Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BACKGROUND (FACE SHEET) INFORMATION AT ADMISSION

SECTION AB. DEMOGRAPHIC INFORMATION

1. DATE OF ENTRY

Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date

Month — Day — Year

2. ADMITTED FROM (AT ENTRY)

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

3. LIVED ALONE (PRIOR TO ENTRY)

0. No
1. Yes
2. In other facility

4. ZIP CODE OF PRIOR PRIMARY RESIDENCE

5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY

(***Check all settings*** *resident* ***lived in*** *during 5 years prior to date of entry given in item AB1 above)*

- Prior stay at this nursing home — a.
- Stay in other nursing home — b.
- Other residential facility—board and care home, assisted living, group home — c.
- MH/psychiatric setting — d.
- MR/DD setting — e.
- *NONE OF ABOVE* — f.

6. LIFETIME OCCUPATION(S) [Put "/" between two occupations]

7. EDUCATION (*Highest Level Completed*)

1. No schooling
2. 8th grade/less
3. 9-11 grades
4. High school
5. Technical or trade school
6. Some college
7. Bachelor's degree
8. Graduate degree

8. LANGUAGE

(*Code for correct response*)

a. Primary Language

0. English 1. Spanish 2. French 3. Other

b. If other, specify

9. MENTAL HEALTH HISTORY

Does resident's RECORD indicate any history of mental retardation, mental illness, or developmental disability problem?

0. No 1. Yes

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*)

- Not applicable—no MR/DD (Skip to AB11) — a.
- MR/DD with organic condition
  - Down's syndrome — b.
  - Autism — c.
  - Epilepsy — d.
  - Other organic condition related to MR/DD — e.
- MR/DD with no organic condition — f.

11. DATE BACKGROUND INFORMATION COMPLETED

Month — Day — Year

SECTION AC. CUSTOMARY ROUTINE

1. CUSTOMARY ROUTINE (*In year prior to DATE OF ENTRY to this nursing home, or year last in community if now being admitted from another nursing home*)

(***Check all that apply.*** *If all information UNKNOWN, check last box only.*)

CYCLE OF DAILY EVENTS

- Stays up late at night (e.g., after 9 pm) — a.
- Naps regularly during day (at least 1 hour) — b.
- Goes out 1+ days a week — c.
- Stays busy with hobbies, reading, or fixed daily routine — d.
- Spends most of time alone or watching TV — e.
- Moves independently indoors (with appliances, if used) — f.
- Use of tobacco products at least daily — g.
- *NONE OF ABOVE* — h.

EATING PATTERNS

- Distinct food preferences — i.
- Eats between meals all or most days — j.
- Use of alcoholic beverage(s) at least weekly — k.
- *NONE OF ABOVE* — l.

ADL PATTERNS

- In bedclothes much of day — m.
- Wakens to toilet all or most nights — n.
- Has irregular bowel movement pattern — o.
- Showers for bathing — p.
- Bathing in PM — q.
- *NONE OF ABOVE* — r.

INVOLVEMENT PATTERNS

- Daily contact with relatives/close friends — s.
- Usually attends church, temple, synagogue (etc.) — t.
- Finds strength in faith — u.
- Daily animal companion/presence — v.
- Involved in group activities — w.
- *NONE OF ABOVE* — x.

UNKNOWN—Resident/family unable to provide information — y.

SECTION AD. FACE SHEET SIGNATURES

SIGNATURES OF PERSONS COMPLETING FACE SHEET:

a. Signature of RN Assessment Coordinator — Date

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature and Title	Sections	Date
b.			
c.			
d.			
e.			
f.			
g.			

☐ = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies