a therapeutic diet or if the child’s diet is intended to facilitate weight loss or gain. Review the medical record to determine what has been ordered for the child and if the physician’s orders are consistent with the diet that the child is receiving.

K6. Parenteral or Enteral Intake
Skip to Section M if K5a. Parenteral/IV nor K5b. Feeding tube is checked.
Record the proportion of calories received and the average fluid intake, through parenteral or tube feeding in the last 7 days.
a. Total Calories. Code the proportion of total calories the individual received through parenteral or tube feeding in the last 7 days. This is the amount of calories ingested (actually received) and not the amount ordered.
   Enter the number corresponding to the most appropriate response.
   0 = None
   1 = 1% to 25%
   2 = 26% to 50%
   3 = 51% to 75%
   4 = 76% to 100%

CHILD: Observe the child and/or interview the parent/caregiver/staff to determine if the child takes any foods by mouth or is being fed exclusively by artificial means. If the child is tube fed, ascertain if the tube feedings are continuous or bolus feedings.
b. Fluid Intake. Code the average fluid intake per day by IV or tube in the last 7 days. Account for the actual amount of fluid the individual received, not the amount ordered. Also include the water used to flush as well as the “free water” in the tube feeding. Amount of fluid in an IV Piggyback solution should be included in the calculation. Do NOT include heparinized saline solution used to flush a heparin lock.
   Enter the number corresponding to the most appropriate response.
   0 = None
   1 = 1 to 500 cc/day
   2 = 501 to 1000 cc/day
   3 = 1001 to 1500 cc/day
   4 = 1501 to 2000 cc/day
   5 = 2001 or more cc/day

CHILD: Interview the parent/caregiver/staff to determine how much fluid the child receives daily by IV or tube

M1. Ulcers
To record the number of skin ulcers, at each ulcer stage, on any part of the body. Interview the individual and review their medical record. Examine the individual and determine the stage and number of ulcers present during last 7 days.
a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Assessing a Stage 1 skin ulcer requires a specially focused assessment for individuals with darker skin tones to take into account variations in ebony-colored skin. To recognize Stage 1 ulcers in ebony complexions, look for:
   • any change in the feel of the tissue in a high-risk area
   • any change in the appearance of the skin in high-risk areas, such as the “orange-peel” look
   • a subtle purplish hue
   • extremely dry, crust-like areas that, upon closer examination, are found to cover a tissue break.

   Enter the number of ulcers found at Stage 1
   0 = non present
   9 = 9 or more ulcers found
b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.
   Enter the number of ulcers found at Stage 2
   0 = non present
   9 = 9 or more ulcers found

C. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues – presents as a deep crater with or without undermining adjacent tissue.
   Enter the number of ulcers found at Stage 3
   0 = non present
   9 = 9 or more ulcers found

d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone. If necrotic eschar is present, prohibiting accurate staging, code the skin ulcer as Stage 4 until the eschar has been debrided (surgically or mechanically) to allow staging.
   Enter the number of ulcers found at Stage 4
   0 = non present
   9 = 9 or more ulcers found

CHILD: Interview the parent/caregiver/staff about any reddened areas, open sores, or other skin problems the child might have. Assess the child’s skin to determine the number of ulcers present and the stage of each. Review the medical record and consult with the parent/caregiver/staff regarding the presence of any skin ulcers.

M2. Type of Ulcer
To record the highest stage for 2 types of skin ulcers: Pressure and Stasis. Review the individual’s medical record and consult with their physician regarding any ulcers during last 7 days.

a. Pressure ulcer. Any lesion caused by pressure resulting in damage of underlying tissue. Other terms used to indicate this condition include bed sores and decubitus ulcers.
   CHILD: Interview the parent/caregiver/staff and examine the child’s ulcers to determine the highest stage present for the child’s pressure ulcers. Review the child’s medical record for supporting documentation such as physician orders, nurse’s notes, or treatment records. Consult with the physician regarding the cause of the ulcer(s).

b. Stasis ulcer. Open lesion caused by poor circulation in the lower extremities. Usually caused by decreased blood flow from chronic venous insufficiency. Other terms include venous ulcer or ulcer related to peripheral vascular disease (PVD) caused by pressure resulting in damage of underlying tissue. Other terms used to indicate this condition include bed sores and decubitus ulcers. Review the individual’s medical record.

M4. Other Skin Problems or Lesions Present

a. Abrasions, Bruises - Includes skin scrapes, skin shears, skin tears not penetrating to subcutaneous tissue (also see M4f), ecchymoses, localized areas of swelling, tenderness and discoloration.

b. Burns (Second or Third Degree) - Includes burns from any cause (e.g., heat, chemicals) in any stage of healing. This category does not include first degree burns (changes in skin color only).

c. Open Lesions/Sores (e.g. cancer lesions) - Code in M4c any skin lesions that are not coded elsewhere in Section M. Include skin ulcers that developed as a result of diseases and conditions such as syphilis and cancer. Do NOT code skin tears or cuts here.

d. Rashes (e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster) - Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (e.g., heat, drugs, bacteria, viruses, contact with irritating substances such as urine or detergents, allergies, shingles, etc.). Intertrigo refers to rashes (dermatitis) within skin folds.

e. Skin Desensitized to Pain or Pressure - The individual is unable to perceive sensations of pain or pressure.

f. Skin Tears or Cuts (Other Than Surgery) - Any traumatic break in the skin penetrating to subcutaneous tissue. Examples include skin tears, skin shears, lacerations, etc. Code skin tears or cuts that do not penetrate to the subcutaneous tissue in M4a.

g. Surgical Wounds - Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. This category does not include healed surgical sites, stomas, or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds.

h. NONE OF ABOVE
   CHILD: Interview the child and parent/caregiver/staff to determine if the child has burns or lesions/sores. Assess the child’s skin for skin problems or lesions. Review the child’s medical record.

M5. Skin Treatments
To document any specific or generic skin treatments the individual has received.
CHECK ALL THAT APPLY:

a. Pressure Relieving Device(s) for Chair. Includes gel, air (e.g., Roho), or other cushioning placed on a chair or wheelchair. Include pressure relieving, pressure reducing, and pressure redistributing devices. Do not include egg crate cushions in this category.

b. Pressure Relieving Device(s) for Bed. Includes air fluidized, low air loss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Include pressure relieving, pressure reducing, and pressure redistributing devices. Do not include egg crate mattresses in this category.

c. Turning/Repositioning Program. Includes a continuous, consistent program for changing the individual’s position and realigning the body. “Program” is defined as “a specific approach that is organized, planned, documented, monitored, and evaluated.”

d. Nutrition or Hydration Intervention to Manage Skin Problems. Dietary measures received by the individual for the purpose of preventing or treating specific skin conditions - e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing. Vitamins and minerals, such as Vitamin C and Zinc, which are used to manage a potential or active skin problem, should be coded here.

e. Ulcer Care. Includes any intervention for treating skin problems coded in M1, M2, and M4c. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.

f. Surgical Wound Care. Includes any intervention for treating or protecting any type of surgical wound. Examples of care include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture removal, and warm soaks or heat application.

g. Application of Dressings. (With or Without Topical Medications) Other Than to Feet - Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles. Dressings do not have to be applied daily in order to be coded. Even if applied once, check.

h. Application of Ointments/Medications (Other Than to Feet). Includes ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents, etc.). This definition does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).

i. Other Preventative or Protective Skin Care (Other Than to Feet). Includes application of creams or bath soaks to prevent dryness, scaling; application of protective elbow pads (e.g., down, padded, quilted).

j. None of above.

CHILD: Interview the parent, caregiver or staff to determine how the child’s skin problems are being treated. Ask if the child uses a special pad in his wheelchair or a pressure-relieving mattress pad for his bed

M6. Foot Problems and Care
To document the presence of foot problems and care to the feet. Ankle problems are not considered foot problems and should NOT be coded in Item M6. Code in Item M5

CHECK ALL THAT APPLY:

a. Individual Has One or More Foot Problems (e.g., Corns, Calluses, Bunions, Hammer Toes, Overlapping Toes, Pain, Structural Problems. includes ulcerated areas over plantar warts on the foot.

b. Infection of the Foot. e.g., Cellulitis, Purulent Drainage

c. Open Lesions On the Foot. Includes cuts, ulcers, fissures.

d. Nails or Calluses Trimmed During the Last 90 Days. Pertains to care of the feet. Includes trimming by nurse or any health professional, including a podiatrist.

f. Received Preventative or Protective Foot Care. Includes any care given for the purpose of preventing skin problems on the feet, such as diabetic foot care, foot soaks, protective booties (e.g., down, sheepskin, padded, quilted), special shoes, orthotics, application of toe pads, toe separators, etc.

f. Application of Dressings (With or Without Topical Medications). Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

g. None of above.

CHILD: To assess, interview the parent, caregiver, or staff member to determine if the child has any open lesions on the foot or if they are being treated for a foot infection. Review the child’s medical record.

O1. Number of Medications
To determine the number of different medications (over-the-counter and prescription drugs) the individual has used in the last 7 days. Count the number of different medications (not the number of doses or different dosages) administered by any route (e.g., oral, IV, injections, patch) at any time during the look back period. Include any routine, prn, and stat doses given. “Medications” include topical preparations, ointments, creams used in wound care (e.g., Elase), eye drops, vitamins, and suppositories. Topical preparations that are used for preventative skin care (i.e. moisturizers and moisture barriers) should not be coded here. Include any medication that the individual
administers to self, if known. If the individual takes both the generic and brand name of a single drug, count as only one medication. Antigens and vaccines also are counted here. Write the appropriate number in the answer box. Count only those medications actually administered and received by the individual. Do not count medications ordered but not given.

Record '0' zero if none used.

If a dietary supplement, given to an individual between meals, has a vitamin as one of its ingredients, code it as a dietary supplement, not as a medication.

O3. Injections
To determine the number of days during the past 7 days that the individual received any type of medication, antigen, vaccine, by subcutaneous, intramuscular or intradermal injection. Although antigens and vaccines are considered "biologics" and not medication per se, it is important to track when they are given to monitor for localized or systemic reactions. This category does not include intravenous (IV) fluids or medications. If an individual received IV fluids, record in Item K5a, Parenteral/IV.

If IV medications were given, record in Item P1ac, IV medications. Enter the total number of DAYS.

O4. Days Received the Following Medication
To record the number of days that the individual received each type of medication listed (antipsychotics, antianxiety, antidepressants, hypnotics, diuretics) in the past 7 days. Includes any of these medications given to the individual by any route (po, IM, or IV) in any setting (e.g., at home, in a hospital emergency room). Review the individual’s medical record for documentation that a medication was received by the individual during the past 7 days.

'0' zero = not used If transmittal records are not clear or do not reference that the individual received the medications, record ‘0’ (not used) If the individual did not use any medications from a drug category, enter ‘0’.

‘1’ = long-acting meds used less than weekly

If the individual uses long-lasting drugs that are taken less often than weekly (e.g., Prolixin (Fluphenazine decanoate) or Haldol (Haloperidol decanoate) given every few weeks or monthly) enter ‘1’.

Code medications according to a drug’s pharmacological classification, not how it is used. For example, Oxazepam (Serax) may be used as a hypnotic, but it is classified as an antianxiety. Serax would be coded as an antianxiety. Over-the-counter sleeping medications are not coded in this item, as they are not classified as hypnotic drugs

a. Antipsychotic
b. Antianxiety
c. Antidepressant
d. Hypnotic
e. Diuretic

P1. Special Treatments, Procedures, and Programs
To identify any special treatments, therapies, or programs that the individual received in the specified time period. Do not code services that were provided solely in conjunction with a surgical or diagnostic procedure and the immediate post-operative or post-procedure recovery period. Review the individual’s medical record.

a. SPECIAL CARE TREATMENTS - The following treatments may be received by an individual at home, at a hospital as an outpatient, or as an inpatient, etc. Record things that occurred in the last 14 days.

a. Chemotherapy. Includes any type of chemotherapy (anticancer drug) given by any route. The drugs coded here are those actually used for cancer treatment. Each drug should be evaluated to determine its reason for use before coding it here. IVs, IV medications, and blood transfusions provided during chemotherapy are not coded under the respective items K5a (parenteral/IV), P1ac (IV medications) and P1ak (transfusions).

b. Dialysis. Includes peritoneal or renal dialysis that occurs at the nursing facility or at another facility. Record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH) and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medications, and blood transfusions administered during dialysis are not coded under the respective items K5a (parenteral/IV), P1ac (IV medications) and P1ak (transfusions).

c. IV Medication. Includes any drug given by intravenous push or drip through a central or peripheral port. Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication. Record the use of an epidural pump in this item. Epidurals, intrathecal, and baclofen pumps may be coded, as they are similar to IV medications in that they must be monitored frequently and they involve continuous administration of a substance. Do not include IV medications that were administered only during dialysis or chemotherapy.

d. Intake/Output. The measurement and evaluation of all fluids the individual received and/or excreted for at least three consecutive shifts (i.e., 24 hours).
e. Monitoring Acute Medical Condition. Includes observation by a licensed nurse for ANY acute physical or psychiatric illness. Note that this is a determination regarding the individual’s clinical status. Payer source is not a factor.

f. Ostomy Care. This item refers only to care that requires nursing assistance. Includes both ostomies used for intake and excretion. Do not include tracheostomy care. Code tracheostomy care by checking Item P1aj.

g. Oxygen Therapy. Includes continuous or intermittent oxygen via mask, cannula, etc. (does not include hyperbaric oxygen for wound therapy). Include self-administered therapies.

h. Radiation. Includes radiation therapy or having a radiation implant.

i. Suctioning. Includes nasopharyngeal or tracheal aspiration only. Oral suctioning should not be coded here.

j. Tracheostomy Care. Includes cleansing of tracheostomy and cannula.

k. Transfusions. Includes transfusions of blood or any blood products (e.g., platelets), which are administered directly into the bloodstream. Do not include transfusions that were administered during dialysis or chemotherapy.

l. Ventilator or Respirator. Assures adequate ventilation in individuals who are, or who may become, unable to support their own respiration. Includes any type of electrically or pneumatically powered closed system mechanical ventilatory support devices. Any individual who was in the process of being weaned off of the ventilator or respirator in the last 14 days should be coded under this definition. Does not include Continuous Positive Airway Pressure (CPAP) or Bi-level Positive Airway Pressure (BIPAP) devices, these should be reported via S8.

m. Alcohol/Drug Treatment Program. A comprehensive interdisciplinary program where interventions are designed specifically for the treatment of alcohol or drug addictions.

n. Alzheimer’s/Dementia Special Care Unit. Any identifiable part of the nursing facility, such as an entire or a contiguous unit, wing, or floor where staffing patterns and individual care interventions are designed specifically for cognitively impaired individuals who may or may not have a specific diagnosis of Alzheimer’s disease.

o. Hospice Care. The individual is identified as being in a hospice program for terminally ill persons where an array of services is necessary for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider.

p. Pediatric Unit. Any identifiable part of the nursing facility, such as an entire or contiguous unit or wing where staffing patterns and individual care interventions are designed specifically for persons aged 22 or younger.

q. Respite Care. Individual’s care program involves a short-term stay in the facility for the purpose of providing relief to a nursing facility-eligible individual’s primary home based caregiver(s).

r. Training in Skills Required to Return to the Community. Individual is regularly involved in individual or group activities with a licensed skilled professional to attain goals necessary for community living (e.g., medication management, housework, shopping, using transportation, activities of daily living). May include training family or other caregivers.

s. None of above.

Check all treatments and procedures that were received during the last 14 days. If no items apply in the last 14 days, check NONE OF ABOVE.

b. THERAPIES - The therapy treatment may occur either inside or outside the facility within the past 7 days. Review the individual’s medical record and consult with each of the qualified therapists. Record the (A) number of days, and (B) total number of minutes each of the following therapies was administered to the individual (for at least 15 minutes a day) in the last 7 days.

a. Speech. Language Pathology, Audiology Services - Services that are provided by a licensed speech-language pathologist.

b. Occupational Therapy. Therapy services that are provided or directly supervised by a licensed occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified occupational therapy assistant who is employed by (or under contract to) the facility only if they are under the direction of a licensed occupational therapist, private company or school.

c. Physical Therapy. Therapy services that are provided or directly supervised by a licensed physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include service provided by a qualified physical therapy assistant who is employed by (or under contract to) the nursing facility only if he or she is under the direction of a licensed physical therapist.
d. Respiratory Therapy. Therapy services that are provided by a qualified professional (respiratory therapists, trained nurse or trained caretaker). Included treatments are coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds, and mechanical ventilation, etc., which must be provided by a qualified professional (i.e., trained nurse, respiratory therapist).

e. Psychological Therapy. Therapy provided only by any licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker. Psychiatric nurses usually have a Masters Degree and/or certification from the American Nurses Association.

**P3. Nursing Rehabilitation/Restorative Care**

Rehabilitation/Restorative Care. Included are nursing interventions that assist or promote the individual's ability to attain their maximum functional potential in the last 7 days. This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in Item P1b. In addition, to be included in this section, a rehabilitation or restorative care must meet all of the following additional criteria:

- Measurable objectives and interventions must be documented in the care plan and in the medical record.
- Evidence of periodic evaluation by licensed nurse must be present in the medical record.
- Nurse assistants/aides must be trained in the techniques that promote individual involvement in the activity.
- These activities are carried out or supervised by members of the nursing staff. Sometimes, under licensed nurse supervision, other staff and volunteers will be assigned to work with specific individuals.
- This category does not include groups with more than four individuals per supervising helper or caregiver.

a. Range of Motion (Passive). The extent to which, or the limits between which, a part of the body can be moved around a fixed point or joint.

b. Range of Motion (Active). Exercises performed by an individual, with cuing, supervision or physical assist by staff, that are planned, scheduled, and documented in the medical record.

c. Splint or Brace Assistance. Assistance can be of 2 types: 1) where staff provides verbal and physical guidance and direction that teaches the individual how to apply, manipulate, and care for a brace or splint, or 2) where parent/caregiver/staff have a scheduled program of applying and removing a splint or brace, assess the individual's skin and circulation under the device, and reposition the limb in correct alignment. These sessions are planned, scheduled, and documented in the medical record.

d. Bed Mobility. Activities used to improve or maintain the individual's self-performance in moving to and from a lying position, turning side to side, and positioning him or herself in bed.

e. Transfer. Activities used to improve or maintain the individual's self-performance in moving between surfaces or planes either with or without assistive devices.

f. Walking. Activities used to improve or maintain the individual's self-performance in walking, with or without assistive devices.

g. Dressing or Grooming. Activities used to improve or maintain the individual's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.

h. Eating or Swallowing. Activities used to improve or maintain the individual's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the individual's ability to ingest nutrition and hydration by mouth.

i. Amputation/Prosthesis Care. Activities used to improve or maintain the individual's self-performance in putting on and removing prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket). Dentures are not considered to be prostheses for coding this item.

j. Communication. Activities used to improve or maintain the individual's self-performance in using newly acquired functional communication skills or assisting the individual in using residual communication skills and adaptive devices.

k. Other. Any other activities used to improve or maintain the individual's self-performance in functioning. This includes, but is not limited to, teaching self-care for diabetic management, self-administration of medications, ostomy care, and cardiac rehabilitation.

**P4. Devices and Restraints**

To record the frequency, over the last 7 days, with which the individual was restrained by any of the devices listed below at any time during the day or night. The intent is to evaluate as part of the screening process whether or not a device meets the definition of a physical restraint, and then to code only those devices categorized in section P4 that have the effect of restraining the individual.

a. Full Bed Rails - Full rails may be one or more rails along both sides of the individual's bed that block three-quarters to the whole length of the mattress from top to bottom. This definition also includes beds with one side placed against the wall (prohibiting the individual from entering and exiting on that side) and the other side...
bounded by a full rail (one or more rails). Include in this category veil screens (used in pediatric units) and enclosed bed systems.

b. Other Types of Bed Rails Used - Any combination of partial rails (e.g., 1/4, 1/3, 1/2, 3/4, etc.) or combination of partial and full rails not covered by the above “full bed rail” category (e.g., one-side half rail, one-side full rail, two-sided half rails, etc.)

c. Trunk Restraint - Includes any device or equipment or material that the individual cannot easily remove (e.g., vest or waist restraint, belts used in wheelchairs).

d. Limb Restraint - Includes any device or equipment or material that the individual cannot easily remove, that restricts movement of any part of an upper extremity (i.e., hand, arm) or lower extremity (i.e., foot, leg). Include in this category mittens.

e. Chair Prevents Rising - Any type of chair with locked lap board or chair that places the individual in a recumbent position that restricts rising or a chair that is soft and low to the floor. Include in this category enclosed framed wheeled walkers with or without a posterior seat and lap cushions that an individual cannot easily remove.

For each device type, enter:

- 0. Not used in last 7 days
- 1. Used, but used less than daily in last 7 days
- 2. Used on a daily basis in last 7 days

P7. Physician Visits
To record the number of days during the last 14 day period a physician has examined the individual. Examination can occur in the facility or in the physician’s office. In some cases, the frequency of physician’s visits is indicative of clinical complexity.

Physician - Includes an MD, DO (osteopath), podiatrist, or dentist who is either the primary physician or consultant. Also, include an authorized physician assistant, nurse practitioner, or clinical nurse specialist working in collaboration with the physician. Does not include visits made by Medicine Men nor licensed psychologists (PhD). The licensed psychologist (PhD) visits may be recorded in P2b.

Physician Exam - May be a partial or full exam at the facility or in the physician’s office. This does not include exams conducted in an emergency room. If the individual was examined by a physician during an unscheduled emergency room visit, record the number of times this happened in the last 90 days in Item P6, “Emergency Room (Visits)”

Enter the number of days the physician examined the individual. If none, enter “0”.

P8. Physician Order
To record the number of days during the last 14-day period in which a physician has changed the individual’s orders. In some cases, the frequency of physician’s order changes is indicative of clinical complexity.

If no order changes, enter “0”.

Q2. Overall Change in Care Needs
To monitor the individual’s overall progress with care over last 90 days, as reported

- Overall Self-Sufficiency: Includes self-care performance and support, continence patterns, involvement patterns, use of treatments, etc.
- Process: Review medical record, transmittal records (if new admission or readmission), previous screenings and care plan. Discuss with direct caregivers.

Record the number corresponding to the most correct response.

U MEDICATIONS
Amount Administered. The number of tablets, capsules, suppositories, or amount of liquid (cc’s, mls, units) per dose that is administered to an individual. To accurately complete the amount administered, it will be necessary to look at the actual medications that are given to the individual. For example, some injectable medications can be provided in vials, ampules, or premeasured syringes.

1. Medication Name and Dose Ordered. Identify and record all medications that the individual received in the last 7 days. Also identify and record any medications that may not have been given in the last 7 days, but are part of the individual regular medication regimen (e.g. monthly B-12 injections). Do not record PRN medications that were not administered in the last 7 days. Record the name of the medication and dose that was ordered by the physician in column 1.

Example, if prescribed Acetaminophen 650 mg, do not write Acetaminophen 325 mg. 2 tabs, even if two 325 mg. tablets are administered to the individual.
S1. Medicaid Information
S1a. NPI Number - Enter your NPI (National Provider Identifier) number
S1b. Purpose Code - Use a purpose code P for a pre-admission screening or for the first time a PASARR is completed. Use a purpose code of 4 if the person has had a change in condition or is being re-assessed
S1c. DADS vendor/Site ID Number
S1d. Contract/Provider Number
S1e. Provider County - County of the provider completing the form

S2. PASARR Information
S2a. To your knowledge, does the individual have an intellectual disability?
   Required field.
   Enter the most appropriate response: Y = YES or N = NO.
S2b. To your knowledge, does the individual have a developmental disability?
   Required field.
   Enter the most appropriate response: Y = YES or N = NO.
S2c. To your knowledge, does the individual have a condition of mental illness according to the PASARR guidelines?
   Required field.
   Enter the most appropriate response: Y = YES or N = NO.
S2d. Is the resident a danger to himself/herself?
   Required field.
   Enter the most appropriate response: Y = YES or N = NO.
   If unknown, then reply with N = NO.
S2e. Is the resident a danger to others?
   Required field.
   Enter the most appropriate response: Y = YES or N = NO.
   If unknown, then reply with N = NO.
S2f. Has the individual had a previous PASARR screening?
   Required field.
   Enter the most appropriate response: Y = YES or N = NO.
   If unknown, then reply with N = NO.
S2g. Date of previous PASARR screening. – Enter the date of previous screening, if applicable.
S2h. Outcome of MN Determination
S2i. Are specialized services indicated?
   This field is disabled and unavailable for data entry.
   Click the “Determine Specialized Services” button and this field will be auto populated with No or Yes.

S3. Physician's Evaluation & Recommendation
S3a. Discharge
   Enter Y if yes. Enter N if no.
S3b. Rehabilitation Potential
   Enter 1 for good
   Enter 2 for fair
   Enter 3 for minimal
   Leave blank if unknown
S3c. Requires NF Care
   Enter Y if yes. Enter N if no.
S3d. MD/DO Last Name
S3e. License number (Needed to send outcome notice to doctor. A doctor’s signature is not required)
S3e1. MD/DO License State
S3f. MD/DO Military Spec.Code
   Only complete the rest if the physician is not licensed in Texas
S3g. MD/DO first name
S3h. MD/DO address
S3i. MD/DO city
S3j. MD/DO state
S3K. MD/DO ZIP code
S3l. MD/DO phone
S4. Licenses & Original Signatures
S4a RN Last Name Name of the licensed nurse overseeing the completion of the form
S4b RN License Number Number of the licensed nurse overseeing completion of the form
S4b1 RN license state
S4a LVN Last Name Name of the licensed nurse assisting in the completion of the form
S4b LVN License Number Number of the licensed nurse assisting in the completion of the form
S4b1 LVN license state

S5. Primary Diagnosis
S5a Primary Diagnosis - Enter the diagnosis that triggered the need for a PASARR screening.

S6. Therapeutic Interventions
S6a. Tracheostomy Care - Enter the number corresponding to the appropriate response.
  0 = Not receiving
  1 = Less than once a week
  2 = 1 to 6 times a week
  3 = Once a day
  4 = Twice a day
  5 = 3 – 11 times a day
  6 = Every 2 hours
  7 = Hourly / continuous

S6b. Ventilator / Respirator Report ALL artificial respiratory support systems including BIPAP/CPAP.
Enter the number corresponding to the appropriate response.
  0 = Less then 6 hours
  6 = 6 – 23 hours
  7 = Hourly / continuous (24 hours)

S7. For DADS only
S7a. MN determination
Enter Y if the person meets medical necessity. Enter N if the person does not.
S7b. RUG
Enter the RUG if the person has one. If unknown, leave blank.
S7c. Effective date
Enter the date of the medical necessity determination
S7d. Expiration date
Enter the expiration date of the medical necessity determination
S7e. County
Enter the county the nursing facility the person being referred to is in
S7f. Region
Enter the DADS region the nursing facility is in

S8. Individual's address
Enter the address of the individual. This information is required for TMHP to notify these parties of approvals and denials and to allow appeals to be made in a timely manner.
S8a. Individual Address - Enter the street address of the client
S8b. City Enter the city of the client
S8c. State Enter the state of the client
S8d. ZIP Code Enter the ZIP code of the client

S9. Legally Authorized Representative (LAR) Address
Enter the address of the individual's legally authorized representative (LAR). This information is required for TMHP to notify these parties of approvals and denials and to allow appeals to be made in a timely manner.
S9a. LAR First Name
S9b. LAR Last Name
S9c. LAR Address - Enter the street address of the LAR
S9d. City - Enter the city of the LAR
S9e. State - Enter the state of the LAR
S9f. ZIP Code - Enter the ZIP code of the LAR
S9g. Phone - Enter the phone number of the LAR

S10. Comments
Enter up to 500 characters if needed.