Coding errors mean returned claims, delayed payments, and hours of re-work – and the coming transition from OASIS-C to OASIS-C1 means even more potential for errors and lost revenue. Now home health agencies can improve OASIS coding accuracy, reduce coding errors, potentially reduce the number of returned claims and protect payments with SHP’s complimentary OASIS-C to OASIS-C1 Crosswalk Guide.

This guide is an excellent reference for anyone who works with OASIS Assessments and will improve accuracy, help reduce coding errors, and potentially reduce the number of returned claims. We recommend printing copies for your staff to aid in the transition to OASIS-C1 and beyond.
SHP is pleased to provide home health agencies with a complete side-by-side comparison of the OASIS-C and OASIS-C1 assessment forms. Color-coded indicators highlight any M-items that have been added, removed, or changed between the two OASIS versions (see the key below). This document includes all M-items recorded at start of care (SOC), resumption of care (ROC), follow-up (FU), transfer (TRF), and at discharge (DC). Next to each M-item is a box listing all assessment reasons (SOC, ROC, FU, TRF, DC) at which each item is recorded.

This guide is an excellent reference for anyone who works with OASIS Assessments and will improve accuracy, help reduce coding errors, and potentially reduce the number of returned claims. We recommend printing copies for your staff to aid in the transition to OASIS-C1 and beyond.

### Outcome and Assessment Information Set (OASIS-C)

#### Items to be Used at Specific Time Points


#### Outcome and Assessment Information Set (OASIS-C1)

#### Items to be Used at Specific Time Points


#### Key

- **New**
- **Changed**
- **Omitted**
- **No change**

Note: This version of OASIS-C1 is current with the OASIS Data Submission Specifications 2.11.0: DRAFT

Note that OASIS-C1 is being implemented in two phases, OASIS-C1/ICD-9 on 1/1/2015 followed by OASIS-C1/ICD-10 on 10/1/2015. The ICD-10 version initiates use of ICD-10 codes and replaces the ICD-9 based items (M1010, M1016, M1020, M1022, M1024) with their ICD-10 equivalents (M1011, M1017, M1021, M1023, M1025). These m-items are indicated in the crosswalk document. There are no other differences between the two OASIS-C1 versions.

This guide is provided by SHP as a service and is for informational use only. Home health agencies should always consult CMS.gov for future changes.
### CLINICAL RECORD ITEMS

<table>
<thead>
<tr>
<th>Number</th>
<th>Discipline of Person Completing Assessment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RN</td>
</tr>
<tr>
<td>2</td>
<td>PT</td>
</tr>
<tr>
<td>3</td>
<td>SLP/ST</td>
</tr>
<tr>
<td>4</td>
<td>OT</td>
</tr>
</tbody>
</table>

**Date Assessment Completed:**

- **Discipline of Person Completing Assessment:** 1-RN 2-PT 3-SLP/ST 4-OT

**Date Assessment Completed:**

- **Discipline of Person Completing Assessment:** 1-RN 2-PT 3-SLP/ST 4-OT

**This Assessment is Currently Being Completed for the Following Reason:**

- **Discipline of Person Completing Assessment:** 1-RN 2-PT 3-SLP/ST 4-OT

**Follow-Up**

- **Discipline of Person Completing Assessment:** 1-RN 2-PT 3-SLP/ST 4-OT

**Transfer to an Inpatient Facility**

- **Discipline of Person Completing Assessment:** 1-RN 2-PT 3-SLP/ST 4-OT

**Discharge from Agency — Not to an Inpatient Facility**

- **Discipline of Person Completing Assessment:** 1-RN 2-PT 3-SLP/ST 4-OT

**Date of Physician-ordered Start of Care (Resumption of Care):** If the physician indicated a specific start of care (resumption of care) date when the patient was referred for home health services, record the date specified.

- **Discipline of Person Completing Assessment:** 1-RN 2-PT 3-SLP/ST 4-OT

**Date of Referral:** Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.

- **Discipline of Person Completing Assessment:** 1-RN 2-PT 3-SLP/ST 4-OT

**Episode Timing:** Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient’s current sequence of adjacent Medicare home health payment episodes?

- **Discipline of Person Completing Assessment:** 1-RN 2-PT 3-SLP/ST 4-OT

**Episode Timing:** Is the Medicare home health payment episode for which this assessment will define a case mix group an "early" episode or a "later" episode in the patient’s current sequence of adjacent Medicare home health payment episodes?

- **Discipline of Person Completing Assessment:** 1-RN 2-PT 3-SLP/ST 4-OT
### PATIENT HISTORY AND DIAGNOSES

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

- □ 1 - Long-term nursing facility (NF)
- □ 2 - Skilled nursing facility (SNF / TCU)
- □ 3 - Short-stay acute hospital (IPP S)
- □ 4 - Long-term care hospital (LTCH)
- □ 5 - Inpatient rehabilitation hospital or unit (IRF)
- □ 6 - Psychiatric hospital or unit
- □ 7 - Other (specify)
- □ NA - Patient was not discharged from an inpatient facility

**Inpatient Discharge Date** (most recent):

- □ / / month / day / year
- □ UK - Unknown

(M1005) Omitted

(M1010) List each Inpatient Diagnosis and ICD-9-C M code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no E-codes, or V-codes):

<table>
<thead>
<tr>
<th>Inpatient Facility Diagnosis</th>
<th>ICD-9-C M Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td></td>
</tr>
</tbody>
</table>

(M1011) List each Inpatient Diagnosis and ICD-10-C M code at the level of highest specificity for only those conditions actively treated during an inpatient stay having a discharge date within the last 14 days (no V, W, X, Y, or Z codes or surgical codes):

<table>
<thead>
<tr>
<th>Inpatient Facility Diagnosis</th>
<th>ICD-10-C M Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
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<td>e.</td>
<td></td>
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<tr>
<td>f.</td>
<td></td>
</tr>
</tbody>
</table>

**Addl Resp.**

- □ NA - Not applicable (patient was not discharged from an inpatient facility)

(M1012) List each Inpatient Procedure and the associated ICD-9-C M procedure code relevant to the plan of care.

<table>
<thead>
<tr>
<th>Omitted</th>
</tr>
</thead>
</table>

(M1016) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient’s Medical Diagnoses and ICD-9-C M codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no surgical, E-codes, or V-codes):

<table>
<thead>
<tr>
<th>Changed Medical Regimen Diagnosis</th>
<th>ICD-9-C M Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
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<tr>
<td>c.</td>
<td></td>
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<tr>
<td>d.</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td></td>
</tr>
</tbody>
</table>

- □ NA - Not applicable (no medical or treatment regimen changes within the past 14 days)

(M1017) Diagnoses Requiring Medical or Treatment Regimen Change Within Past 14 Days: List the patient’s Medical Diagnoses and ICD-10-C M codes at the level of highest specificity for those conditions requiring changed medical or treatment regimen within the past 14 days (no V, W, X, Y, or Z codes or surgical codes):

<table>
<thead>
<tr>
<th>Changed Medical Regimen Diagnosis</th>
<th>ICD-10-C M Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
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</tr>
<tr>
<td>e.</td>
<td></td>
</tr>
<tr>
<td>f.</td>
<td></td>
</tr>
</tbody>
</table>

- □ NA - Not applicable (no medical or treatment regimen changes within the past 14 days)
Diagnoses, Symptom Control, and Payment Diagnoses: List each diagnosis for which the patient is receiving home care (Column 1) and enter its ICD-9-C M code at the level of highest specificity (no surgical/procedure codes) (Column 2). Diagnoses are listed in the order that best reflect the seriousness of each condition and support the disciplines and services provided. Rate the degree of symptom control for each condition (Column 2). Choose one value that represents the degree of symptom control appropriate for each diagnosis: V-codes (for M1020 or M1022) or E-codes (for M1022 only) may be used. ICD-9-C M sequencing requirements must be followed if multiple coding is indicated for any diagnoses. If a V-code is reported in place of a case mix diagnosis, then optional item M1024 Payment Diagnoses (Columns 3 and 4) may be completed. A case mix diagnosis is a diagnosis that determines the Medicare PPS case mix group. Do not assign symptom control ratings for V- or E-codes.

Rate the degree of symptom control for the condition listed in Column 1 using the following scale:

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

Note that in Column 2 the rating for symptom control of each condition should not be used to determine the sequencing of the diagnoses listed in Column 1. These are separate items and sequencing may not coincide. Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.

Column 3: (OPTIONAL) If a V-code is assigned to any row in Column 2, in place of a case mix diagnosis, it may be necessary to complete optional item M1024 Payment Diagnoses (Columns 3 and 4). See OASIS-C Guidance Manual.

Column 4: (OPTIONAL) If a V-code in Column 2 is reported in place of a case mix diagnosis that requires multiple diagnosis codes under ICD-9-C M coding guidelines, enter the diagnosis descriptions and the ICD-9-C M codes in the same row in Columns 3 and 4. For example, if the case mix diagnosis is a manifestation code, record the diagnosis description and ICD-9-C M code for the underlying condition in Column 3 of that row and the diagnosis description and ICD-9-C M code for the manifestation in Column 4 of that row. Otherwise, leave Column 4 blank in that row.

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

Column 1: Enter the description of the diagnosis.

Column 2: Enter the ICD-9-C M code for the diagnosis described in Column 1;

Column 3: (OPTIONAL) There is no requirement that HHAs enter a diagnosis code in M1025 (Columns 3 and 4). See OASIS-C Guidance Manual for additional directions on how to complete M1021, M1023 and M1025.

Some Instruc.

Change
### OASIS C1/ICD-10 Change (effective 10/1/2015)

#### Diagnoses (Sequencing of Conditions)

(a) Primary Diagnosis

(b) Other Diagnoses

(c) Other Diagnoses (OPTIMAL)

(d) Other Diagnoses (not used for payment)

#### Description

- Complete only if the Optional Code (V, W, X, Y codes) is listed in Column 2.
- Complete only if a V-code is listed in Column 2. V codes must be placed in Column 2 in the appropriate sequence as described in the instruction to the providers.

#### Coding Situation (e.g., a change in the severity of each condition or a change in the disciplines/services provided)

- Complete only if the Optional Code (V, W, X, Y codes) is listed in Column 2.
- Complete only if a V-code is listed in Column 2. V codes must be placed in Column 2 in the appropriate sequence as described in the instruction to the providers.

#### Coding Situation

- Complete only if a V-code is listed in Column 2. V codes must be placed in Column 2 in the appropriate sequence as described in the instruction to the providers.

#### V or E-codes are allowed

- Complete only if a V-code is listed in Column 2. V codes must be placed in Column 2 in the appropriate sequence as described in the instruction to the providers.

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(a) Primary Diagnosis

(b) Other Diagnoses

(c) Other Diagnoses (OPTIMAL)

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#### Description

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#### V or E-codes are allowed

- Complete only if a V-code is listed in Column 2. V codes must be placed in Column 2 in the appropriate sequence as described in the instruction to the providers.

#### Diagnoses (Sequencing of Diagnoses)

(a) Primary Diagnosis

(b) Other Diagnoses

(c) Other Diagnoses (OPTIMAL)

(d) Other Diagnoses (not used for payment)
(M1030) Threats the patient receives at home: (Mark all that apply.)
- 1 - Intravenous or infusion therapy (excludes TPN)
- 2 - Parenteral nutrition (TPN or lipids)
- 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- 4 - None of the above

(M1032) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)
- 1 - Recent decline in mental, emotional, or behavioral status
- 2 - Multiple hospitalizations (2 or more) in the past 12 months
- 3 - History of falls (2 or more falls - or any fall with an injury - in the past year)
- 4 - Taking five or more medications
- 5 - Frailty indicators, e.g., weight loss, self-reported exhaustion
- 6 - Other
- 7 - None of the above

Response 5 broken out into 2 & 8

(M1034) Overall Status: Which description best fits the patient’s overall status? (Check one)
- 0 - The patient is stable with no heightened risk(s) for serious complications and death (beyond those typical of the patient’s age).
- 1 - The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient’s age).
- 2 - The patient is likely to remain in fragile health and have ongoing high risk(s) of serious complications and death.
- 3 - The patient has serious progressive conditions that could lead to death within a year.
- 4 - The patient is temporarily facing high health risk(s) but is likely to return to being stable without heightened risk(s) for serious complications and death (beyond those typical of the patient’s age).
- 5 - Decline in mental, emotional, or behavioral status in the past 3 months
- 6 - Multiple hospitalizations (2 or more) in the past 6 months
- 7 - Parenteral nutrition (TPN or lipids)
- 8 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)

UK - The patient’s situation is unknown or unclear.

(M1036) Risk Factors, either present or past, likely to affect current health status and/or outcome: (Mark all that apply.)
- 1 - Smoking
- 2 - Obesity
- 3 - Alcohol dependency
- 4 - Drug dependency
- 5 - None of the above
- 6 - Other
- 7 - None of the above

UK - Unknown

(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? (Mark all that apply.)
- 1 - History of falls (2 or more falls - or any fall with an injury - in the past 12 months)
- 2 - Unintentional weight loss of a total of 10 pounds or more in the past 12 months
- 3 - Multiple hospitalizations (2 or more) in the past 12 months
- 4 - Multiple emergency department visits (2 or more) in the past 6 months
- 5 - Decline in mental, emotional, or behavioral status in the past 3 months
- 6 - Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
- 7 - Currently taking 5 or more medications
- 8 - Currently reports exhaustion
- 9 - Other risk(s) not listed in 1 - 8
- 10 - None of the above
(M1040) Influenza Vaccine: Did the patient receive the influenza vaccine from your agency for this year’s influenza season (October 1 through March 31) during this episode of care?

- 0 - No
- 1 - Yes [Go to M1050]
- NA - Does not apply because entire episode of care (SOC/ROC to Transfer/Discharge) is outside this influenza season. [Go to M1050]

(M1045) Reason Influenza Vaccine not received: If the patient did not receive the influenza vaccine from your agency during this episode of care, state reason:

- 1 - Received from another health care provider (e.g., physician)
- 2 - Received from your agency previously during this year’s flu season
- 3 - Offered and declined
- 4 - Assessed and determined to have medical contraindication(s)
- 5 - Not indicated; patient does not meet age/condition guidelines for influenza vaccine
- 6 - Inability to obtain vaccine due to declared shortage
- 7 - None of the above

(M1050) Pneumococcal Vaccine: Did the patient receive pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge)?

- 0 - No
- 1 - Yes [Go to M1500 at TRN; Go to M1230 at DC]

(M1055) Reason PPV not received: If patient did not receive the pneumococcal polysaccharide vaccine (PPV) from your agency during this episode of care (SOC/ROC to Transfer/Discharge), state reason:

- 1 - Patient has received PPV in the past
- 2 - Offered and declined
- 3 - Assessed and determined to have medical contraindication(s)
- 4 - Not indicated; patient does not meet age/condition guidelines for PPV
- 5 - None of the above

LIVING ARRANGEMENTS

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

<table>
<thead>
<tr>
<th>Living Arrangement</th>
<th>Availability of Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Around the clock</td>
</tr>
<tr>
<td>a. Patient lives alone</td>
<td>☐ 01</td>
</tr>
<tr>
<td>b. Patient lives with other person(s) in the home</td>
<td>☐ 06</td>
</tr>
<tr>
<td>c. Patient lives in congregate situation (e.g., assisted living)</td>
<td>☐ 11</td>
</tr>
</tbody>
</table>

(M1041) Influenza Vaccine Data Collection Period: Does this episode of care (SOC/ROC to Transfer/Discharge) include any dates on or between October 1 and March 31?

- Reworked
  - 0 - No [Go to M1051]
  - 1 - Yes

(M1046) Influenza Vaccine Received: Did the patient receive the influenza vaccine for this year’s flu season?

- Reworked
  - 1 - Yes; received from your agency during this episode of care (SOC/ROC to Transfer/Discharge)
  - 2 - Yes; received from your agency during a prior episode of care (SOC/ROC to Transfer/Discharge)
  - 3 - Yes; received from another health care provider (for example: physician, pharmacist)
  - 4 - No; patient offered and declined
  - 5 - No; patient assessed and determined to have medical contraindication(s)
  - 6 - No; not indicated - patient does not meet age/condition guidelines for influenza vaccine
  - 7 - No; inability to obtain vaccine due to declared shortage
  - 8 - No; patient did not receive the vaccine due to reasons other than those listed in responses 4 – 7.

(M1051) Pneumococcal Vaccine: Has the patient ever received the pneumococcal vaccination (PPV)?

- 0 - No
- 1 - Yes [Go to M1500 at TRN; Go to M1230 at DC]

(M1056) Reason PPV not received: If patient has never received the pneumococcal vaccination (PPV), state reason:

- 1 - Offered and declined
- 2 - Assessed and determined to have medical contraindication(s)
- 3 - Not indicated; patient does not meet age/condition guidelines for PPV
- 4 - None of the above

LIVING ARRANGEMENTS

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

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<td>b. Patient lives with other person(s) in the home</td>
<td>☐ 06</td>
</tr>
<tr>
<td>c. Patient lives in congregate situation (for example: assisted living, residential care home)</td>
<td>☐ 11</td>
</tr>
</tbody>
</table>
### Sensory Status

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

#### Ability to Hear (with hearing aid or hearing appliance if normally used):
- **0**: Adequate: hears normal conversation without difficulty.
- **1**: Mildly to Moderately Impaired: difficulty hearing in some environments or speaker may need to increase volume or speak distinctly.
- **2**: Severely Impaired: absence of useful hearing.
- **UK**: Unable to assess hearing.

#### Understanding of Verbal Content in patient’s own language (with hearing aid or device if used):
- **0**: Understands: clear comprehension without cues or repetitions.
- **1**: Usually Understands: understands most conversations, but misses some part/intent of message. Requires cues at times to understand.
- **2**: Sometimes Understands: understands only basic conversations or simple, direct phrases. Frequently requires cues to understand.
- **3**: Rarely/Never Understands
- **UK**: Unable to assess understanding.

#### Speech and Oral (Verbal) Expression of Language (in patient’s own language):
- **0**: Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
- **1**: Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
- **2**: Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
- **3**: Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
- **4**: Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).
- **5**: Patient nonresponsive or unable to speak.

#### Frequency of Pain Interfering with patient’s activity or movement:
- **0**: Patient has no pain
- **1**: Patient has pain that does not interfere with activity or movement
- **2**: Less often than daily
- **3**: Daily, but not constantly
- **4**: All of the time
**INTEGUMENTARY STATUS**

**M1300** Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?

- 0 - No assessment conducted [Go to M1306]
- 1 - Yes, based on an evaluation of clinical factors, e.g., mobility, incontinence, nutrition, etc., without use of standardized tool
- 2 - Yes, using a standardized tool, e.g., Braden, Norton, other

**M1302** Does this patient have a Risk of Developing Pressure Ulcers?

- 0 - No
- 1 - Yes

**M1306** Does this patient have at least one Unhealed Pressure Ulcer at Stage II or Higher, or designated as "unstageable"?

- 0 - No [Go to M1322]
- 1 - Yes

**M1307** The Oldest Unstageable Stage II Pressure Ulcer that is present at discharge

- 1 - Was present at the most recent SOC/ROC assessment
- 2 - Developed since the most recent SOC/ROC assessment; record date pressure ulcer first identified: month / day / year

**M1308** Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage:

(Enter "0" if none; excludes Stage I pressure ulcers)

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete at SOC/ROC, FU &amp; D/C</td>
<td>Complete at FU &amp; D/C</td>
</tr>
</tbody>
</table>

Stage description – unhealed pressure ulcers

- **Stage II**: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.

- **Stage III**: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscles are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.

- **Stage IV**: Full thickness tissue loss with visible bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.

- **Unstageable**: Known or likely but unstageable due to non-removable dressing or device.

- **Unstageable**: Known or likely but unstageable due to coverage of wound bed by slough and/or eschar.

- **Unstageable**: Suspected deep tissue injury in evolution.

**M1309** Worsening in Pressure Ulcer Status since SOC/ROC:

Instructions for a – c: For Stage II, III, and IV pressure ulcers, report the number that are new or have increased in numerical stage since the most recent SOC/ROC.

```
New

<table>
<thead>
<tr>
<th>Stage II</th>
<th>Stage III</th>
<th>Stage IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Enter &quot;0&quot; if there are no current Stage II, III or IV pressure ulcers or if all current Stage II, III or IV pressure ulcers existed at the same numerical stage at most recent SOC/ROC)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
```

**M1310** Pressure Ulcer Length: Longest length (head-to-toe) (cm)

**M1312** Pressure Ulcer Width: Width of the same pressure ulcer; greatest width perpendicular to the length (cm)

**M1314** Pressure Ulcer Depth: Depth of the same pressure ulcer; from visible surface to the deepest area (cm)
(M1320) Status of Most Problematic (Observable) Pressure Ulcer:

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/Partial granulation
- 3 - Not healing
- NA - No observable pressure ulcer

(M1322) Current Number of Stage I Pressure Ulcers:

- 0 - No
- 1 - Yes

(M1324) Stage of Most Problematic Unhealed (Observable) Pressure Ulcer:

- 1 - Stage I
- 2 - Stage II
- 3 - Stage III
- 4 - Stage IV
- NA - No observable pressure ulcer

(M1330) Does this patient have a Stasis Ulcer?

- 0 - No
- 1 - Yes, patient has BOTH observable and unobservable stasis ulcers
- 2 - Yes, patient has observable stasis ulcers ONLY
- 3 - Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing) [Go to M1340]

(M1332) Current Number of (Observable) Stasis Ulcer(s):

- 1 - One
- 2 - Two
- 3 - Three
- 4 - Four or more

(M1334) Status of Most Problematic (Observable) Stasis Ulcer:

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

(M1340) Does this patient have a Surgical Wound?

- 0 - No
- 1 - Yes, patient has at least one observable surgical wound

(M1342) Status of Most Problematic (Observable) Surgical Wound:

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

(M1350) Does this patient have a Skin Lesion or Open Wound, excluding bowel ostomy, other than those described above that is receiving intervention by the home health agency?

- 0 - No
- 1 - Yes

(Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)

- 1 - Stage I
- 2 - Stage II
- 3 - Stage III
- 4 - Stage IV
- NA - Patient has no pressure ulcers or no stageable pressure ulcers

- 0 - No
- 1 - Yes, patient has BOTH observable and unobservable stasis ulcers
- 2 - Yes, patient has observable stasis ulcers ONLY
- 3 - Yes, patient has unobservable stasis ulcers ONLY (known but not observable due to non-removable dressing/device) [Go to M1340]

- 1 - One
- 2 - Two
- 3 - Three
- 4 - Four or more

- 1 - Fully granulating
- 2 - Early/Partial granulation
- 3 - Not healing

- 0 - No [At SOC/ROC, go to M1350; At TRN/DC, go to M1400]
- 1 - Yes, patient has at least one observable surgical wound

- 0 - Newly epithelialized
- 1 - Fully granulating
- 2 - Early/Partial granulation
- 3 - Not healing
RESPIRATORY STATUS

(M1400) When is the patient dyspneic or noticeably Short of Breath?

- 0 - Patient is not short of breath
- 1 - When walking more than 20 feet, climbing stairs
- 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
- 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
- 4 - At rest (during day or night)

(M1410) Respiratory Treatments utilized at home: (Mark all that apply.)

- 1 - Oxygen (intermittent or continuous)
- 2 - Ventilator (continually or at night)
- 3 - Continuous / Bi-level positive airway pressure
- 4 - None of the above

CARDIAC STATUS

(M1500) Symptoms in Heart Failure Patients: If patient has been diagnosed with heart failure, did the patient exhibit symptoms indicated by clinical heart failure guidelines (including dyspnea, orthopnea, edema, or weight gain) at the time of or at any time since the previous OASIS assessment?

- 0 - No [Go to M2004 at TRN; Go to M1600 at DC]
- 1 - Yes
- 2 - Not assessed [Go to M2004 at TRN; Go to M1600 at DC]
- NA - Patient does not have diagnosis of heart failure [Go to M2004 at TRN; Go to M1600 at DC]

(M1510) Heart Failure Follow-up: If patient has been diagnosed with heart failure and has exhibited symptoms indicative of heart failure since the previous OASIS assessment, what action(s) has (have) been taken to respond? (Mark all that apply.)

- 0 - No action taken
- 1 - Patient’s physician (or other primary care practitioner) contacted the same day
- 2 - Patient advised to get emergency treatment (e.g., call 911 or go to emergency room)
- 3 - Implement physician-ordered patient-specific established parameters for treatment
- 4 - Patient education or other clinical interventions
- 5 - Obtained change in care plan orders (e.g., increased monitoring by agency, change in visit frequency, telehealth, etc.)
ELIMINATION STATUS
(M1600) Has this patient been treated for a Urinary Tract Infection in the past 14 days?

☐ 0  - No
☐ 1  - Yes
☐ NA - Patient on prophylactic treatment
☐ UK - Unknown [Omit “UK” option on DC]

(M1610) Urinary Incontinence or Urinary Catheter Presence:

☐ 0  - No incontinence or catheter (includes anuria or ostomy for urinary drainage) [Go to M1620]
☐ 1  - Patient is incontinent
☐ 2  - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) [Go to M1620]

(M1615) When does Urinary Incontinence occur?

☐ 0  - Timed-voiding defers incontinence
☐ 1  - Occasional stress incontinence
☐ 2  - During the night only
☐ 3  - During the day only
☐ 4  - During the day and night

(M1620) Bowel Incontinence Frequency:

☐ 0  - Very rarely or never has bowel incontinence
☐ 1  - Less than once weekly
☐ 2  - One to three times weekly
☐ 3  - Four to six times weekly
☐ 4  - On a daily basis
☐ 5  - More often than once daily
☐ NA - Patient has ostomy for bowel elimination
☐ UK - Unknown [Omit “UK” option on FU, DC]

(M1630) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen?

☐ 0  - Patient does not have an ostomy for bowel elimination.
☐ 1  - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.
☐ 2  - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

ELIMINATION STATUS
(M1600) Has this patient been treated for a Urinary Tract Infection in the past 14 days?

☐ 0  - No
☐ 1  - Yes
☐ NA - Patient on prophylactic treatment
☐ UK - Unknown [Omit “UK” option on DC]

(M1610) Urinary Incontinence or Urinary Catheter Presence:

☐ 0  - No incontinence or catheter (includes anuria or ostomy for urinary drainage) [Go to M1620]
☐ 1  - Patient is incontinent
☐ 2  - Patient requires a urinary catheter (specifically: external, indwelling, intermittent, suprapubic) [Go to M1620]

(M1615) When does Urinary Incontinence occur?

☐ 0  - Timed-voiding defers incontinence
☐ 1  - Occasional stress incontinence
☐ 2  - During the night only
☐ 3  - During the day only
☐ 4  - During the day and night

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(M1630) Ostomy for Bowel Elimination: Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen?

☐ 0  - Patient does not have an ostomy for bowel elimination.
☐ 1  - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.
☐ 2  - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.
NEURO/EMOTIONAL/BEHAVIORAL STATUS

(M1700) Cognitive Functioning: Patient’s current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

- 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- 1 - Requires prompting (cuing, repetition, reminders) only under stressful or unfamiliar conditions.
- 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

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

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

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

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

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

- 0 - No
- 1 - Yes, patient was screened using the PHQ-2© scale. (Instructions for this two-question tool: Ask patient: “Over the last two weeks, how often have you been bothered by any of the following problems?”)
- 2 - Yes, patient was screened with a different standardized assessment-and the patient meets criteria for further evaluation for depression.
- 3 - Yes, patient was screened with a different standardized assessment-and the patient does not meet criteria for further evaluation for depression.

<table>
<thead>
<tr>
<th>PHQ-2© Pfizer</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half of the days</th>
<th>Nearly every day</th>
<th>N/A Unable to respond</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>b) Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>PHQ-2©*</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half of the days</th>
<th>Nearly every day</th>
<th>N/A Unable to respond</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Little interest or pleasure in doing things</td>
<td>0</td>
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<td>2</td>
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<td></td>
</tr>
<tr>
<td>b) Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

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

(M1750) Is this patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?

- [ ] 0 - No
- [ ] 1 - Yes

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

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

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

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

(M1750) Is this patient receiving Psychiatric Nursing Services at home provided by a qualified psychiatric nurse?

- [ ] 0 - No
- [ ] 1 - Yes
**ADL/IADLs**

**(M1810) Current Ability to Dress Upper Body** (safety with or without dressing aids) including undergarments, leggings, front-opening shirts and blouses, managing zippers, buttons, and snaps:
- 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- 2 - Patient must help the patient put on upper body clothing.
- 3 - Patient depends entirely upon another person to dress the upper body.

**(M1820) Current Ability to Dress Lower Body** (safety with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:
- 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
- 2 - Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders; OR (b) to get in and out of the shower or tub; OR (c) for washing difficult to reach areas.
- 3 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
- 4 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath.
- 5 - Unable to participate effectively in bathing and is bathed totally by another person.

**(M1830) Bathing**:
- Excludes grooming (washing face, washing hands, shaving or make up, teeth or denture care, fingernail care).
- 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower.
- 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower.
- 2 - Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders; OR (b) to get in and out of the shower or tub; OR (c) for washing difficult to reach areas.
- 3 - Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- 4 - Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode.
- 5 - Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person throughout the bath.
- 6 - Unable to participate effectively in bathing and is bathed totally by another person.

**(M1840) Toilet Transferring**:
- 0 - Able to get to and from the toilet or bedside commode safely and transfer on and off toilet/commode.
- 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet and transfer.
- 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
- 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/Urinal independently.
- 4 - Is totally dependent in toileting.
Toileting Hygiene: Current ability to maintain perineal hygiene safely, adjust clothes and/or incontinence pads before and after using toilet, commode, bedpan, urinal. If managing ostomy, includes cleaning area around stoma, but not managing equipment.

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

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

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

Ability to Plan and Prepare Light Meals

- (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
- (c) A liquid, pureed or ground meat diet.
- (b) Intermittent assistance or supervision from another person; OR
- (a) Meal set-up; OR
- (c) A liquid, pureed or ground meat diet.
- 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.
- 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- 5 - Unable to take in nutrients orally or by tube feeding.

Current Ability to Plan and Prepare Light Meals (e.g., cereal, sandwich) or reheat delivered meals safely:

- 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR
- (b) Physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
- 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- 2 - Unable to prepare any light meals or reheat any delivered meals.

Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

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

Current Ability to Plan and Prepare Light Meals (for example: cereal, sandwich) or reheat delivered meals safely:

- 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR
- (b) Physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
- 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- 2 - Unable to prepare any light meals or reheat any delivered meals.
(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing numbers, and effectively using the telephone to communicate.

☐ 0 - Able to dial numbers and answer calls appropriately and as desired.
☐ 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.
☐ 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with calling.
☐ 3 - Unable to answer the telephone or able to carry on only a limited conversation.
☐ 4 - Unable to answer the telephone at all but can listen if assisted with equipment.
☐ 5 - Totally unable to use the telephone.
NA - Patient does not have a telephone.

(M1900) Prior Functional ADL/IADL: Indicate the patient’s usual ability with everyday activities prior to this current illness, exacerbation, or injury. Check only one box in each row.

<table>
<thead>
<tr>
<th>Functional Area</th>
<th>Independent</th>
<th>Needed Some Help</th>
<th>Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Self-Care (e.g., grooming, dressing, and bathing)</td>
<td>☐ 0</td>
<td>☑ 1</td>
<td>☐ 2</td>
</tr>
<tr>
<td>b. Ambulation</td>
<td>☐ 0</td>
<td>☑ 1</td>
<td>☐ 2</td>
</tr>
<tr>
<td>c. Transfer</td>
<td>☐ 0</td>
<td>☑ 1</td>
<td>☐ 2</td>
</tr>
<tr>
<td>d. Household tasks (e.g., light meal preparation, laundry, shopping)</td>
<td>☐ 0</td>
<td>☑ 1</td>
<td>☐ 2</td>
</tr>
</tbody>
</table>

(M1910) Has this patient had a multi-factor Fall Risk Assessment (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?

☐ 0 - No multi-factor falls risk assessment conducted.
☐ 1 - Yes, and it does not indicate a risk for falls.
☐ 2 - Yes, and it indicates a risk for falls.

MEDICATIONS

(M2000) Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplication therapy, dosages errors, or noncompliance?

☐ 0 - Not assessed/reviewed (Go to M2010)
☐ 1 - No problems found during review (Go to M2010)
☐ 2 - Problems found during review (Go to M2040)
NA - Patient is not taking any medications (Go to M2040)

(M2002) Medication Follow-up: Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?

☐ 0 - No
☐ 1 - Yes

(M2004) Medication Intervention: If there were any clinically significant medication issues since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day of the assessment to resolve clinically significant medication issues, including reconciliation?

☐ 0 - No
☐ 1 - Yes
NA - No clinically significant medication issues identified since the previous OASIS assessment

(M2000) Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues (for example: adverse drug reactions, ineffective drug therapy, significant side effects, drug interactions, duplicate therapy, omissions, dosages errors, or noncompliance (non-adherence))?

☐ 0 - Not assessed/reviewed (Go to M2010)
☐ 1 - No problems found during review (Go to M2010)
☐ 2 - Problems found during review (Go to M2040)
NA - Patient is not taking any medications (Go to M2040)

(M2002) Medication Follow-up: Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?

☐ 0 - No
☐ 1 - Yes

(M2004) Medication Intervention: If there were any clinically significant medication issues at the time of, or at any time since the previous OASIS assessment, was a physician or the physician-designee contacted within one calendar day of the assessment to resolve any identified clinically significant medication issues, including reconciliation?

☐ 0 - No
☐ 1 - Yes
NA - No clinically significant medication issues identified at the time of or at any time since the previous OASIS assessment
(M2010) Patient/Caregiver High Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?
- 0 - No
- 1 - Yes
- NA - Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

(M2015) Patient/Caregiver Drug Education Intervention: Since the previous OASIS assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects, and how and when to report problems that may occur?
- 0 - No
- 1 - Yes
- NA - Patient not taking any drugs

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

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

(M2040) Prior Medication Management: Indicate the patient’s usual ability with managing oral and injectable medications prior to this current illness, exacerbation, or injury. Check only one box in each row.

<table>
<thead>
<tr>
<th>Functional Area</th>
<th>Independent</th>
<th>Needed Some Help</th>
<th>Dependent</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Oral medications</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ NA</td>
</tr>
<tr>
<td>b. Injectable medications</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ NA</td>
</tr>
</tbody>
</table>

(M2040) Prior Medication Management: Indicate the patient’s usual ability with managing oral and injectable medications prior to his/her most recent illness, exacerbation, or injury. Check only one box in each row.

<table>
<thead>
<tr>
<th>Functional Area</th>
<th>Independent</th>
<th>Needed Some Help</th>
<th>Dependent</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Oral medications</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ NA</td>
</tr>
<tr>
<td>b. Injectable medications</td>
<td>☐ 0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ NA</td>
</tr>
</tbody>
</table>
### CARE MANAGEMENT

**(M2100)** Types and Sources of Assistance: Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. (Check only one box in each row.)

<table>
<thead>
<tr>
<th>Type of Assistance</th>
<th>Caregiver(s) currently provides assistance</th>
<th>Caregiver(s) need training/ supportive services to provide assistance</th>
<th>Caregiver(s) not likely to provide assistance</th>
<th>Unclear if Caregiver(s) will provide assistance</th>
<th>Assistance needed, but no Caregiver(s) available</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ADL assistance</td>
<td>☐   0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>(e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. IADL assistance</td>
<td>☐   0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>(e.g., meals, housekeeping, laundry, telephone, shopping, finances)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Medication administration (e.g., oral, inhalated or injectable)</td>
<td>☐   0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>d. Medical procedures/treatments (e.g., changing wound dressing)</td>
<td>☐   0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>e. Management of Equipment (includes oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)</td>
<td>☐   0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>f. Supervision and safety (e.g., due to cognitive impairment)</td>
<td>☐   0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>g. Advocacy or facilitation of patient’s participation in appropriate medical care (includes transportation to or from appointments)</td>
<td>☐   0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
</tbody>
</table>

#### (M2110) How Often does the patient receive ADL or IADL assistance from any caregiver(s) (other than home health agency staff)?

- ☐ 1 - At least daily
- ☐ 2 - Three or more times per week
- ☐ 3 - One to two times per week
- ☐ 4 - Received, but less often than weekly
- ☐ 5 - No assistance received
- ☐ UK - Unknown (Omit "UK" option on DC)

### CARE MANAGEMENT

**(M2102)** Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. EXCLUDES all care by your agency staff. (Check only one box in each row.)

<table>
<thead>
<tr>
<th>Type of Assistance</th>
<th>No assistance needed – patient is independent or does not have needs in this area</th>
<th>Non-agency caregiver(s) currently provide assistance</th>
<th>Non-agency caregiver(s) need training/supportive services to provide assistance</th>
<th>Unclear if they will provide assistance</th>
<th>Assistance needed, but no non-agency caregiver(s) available</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. ADL assistance</td>
<td>☐   0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>(for example: transfer/ambulation, bathing, dressing, toileting, eating/feeding)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. IADL assistance</td>
<td>☐   0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>(for example: meals, housekeeping, laundry, telephone, shopping, finances)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Medication administration (for example: oral, inhalated or injectable)</td>
<td>☐   0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>d. Medical procedures/treatments (for example: changing wound dressing, home exercise program)</td>
<td>☐   0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>e. Management of Equipment (for example: oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies)</td>
<td>☐   0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>f. Supervision and safety (for example: due to cognitive impairment)</td>
<td>☐   0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
<tr>
<td>g. Advocacy or facilitation of patient’s participation in appropriate medical care (for example: transportation to or from appointments)</td>
<td>☐   0</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
</tr>
</tbody>
</table>

#### (M2110) How Often does the patient receive ADL or IADL assistance from any caregiver(s) (other than home health agency staff)?

- ☐ 1 - At least daily
- ☐ 2 - Three or more times per week
- ☐ 3 - One to two times per week
- ☐ 4 - Received, but less often than weekly
- ☐ 5 - No assistance received
- ☐ UK - Unknown
**THERAPY NEED AND PLAN OF CARE**

(M2200) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? (Enter zero "000" if no therapy visits indicated.)

( ___ ___ ) Number of therapy visits indicated (total of physical, occupational and speech-language pathology combined).

☐ NA - Not Applicable: No case mix group defined by this assessment.

(M2250) Plan of Care Synopsis: (Check only one box in each row.) Does the physician-ordered plan of care include the following:

<table>
<thead>
<tr>
<th>Plan / Intervention</th>
<th>No</th>
<th>Yes</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Patient-specific parameters for notifying physician of changes in vital signs or other clinical findings</td>
<td>☐0</td>
<td>☑1</td>
<td>☐na</td>
</tr>
<tr>
<td>b. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care</td>
<td>☐0</td>
<td>☑1</td>
<td>☐na</td>
</tr>
<tr>
<td>c. Falls prevention interventions</td>
<td>☐0</td>
<td>☑1</td>
<td>☐na</td>
</tr>
<tr>
<td>d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment</td>
<td>☐0</td>
<td>☑1</td>
<td>☐na</td>
</tr>
<tr>
<td>e. Intervention(s) to monitor and mitigate pain</td>
<td>☐0</td>
<td>☑1</td>
<td>☐na</td>
</tr>
<tr>
<td>f. Intervention(s) to prevent pressure ulcers</td>
<td>☐0</td>
<td>☑1</td>
<td>☐na</td>
</tr>
<tr>
<td>g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician</td>
<td>☐0</td>
<td>☑1</td>
<td>☐na</td>
</tr>
</tbody>
</table>

**THERAPY NEED AND PLAN OF CARE**

(M2200) Therapy Need: In the home health plan of care for the Medicare payment episode for which this assessment will define a case mix group, what is the indicated need for therapy visits (total of reasonable and necessary physical, occupational, and speech-language pathology visits combined)? (Enter zero "000" if no therapy visits indicated.)

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<td>☑1</td>
<td>☐na</td>
</tr>
<tr>
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<td>☐0</td>
<td>☑1</td>
<td>☐na</td>
</tr>
<tr>
<td>d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment</td>
<td>☐0</td>
<td>☑1</td>
<td>☐na</td>
</tr>
<tr>
<td>e. Intervention(s) to monitor and mitigate pain</td>
<td>☐0</td>
<td>☑1</td>
<td>☐na</td>
</tr>
<tr>
<td>f. Intervention(s) to prevent pressure ulcers</td>
<td>☐0</td>
<td>☑1</td>
<td>☐na</td>
</tr>
<tr>
<td>g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician</td>
<td>☐0</td>
<td>☑1</td>
<td>☐na</td>
</tr>
</tbody>
</table>

**Plan of Care Synopsis:**

- Does the physician-ordered plan of care include the following:

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<tr>
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<td>☑1</td>
<td>☐na</td>
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<tr>
<td>c. Falls prevention interventions</td>
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<td>☑1</td>
<td>☐na</td>
</tr>
<tr>
<td>d. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment</td>
<td>☐0</td>
<td>☑1</td>
<td>☐na</td>
</tr>
<tr>
<td>e. Intervention(s) to monitor and mitigate pain</td>
<td>☐0</td>
<td>☑1</td>
<td>☐na</td>
</tr>
<tr>
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<td>☑1</td>
<td>☐na</td>
</tr>
<tr>
<td>g. Pressure ulcer treatment based on principles of moist wound healing OR order for treatment based on moist wound healing has been requested from physician</td>
<td>☐0</td>
<td>☑1</td>
<td>☐na</td>
</tr>
</tbody>
</table>
EMERGENT CARE

(M2300) Emergent Care: Since the last time OASIS data were collected, has the patient utilized a hospital emergency department (includes holding/observation)?

[ ] 0 - No [ Go to M2400 ]
[ ] 1 - Yes, used hospital emergency department WITHOUT hospital admission
[ ] 2 - Yes, used hospital emergency department WITH hospital admission
[ ] UK - Unknown [ Go to M2400 ]

(M2310) Reason for Emergent Care: For what reason(s) did the patient receive emergent care (with or without hospitalization)?

[ ] 1 - Improper medication administration, medication side effects, toxicity, anaphylaxis
[ ] 2 - Injury caused by fall
[ ] 3 - Respiratory infection (e.g., pneumonia, bronchitis)
[ ] 4 - Other respiratory problem
[ ] 5 - Heart failure (e.g., fluid overload)
[ ] 6 - Cardiac dysrhythmia (irregular heartbeat)
[ ] 7 - Myocardial infarction or chest pain
[ ] 8 - Other heart disease
[ ] 9 - Stroke (CVA) or TIA
[ ] 10 - Hypo/Hyperglycemia, diabetes out of control
[ ] 11 - GI bleeding, obstruction, constipation, impaction
[ ] 12 - Dehydration, malnutrition
[ ] 13 - Urinary tract infection
[ ] 14 - IV catheter-related infection or complication
[ ] 15 - Wound infection or deterioration
[ ] 16 - Uncontrolled pain
[ ] 17 - Acute mental/behavioral health problem
[ ] 18 - Deep vein thrombosis, pulmonary embolus
[ ] 19 - Other than above reasons
[ ] UK - Reason unknown
### DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY

#### DISCHARGE ONLY (M2400)

**Intervention Synopsis:** (Check only one box in each row.) Since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

<table>
<thead>
<tr>
<th>Plan / Intervention</th>
<th>No</th>
<th>Yes</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Diabetic foot care including monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care</td>
<td>☐️</td>
<td>☑️</td>
<td>☐️</td>
</tr>
<tr>
<td>Patient is not diabetic or is bilateral amputee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Falls prevention interventions</td>
<td>☐️</td>
<td>☑️</td>
<td>☐️</td>
</tr>
<tr>
<td>Formal multi-factor Fall Risk Assessment indicates the patient was not at risk for falls since the last OASIS assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment</td>
<td>☐️</td>
<td>☑️</td>
<td>☐️</td>
</tr>
<tr>
<td>Formal assessment indicates patient did not meet criteria for depression AND patient did not have diagnosis of depression since the last OASIS assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Intervention(s) to monitor and mitigate pain</td>
<td>☐️</td>
<td>☑️</td>
<td>☐️</td>
</tr>
<tr>
<td>Formal assessment did not indicate pain since the last OASIS assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Intervention(s) to prevent pressure ulcers</td>
<td>☐️</td>
<td>☑️</td>
<td>☐️</td>
</tr>
<tr>
<td>Formal assessment indicates the patient was not at risk of pressure ulcers since the last OASIS assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Pressure ulcer treatment based on principles of moist wound healing</td>
<td>☐️</td>
<td>☑️</td>
<td>☐️</td>
</tr>
<tr>
<td>Dressings that support the principles of moist wound healing not indicated for this patient’s pressure ulcers OR patient has no pressure ulcers with need for moist wound healing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### To which Inpatient Facility has the patient been admitted?

- 1 - Hospital [Go to M2430 ]
- 2 - Rehabilitation facility [Go to M0903 ]
- 3 - Nursing home [Go to M2440 ]
- 4 - Hospice [Go to M0903 ]
- NA - No inpatient facility admission [Omit “NA” option on TRN]

#### Discharge Disposition: Where is the patient after discharge from your agency? (Choose only one answer.)

- 1 - Patient remained in the community (without formal assistive services)
- 2 - Patient remained in the community (with formal assistive services)
- 3 - Patient transferred to a non-institutional hospice
- 4 - Unknown because patient moved to a geographic location not served by this agency
- UK - Other unknown [Go to M0903 ]

---

#### DATA ITEMS COLLECTED AT INPATIENT FACILITY ADMISSION OR AGENCY

#### DISCHARGE ONLY (M2400)

**Intervention Synopsis:** (Check only one box in each row.) At the time of or at any time since the previous OASIS assessment, were the following interventions BOTH included in the physician-ordered plan of care AND implemented?

<table>
<thead>
<tr>
<th>Plan / Intervention</th>
<th>No</th>
<th>Yes</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Diabetic foot care excluding monitoring for the presence of skin lesions on the lower extremities and patient/caregiver education on proper foot care</td>
<td>☐️</td>
<td>☑️</td>
<td>☐️</td>
</tr>
<tr>
<td>b. Falls prevention interventions</td>
<td>☐️</td>
<td>☑️</td>
<td>☐️</td>
</tr>
<tr>
<td>c. Depression intervention(s) such as medication, referral for other treatment, or a monitoring plan for current treatment</td>
<td>☐️</td>
<td>☑️</td>
<td>☐️</td>
</tr>
<tr>
<td>d. Intervention(s) to monitor and mitigate pain</td>
<td>☐️</td>
<td>☑️</td>
<td>☐️</td>
</tr>
<tr>
<td>e. Intervention(s) to prevent pressure ulcers</td>
<td>☐️</td>
<td>☑️</td>
<td>☐️</td>
</tr>
<tr>
<td>f. Pressure ulcer treatment based on principles of moist wound healing</td>
<td>☐️</td>
<td>☑️</td>
<td>☐️</td>
</tr>
</tbody>
</table>

---

#### To which Inpatient Facility has the patient been admitted?

- 1 - Hospital [Go to M2430 ]
- 2 - Rehabilitation facility [Go to M0903 ]
- 3 - Nursing home [Go to M0903 ]
- 4 - Hospice [Go to M0903 ]
- NA - No inpatient facility admission [Omit “NA” option on TRN]

#### Discharge Disposition: Where is the patient after discharge from your agency? (Choose only one answer.)

- 1 - Patient remained in the community (without formal assistive services)
- 2 - Patient remained in the community (with formal assistive services)
- 3 - Patient transferred to a non-institutional hospice
- 4 - Unknown because patient moved to a geographic location not served by this agency
- UK - Other unknown [Go to M0903 ]
Reason for Hospitalization: For what reason(s) did the patient require hospitalization? (Mark all that apply.)

- Improper medication administration, medication side effects, toxicity, anaphylaxis
- Injury caused by fall
- Respiratory infection (e.g., pneumonia, bronchitis)
- Other respiratory problem
- Heart failure (e.g., fluid overload)
- Cardiac dysrhythmia (irregular heartbeat)
- Myocardial infarction or chest pain
- Other heart disease
- Stroke (CVA) or TIA
- Hypo/Hyperglycemia, diabetes out of control
- GI bleeding, obstruction, constipation, impaction
- Dehydration, malnutrition
- Urinary tract infection
- IV catheter-related infection or complication
- Wound infection or deterioration
- Uncontrolled pain
- Acute mental/behavioral health problem
- Deep vein thrombosis, pulmonary embolus
- Scheduled treatment or procedure
- Other than above reasons
- Reason unknown

Reason for Hospitalization: For what reason(s) did the patient require hospitalization? (Mark all that apply.)

- Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis
- Injury caused by fall
- Respiratory infection (for example: pneumonia, bronchitis)
- Other respiratory problem
- Heart failure (for example: fluid overload)
- Cardiac dysrhythmia (irregular heartbeat)
- Myocardial infarction or chest pain
- Other heart disease
- Stroke (CVA) or TIA
- Hypo/Hyperglycemia, diabetes out of control
- GI bleeding, obstruction, constipation, impaction
- Dehydration, malnutrition
- Urinary tract infection
- IV catheter-related infection or complication
- Wound infection or deterioration
- Uncontrolled pain
- Acute mental/behavioral health problem
- Deep vein thrombosis, pulmonary embolus
- Scheduled treatment or procedure
- Other than above reasons
- Reason unknown

For what Reason(s) was the patient Admitted to a Nursing Home? (Mark all that apply.)

- Therapy services
- Respite care
- Hospice care
- Permanent placement
- Unsafe for care at home
- Other
- Reason unknown

Date of Last (Most Recent) Home Visit:

Discharge/Transfer/Death Date:
Enter the date of the discharge, transfer, or death (at home) of the patient.