NHSN ID	Hospital	Have not yet conferred rights:
13867	Adventist Medical Center	Cottage Grove
13917	Ashland Community Hospital	Grande Ronde
13654	Bay Area Hospital	Harney
13763	Blue Mountain Hospital	Lake
14061	Columbia Memorial Hospital	Lower Umpqua
13834	Coquille Valley Hospital	McKenzie-Willamette
13783	Good Samaritan Regional Medical Center	Mercy
13871	Holy Rosary Medical Center	Pioneer (H)
10400	Kaiser Sunnyside Medical Center	St. Elizabeth
10598	Legacy Emanuel Hospital and Health Center	Curry
10597	Legacy Good Samaritan Hospital and Medical Center	
13821	Legacy Meridian Park Hospital	
14002	Legacy Mount Hood Medical Center	
14173	Mid Columbia Medical Center	
13856	Mountain View Hospital	
10074	Oregon Health & Science University Hospitals & Clinics	
10997	Peace Harbor Hospital	
13419	Pioneer Memorial Hospital (P)	
13382	Providence Hood River Memorial Hospital	
13313	Providence Medford Medical Center	
12445	Providence Milwaukie Hospital	
11121	Providence Newberg Medical Center	
13724	Providence Portland Medical Center	
13303	Providence Seaside Hospital	
10095	Providence St. Vincent Medical Center	
12648	Sacred Heart Medical Center	
13910	Salem Hospital	
13787	Samaritan Albany General Hospital	
13720	Samaritan Lebanon Community Hospital	
13780	Samaritan North Lincoln Hospital	
13722	Samaritan Pacific Communities Hospital	
14224	Santiam Memorial Hospial	
13984	Shriners Hospital for Children	
13685	Silverton Hospital	
14288	Sky Lake Medical Center	
14013	Southern Coos Hospital and Health Center	
13618	St. Anthony Hospital	
13402	St. Charles Medical Center-Bend	
13418	St. Charles Medical Center-Redmond	
11409	Three Rivers Community Hospital	
13383	Tillamook County General Hospital	
13786	Tuality Healthcare	
13796	Wallowa Memorial Hospital	
14087	West Valley Hospital	
13738	Willamette Falls Hospital	
13930	Willamette Valley Medical Center	
14144	Rogue Valley Medical Center	

Methicillin

Resistant
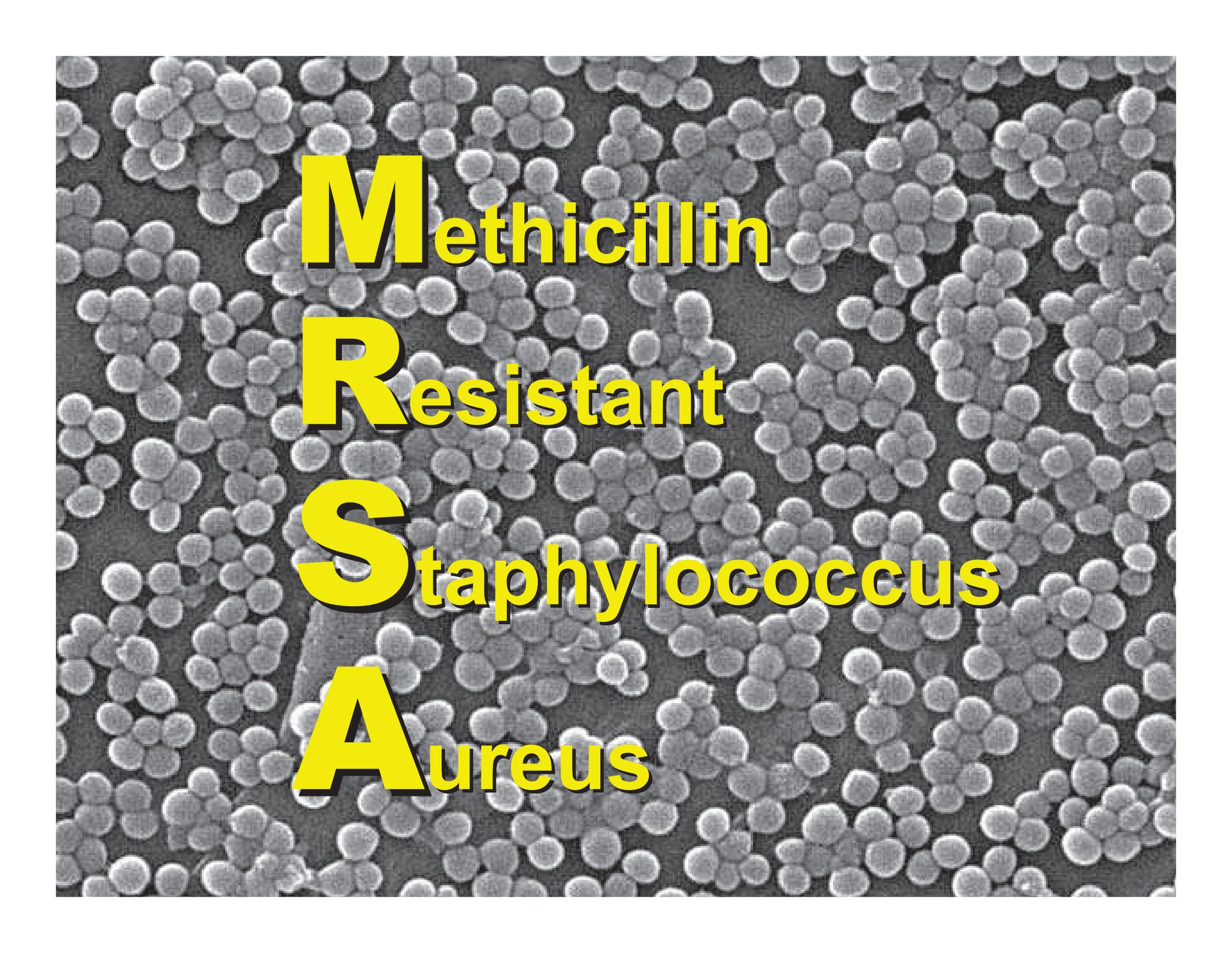
Staphylococcus

Aureus

Key Terms

- Methicillin Resistant: not susceptible to penicillin-like antibiotics (penicillin, methicillin, oxacillin, and amoxicillin).
  - Note that MRSA is also resistant to other classes of antibiotics.

Key Terms

- Staphylococcus aureus (S. aureus): spherical bacteria commonly found on the skin or in the nose of healthy people

- Colonization: presence of bacteria without signs or symptoms of infection
  - ~30% of US population is colonized with S. aureus
 - ~1% of US population is colonized with MRSA
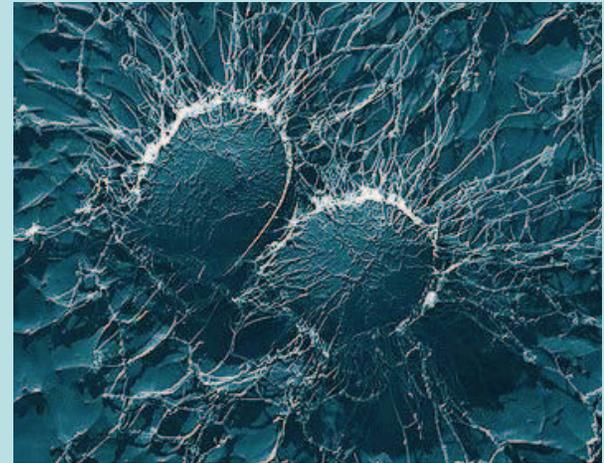
Key Terms

- Invasive: infection of a body site that is normally sterile (such as blood)
- Community acquired (CA) MRSA: generally an infection that occurs without previous exposure to healthcare
  - About 15% of invasive MRSA is CA
- Healthcare associated (HA) MRSA: generally an infection that occurs at least 48 hours after exposure to healthcare
  - About 85% of invasive MRSA is HA

Key Terms

- Oregon ABCs: Oregon Active Bacterial Core Surveillance (Public Health Division)
  - Produces an annual invasive MRSA surveillance report (Tri-County area only)
- USA100: strain most often identified in HA-MRSA
- USA300: strain most often identified in CA-MRSA
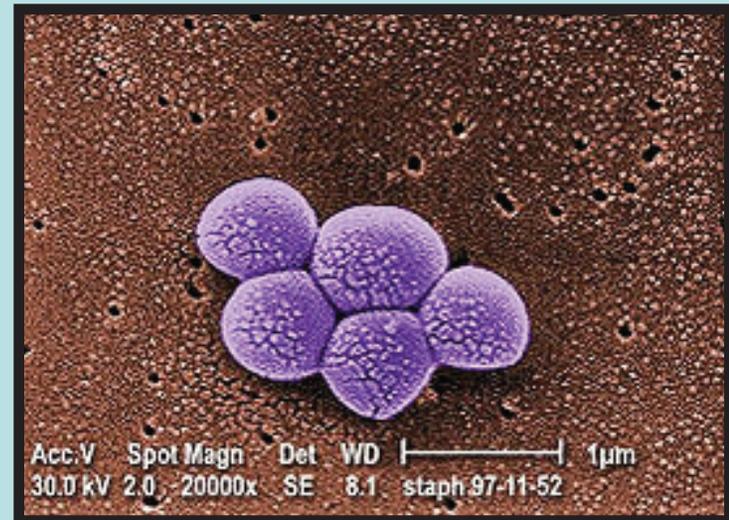
Outcomes in Oregon

- Overall MRSA rate is decreasing in the Tri-County Area

Figure 1: Incidence of Invasive MRSA Cases, by Infection Type, 2004-2007.
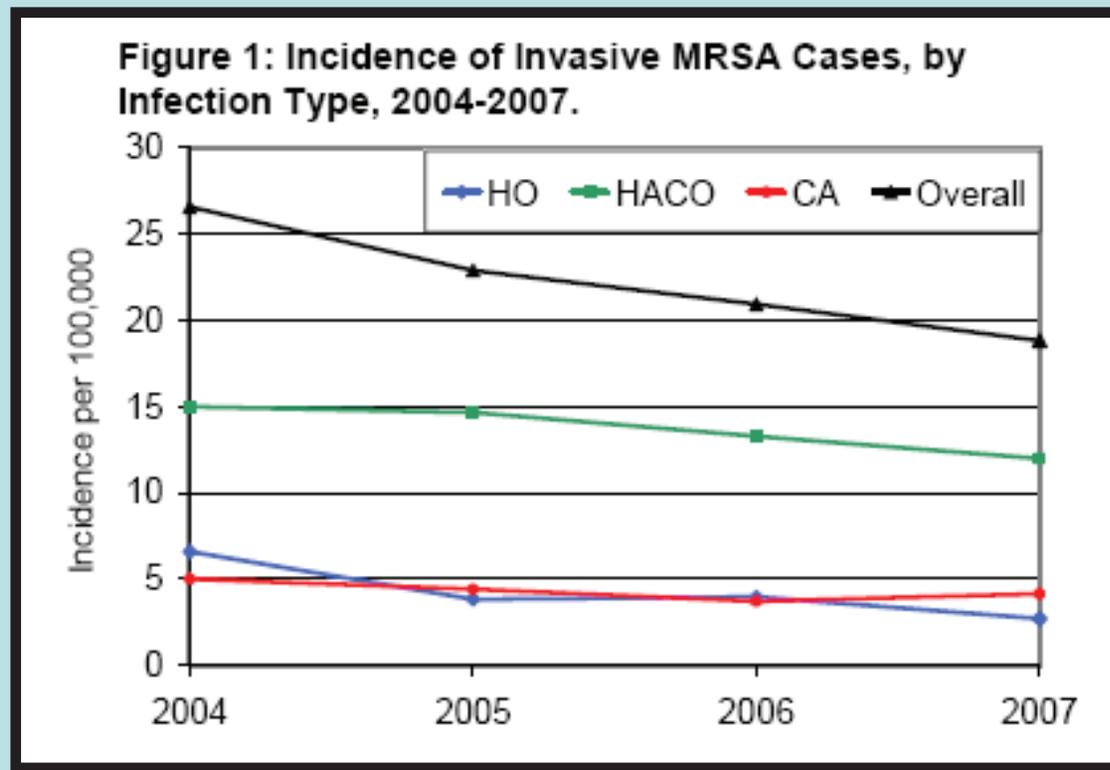
Outcomes in Oregon

- The overall MRSA rate increases with age

Figure 2: Incidence of Invasive MRSA, by Infection Type and Age, 2007.
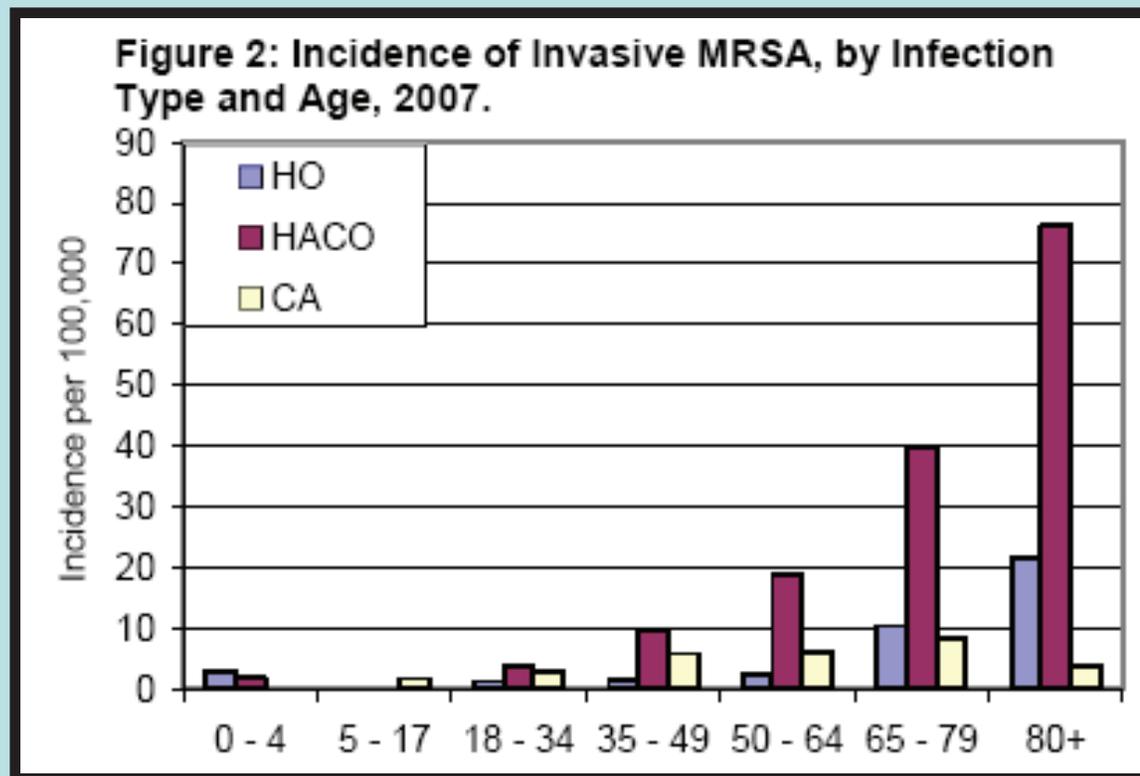
Outcomes in Oregon

- In 2007 about 13% of cases were fatal
  - This has not changed since 2004
  - Age 65+: 20% of cases were fatal
  - US: about 18% of cases were fatal in 2005
- Common risk factors:
  - HA: common chronic conditions such as heart disease, diabetes, renal failure, and cancer
    - Most patients have two or more risk factors
  - CA: smoking and IV drug use

The Latest News

- NHSN report in the Journal of the American Medical Association (2/18/09)
    - CLABSI rate for MRSA decreased by 49.6% from 1997 (4.3/10,000 central line days) to 2007 (2.1/10,000 central line days)
    - Caveat from CDC: "These data do not account for other types of healthcare-associated MRSA infection, such as surgical-related infections, or infections occurring outside of the ICU, where a large burden of healthcare-associated MRSA does exist."

The Latest News

- Are there specific reasons for this trend?
  - "Although the cause of this dramatic decline could not be evaluated by this analysis, improvements in healthcare have likely contributed to this downward trend. Some of those efforts include improvement in central line insertion and care practices, dissemination of prevention guidelines and increasing success in preventing MRSA transmission between patients. "
  - "Participation in the surveillance process itself likely has a positive influence on hospital infection control efforts and central line-associated BSI risk."

The Joint Commission

- Hospital Accreditation Program
  - National Patient Safety Goal 07.03.01
    - "Implement evidence-based practices to prevent healthcare-associated infections due to mutidrug-resistant organisms in acute care hospitals."
    - Includes, but is not limited to, MRSA, Clostridium difficile, and vancomycin-resistant Enterococci
    - As of Jan. 1, 2010, the hospital measures infection rates using evidence-based metrics and provides the data to key stakeholders

NHSN MDRO Module

- Module for reporting invasive infections due to multidrug-resistant organisms (MDROs)
  - Includes MRSA, C. difficile, and others
- Module will go live on April 12, 2009
  - Caveat: there have been many delays
- Minimum requirements
  - One organism
  - One hospital location (or facility-wide)
  - Three consecutive months

NHSN MDRO Module

- Laboratory-Identified Events
  - Allows hospital to identify events with lab data
  - Denominators: admissions and patient days
  - Process measures are optional
  - Healthcare onset (HO): specimen collected more than 3 days after admission
  - Community onset (CO): specimen collected within 3 days of admission

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- Burton DC, et al. "Methicillin-Resistant Staphylococcus aureus Central Line Associated Bloodstream Infections in US Intensive Care Units, 1997-2007." *JAMA.* 2009;301(7):727-736.

- The Joint Commission on Accreditation of Healthcare Organizations. "2009 National Patient Safety Goals Manual Chapter." http://www.jointcommission.org/NR/rdonlyres/31666E86-E7F4-423E-9BE8-F05BD1CB0AA8/0/HAP_NPSG.pdf (accessed February 12, 2009).

- Klevens RM, et al. "Invasive Methicillin-Resistant *Staphylococcus aureus* Infections in the United States ." *JAMA.* 2007;298(15):1763-1771.

- Centers for Disease Control and Prevention. "The National Healthcare Safety Network Manual: Multidrug-resistant Organism (MDRO) and *Clostridium difficile*-Associated Disease (CDAD) Module." http://www.cdc.gov/ncidod/dhqp/pdf/nhsn/MDRO_CDADprotocolv41Dec08final.pdf (accessed February 2, 2009).

MINIMUM DATA SET (MDS) — *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME⊛				
		a. (First)	**b.** (Middle Initial)	**c.** (Last)	**d.** (Jr/Sr)
2.	GENDER⊛	1. Male	2. Female		
3.	BIRTHDATE⊛	Month — Day — Year			
4.	RACE/ETHNICITY	1. American Indian/Alaskan Native 4. Hispanic 2. Asian/Pacific Islander 5. White, not of 3. Black, not of Hispanic origin Hispanic origin			
5.	SOCIAL SECURITY⊛ AND MEDICARE NUMBERS⊛ [C in 1ˢᵗ box if non med. no.]	**a.** Social Security Number **b.** Medicare number (or comparable railroad insurance number)			
6.	FACILITY PROVIDER NO.⊛	**a.** State No. **b.** Federal No.			
7.	MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] ⊛				
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] **a.** Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* **b.** *Codes for assessments required for Medicare PPS or the State* *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*			

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

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 partici-pation in the government-funded health care programs is conditioned on the accuracy and truthful-ness 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
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		
i.		
j.		
k.		
l.		

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

⊛ = Key items for computerized resident tracking

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

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.	RESIDEN-TIAL 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 OCCUPA-TION(S) [Put "/" between two occupations]	☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

7.	EDUCATION (*Highest Level Completed*)	1. No schooling 5. Technical or trade school 2. 8th grade/less 6. Some college 3. 9-11 grades 7. Bachelor's degree 4. High school 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 BACK-GROUND INFORMA-TION 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 partici-pation in the government-funded health care programs is conditioned on the accuracy and truthful-ness 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

Resident _____ Numeric Identifier _____

<div align="center">

MINIMUM DATA SET (MDS) — *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM
(Status in last 7 days, unless other time frame indicated)

</div>

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME

a. (First)　　b. (Middle Initial)　　c. (Last)　　d. (Jr/Sr)

2. ROOM NUMBER

3. ASSESS-MENT REFERENCE DATE
a. *Last day of MDS observation period*

Month — Day — Year

b. Original (0) or corrected copy of form (enter number of correction)

4a. DATE OF REENTRY
Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)

Month — Day — Year

5. MARITAL STATUS
1. Never married 　3. Widowed 　5. Divorced
2. Married 　4. Separated

6. MEDICAL RECORD NO.

7. CURRENT PAYMENT SOURCES FOR N.H. STAY
(*Billing Office to indicate; **check all that apply in last 30 days***)

Medicaid per diem	a.	VA per diem	f.
Medicare per diem	b.	Self or family pays for full per diem	g.
Medicare ancillary part A	c.	Medicaid resident liability or Medicare co-payment	h.
Medicare ancillary part B	d.	Private insurance per diem (including co-payment)	i.
CHAMPUS per diem	e.	Other per diem	j.

8. REASONS FOR ASSESS-MENT

[Note—If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed]

a. Primary reason for assessment
1. Admission assessment (required by day 14)
2. Annual assessment
3. Significant change in status assessment
4. Significant correction of prior full assessment
5. Quarterly review assessment
6. Discharged—return not anticipated
7. Discharged—return anticipated
8. Discharged prior to completing initial assessment
9. Reentry
10. Significant correction of prior quarterly assessment
0. *NONE OF ABOVE*

b. **Codes for assessments required for Medicare PPS or the State**
1. *Medicare 5 day assessment*
2. *Medicare 30 day assessment*
3. *Medicare 60 day assessment*
4. *Medicare 90 day assessment*
5. *Medicare readmission/return assessment*
6. *Other state required assessment*
7. *Medicare 14 day assessment*
8. *Other Medicare required assessment*

9. RESPONSI-BILITY/ LEGAL GUARDIAN
(***Check all that apply***)

Legal guardian	a.	Durable power attorney/financial	d.
Other legal oversight	b.	Family member responsible	e.
Durable power of attorney/health care	c.	Patient responsible for self	f.
		NONE OF ABOVE	g.

10. ADVANCED DIRECTIVES
(*For those items with supporting **documentation** in the medical record, **check all that apply***)

Living will	a.	Feeding restrictions	f.
Do not resuscitate	b.	Medication restrictions	g.
Do not hospitalize	c.	Other treatment restrictions	h.
Organ donation	d.	*NONE OF ABOVE*	i.
Autopsy request	e.		

SECTION B. COGNITIVE PATTERNS

1. COMATOSE
(*Persistent vegetative state/no discernible consciousness*)
0. No 　1. Yes 　(**If yes, skip to Section G**)

2. MEMORY
(*Recall of what was learned or known*)

a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 　1. Memory problem

b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 　1. Memory problem

3. MEMORY/ RECALL ABILITY
(***Check all** that resident was **normally able to recall during last 7 days***)

Current season	a.	That he/she is in a nursing home	d.
Location of own room	b.		
Staff names/faces	c.	*NONE OF ABOVE* are recalled	e.

4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING
(*Made decisions regarding tasks of daily life*)
0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

5. INDICATORS OF DELIRIUM— PERIODIC DISOR-DERED THINKING/ AWARENESS
(*Code for behavior in the **last 7 days**.*) [*Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time*].

0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)

b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)

d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)

e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)

f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

6. CHANGE IN COGNITIVE STATUS
Resident's cognitive status, skills, or abilities have changed as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 　1. Improved 　2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING
(*With hearing appliance, if used*)
0. *HEARS ADEQUATELY*—normal talk, TV, phone
1. *MINIMAL DIFFICULTY* when not in quiet setting
2. *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly
3. *HIGHLY IMPAIRED*/absence of useful hearing

2. COMMUNI-CATION DEVICES/ TECH-NIQUES
(***Check all that apply** during last 7 days*)

Hearing aid, present and used	a.
Hearing aid, present and not used regularly	b.
Other receptive comm. techniques used (e.g., lip reading)	c.
NONE OF ABOVE	d.

3. MODES OF EXPRESSION
(***Check all used** by resident to make needs known*)

Speech	a.	Signs/gestures/sounds	d.
Writing messages to express or clarify needs	b.	Communication board	e.
American sign language or Braille	c.	Other	f.
		NONE OF ABOVE	g.

4. MAKING SELF UNDER-STOOD
(*Expressing information content—however able*)
0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

5. SPEECH CLARITY
(*Code for speech in the **last 7 days***)
0. *CLEAR SPEECH*—distinct, intelligible words
1. *UNCLEAR SPEECH*—slurred, mumbled words
2. *NO SPEECH*—absence of spoken words

6. ABILITY TO UNDER-STAND OTHERS
(*Understanding verbal information content—however able*)
0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

7. CHANGE IN COMMUNI-CATION/ HEARING
Resident's ability to express, understand, or hear information has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days)
0. No change 　1. Improved 　2. Deteriorated

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

SECTION D. VISION PATTERNS

1.	VISION	(*Ability to see in adequate light and with glasses if used*)	
		0. *ADEQUATE*—sees fine detail, including regular print in newspapers/books	
		1. *IMPAIRED*—sees large print, but not regular print in newspapers/books	
		2. *MODERATELY IMPAIRED*—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*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self)	a.
		Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes	b.
		NONE OF ABOVE	c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

| 1. | INDICATORS OF DEPRES-SION, ANXIETY, SAD MOOD | (*Code for indicators observed in last 30 days, irrespective of the assumed cause*) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week) |

VERBAL EXPRESSIONS OF DISTRESS

a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"

b. Repetitive questions—e.g., "*Where do I go; What do I do?*"

c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")

d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received

e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"

f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others

g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack

h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions

i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues

SLEEP-CYCLE ISSUES

j. Unpleasant mood in morning

k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE

l. Sad, pained, worried facial expressions—e.g., furrowed brows

m. Crying, tearfulness

n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST

o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends

p. Reduced social interaction

| 2. | MOOD PERSIS-TENCE | **One or more indicators** of depressed, sad or anxious mood **were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days** 0. No mood indicators   1. Indicators present, easily altered   2. Indicators present, not easily altered |

| 3. | CHANGE IN MOOD | Resident's mood status has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change   1. Improved   2. Deteriorated |

| 4. | BEHAVIORAL SYMPTOMS | **(A)** *Behavioral symptom frequency in last 7 days* 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily |

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

		(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)			
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)			
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, 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 eating)			

| 5. | CHANGE IN BEHAVIORAL SYMPTOMS | Resident's behavior status has changed as compared to **status of 90 days ago** (or since last assessment if less than 90 days) 0. No change   1. Improved   2. Deteriorated |

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVE-MENT	At ease interacting with others	a.
		At ease doing planned or structured activities	b.
		At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED RELATION-SHIPS	Covert/open conflict with or repeated criticism of staff	a.
		Unhappy with roommate	b.
		Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family/friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b.
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	c.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

| 1. | **(A)** ADL SELF-PERFORMANCE—(*Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup*) |

0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days

1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days

2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days

3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
—Weight-bearing support
— Full staff performance during part (but not all) of last 7 days

4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days

8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—(*Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days*; *code regardless* of resident's self-performance classification)
0. No setup or 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 entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMO-TION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMO-TION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of **street clothing**, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

2.	BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) ***Code for most dependent*** in self-performance and support. **(A)** BATHING SELF-PERFORMANCE codes appear below	(A)	(B)
		0. Independent—No help provided		
		1. Supervision—Oversight help only		
		2. Physical help limited to transfer only		
		3. Physical help in part of bathing activity		
		4. Total dependence		
		8. Activity itself did not occur during entire 7 days *(Bathing support codes are as defined in **Item 1, code B above**)*		

3.	TEST FOR BALANCE (see training manual)	(Code for ability during test in the *last 7 days*) 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help	
		a. Balance while standing	
		b. Balance while sitting—position, trunk control	

4.	FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)	(Code for limitations during **last 7 days** that interfered with daily functions or placed resident at risk of injury) **(A)** *RANGE OF MOTION* **(B)** *VOLUNTARY MOVEMENT* 0. No limitation 0. No loss 1. Limitation on one side 1. Partial loss 2. Limitation on both sides 2. Full loss	(A)	(B)
		a. Neck		
		b. Arm—Including shoulder or elbow		
		c. Hand—Including wrist or fingers		
		d. Leg—Including hip or knee		
		e. Foot—Including ankle or toes		
		f. Other limitation or loss		

5.	MODES OF LOCOMOTION	(***Check all that apply*** during last 7 days)		
		Cane/walker/crutch	a.	Wheelchair primary mode of locomotion	d.
		Wheeled self	b.		
		Other person wheeled	c.	NONE OF ABOVE	e.

6.	MODES OF TRANSFER	(***Check all that apply*** during last 7 days)		
		Bedfast all or most of time	a.	Lifted mechanically	d.
		Bed rails used for bed mobility or transfer	b.	Transfer aid (e.g., slide board, trapeze, cane, walker, brace)	e.
		Lifted manually	c.	NONE OF ABOVE	f.

7.	TASK SEGMENTATION	Some or all of ADL activities were broken into subtasks during **last 7 days** so that resident could perform them 0. No 1. Yes	

8.	ADL FUNCTIONAL REHABILITATION POTENTIAL	Resident believes he/she is capable of increased independence in at least some ADLs	a.
		Direct care staff believe resident is capable of increased independence in at least some ADLs	b.
		Resident able to perform tasks/activity but is very slow	c.
		Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings	d.
		NONE OF ABOVE	e.

9.	CHANGE IN ADL FUNCTION	Resident's ADL self-performance status has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	

SECTION H. CONTINENCE IN LAST 14 DAYS

1.	CONTINENCE SELF-CONTROL CATEGORIES (***Code for resident's PERFORMANCE OVER ALL SHIFTS***)
	0. *CONTINENT*—Complete control *[includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]*
	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 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	

2.	BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days	a.	Diarrhea	c.
				Fecal impaction	d.
		Constipation	b.	NONE OF ABOVE	e.

3.	APPLIANCES AND PROGRAMS	Any scheduled toileting plan	a.	Did not use toilet room/commode/urinal	f.
		Bladder retraining program	b.	Pads/briefs used	g.
		External (condom) catheter	c.	Enemas/irrigation	h.
		Indwelling catheter	d.	Ostomy present	i.
		Intermittent catheter	e.	NONE OF ABOVE	j.

4.	CHANGE IN URINARY CONTINENCE	Resident's urinary continence has changed as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	

SECTION I. DISEASE DIAGNOSES

Check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses.)

1.	DISEASES	(*If none apply, CHECK the NONE OF ABOVE box*)		
		ENDOCRINE/METABOLIC/NUTRITIONAL	Hemiplegia/Hemiparesis	v.
			Multiple sclerosis	w.
		Diabetes mellitus	a.	Paraplegia	x.
		Hyperthyroidism	b.	Parkinson's disease	y.
		Hypothyroidism	c.	Quadriplegia	z.
		HEART/CIRCULATION	Seizure disorder	aa.
		Arteriosclerotic heart disease (ASHD)	d.	Transient ischemic attack (TIA)	bb.
		Cardiac dysrhythmias	e.	Traumatic brain injury	cc.
		Congestive heart failure	f.	**PSYCHIATRIC/MOOD**	
		Deep vein thrombosis	g.	Anxiety disorder	dd.
		Hypertension	h.	Depression	ee.
		Hypotension	i.	Manic depression (bipolar disease)	ff.
		Peripheral vascular disease	j.	Schizophrenia	gg.
		Other cardiovascular disease	k.	**PULMONARY**	
		MUSCULOSKELETAL	Asthma	hh.
		Arthritis	l.	Emphysema/COPD	ii.
		Hip fracture	m.	**SENSORY**	
		Missing limb (e.g., amputation)	n.	Cataracts	jj.
		Osteoporosis	o.	Diabetic retinopathy	kk.
		Pathological bone fracture	p.	Glaucoma	ll.
		NEUROLOGICAL	Macular degeneration	mm.
		Alzheimer's disease	q.	**OTHER**	
		Aphasia	r.	Allergies	nn.
		Cerebral palsy	s.	Anemia	oo.
		Cerebrovascular accident (stroke)	t.	Cancer	pp.
				Renal failure	qq.
		Dementia other than Alzheimer's disease	u.	NONE OF ABOVE	rr.

2.	INFECTIONS	(*If none apply, CHECK the NONE OF ABOVE box*)		
		Antibiotic resistant infection (e.g., Methicillin resistant staph)	a.	Septicemia	g.
				Sexually transmitted diseases	h.
		Clostridium difficile (c. diff.)	b.	Tuberculosis	i.
		Conjunctivitis	c.	Urinary tract infection **in last 30 days**	j.
		HIV infection	d.	Viral hepatitis	k.
		Pneumonia	e.	Wound infection	l.
		Respiratory infection	f.	NONE OF ABOVE	m.

3.	OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES	a. _____	| | | • |
		b. _____	| | | • |
		c. _____	| | | • |
		d. _____	| | | • |
		e. _____	| | | • |

SECTION J. HEALTH CONDITIONS

1.	PROBLEM CONDITIONS	(***Check all problems present*** in last 7 days unless other time frame is indicated)		
		INDICATORS OF FLUID STATUS	Dizziness/Vertigo	f.
			Edema	g.
		Weight gain or loss of 3 or more pounds within a 7 day period	a.	Fever	h.
				Hallucinations	i.
				Internal bleeding	j.
		Inability to lie flat due to shortness of breath	b.	Recurrent lung aspirations in **last 90 days**	k.
		Dehydrated; output exceeds input	c.	Shortness of breath	l.
				Syncope (fainting)	m.
		Insufficient fluid; did **NOT** consume all/almost all liquids provided during **last 3 days**	d.	Unsteady gait	n.
				Vomiting	o.
		OTHER	NONE OF ABOVE	p.
		Delusions	e.		

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SECTION M. SKIN CONDITION

			Number at Stage
1.	ULCERS (Due to any cause)	(Record the number of ulcers at each ulcer stage—regardless of cause. If none present at a stage, record "0" (zero). Code all that apply during **last 7 days**. Code 9 = 9 or more.) **[Requires full body exam.]**	
		a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.	
		b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.	
		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.	
		d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.	
2.	TYPE OF ULCER	(For each type of ulcer, **code for the highest stage in the last 7 days** using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)	
		a. Pressure ulcer—any lesion caused by pressure resulting in damage of underlying tissue	
		b. Stasis ulcer—open lesion caused by poor circulation in the lower extremities	
3.	HISTORY OF RESOLVED ULCERS	Resident had an ulcer that was resolved or cured **in LAST 90 DAYS** 0. No 1. Yes	
4.	OTHER SKIN PROBLEMS OR LESIONS PRESENT	(**Check all that apply** during **last 7 days**)	
		Abrasions, bruises	a.
		Burns (second or third degree)	b.
		Open lesions other than ulcers, rashes, cuts (e.g., cancer lesions)	c.
		Rashes—e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster	d.
		Skin desensitized to pain or pressure	e.
		Skin tears or cuts (other than surgery)	f.
		Surgical wounds	g.
		NONE OF ABOVE	h.
5.	SKIN TREAT-MENTS	(**Check all that apply** during **last 7 days**)	
		Pressure relieving device(s) for chair	a.
		Pressure relieving device(s) for bed	b.
		Turning/repositioning program	c.
		Nutrition or hydration intervention to manage skin problems	d.
		Ulcer care	e.
		Surgical wound care	f.
		Application of dressings (with or without topical medications) other than to feet	g.
		Application of ointments/medications (other than to feet)	h.
		Other preventative or protective skin care (other than to feet)	i.
		NONE OF ABOVE	j.
6.	FOOT PROBLEMS AND CARE	(**Check all that apply** during **last 7 days**)	
		Resident has one or more foot problems—e.g., corns, callouses, bunions, hammer toes, overlapping toes, pain, structural problems	a.
		Infection of the foot—e.g., cellulitis, purulent drainage	b.
		Open lesions on the foot	c.
		Nails/calluses trimmed during **last 90 days**	d.
		Received preventative or protective foot care (e.g., used special shoes, inserts, pads, toe separators)	e.
		Application of dressings (with or without topical medications)	f.
		NONE OF ABOVE	g.

2.	PAIN SYMPTOMS	(Code the **highest level of pain** present in the **last 7 days**)	
		a. FREQUENCY with which resident complains or shows evidence of pain 0. No pain (**skip to J4**) 1. Pain less than daily 2. Pain daily	**b. INTENSITY** of pain 1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating

3.	PAIN SITE	(If pain present, **check all sites** that apply in **last 7 days**)			
		Back pain		Incisional pain	f.
		Bone pain	a.	Joint pain (other than hip)	g.
		Chest pain while doing usual activities	b.	Soft tissue pain (e.g., lesion, muscle)	h.
		Headache	c.	Stomach pain	i.
		Hip pain	d.	Other	j.
			e.		

4.	ACCIDENTS	(**Check all that apply**)			
		Fell in **past 30 days**		Hip fracture in **last 180 days**	c.
		Fell in **past 31-180 days**	a.	Other fracture in **last 180 days**	d.
			b.	NONE OF ABOVE	e.

5.	STABILITY OF CONDITIONS		
		Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating)	a.
		Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem	b.
		End-stage disease, 6 or fewer months to live	c.
		NONE OF ABOVE	d.

SECTION K. ORAL/NUTRITIONAL STATUS

1.	ORAL PROBLEMS		
		Chewing problem	a.
		Swallowing problem	b.
		Mouth pain	c.
		NONE OF ABOVE	d.

2.	HEIGHT AND WEIGHT	Record (**a.**) height in inches and (**b.**) weight in pounds. Base weight on most recent measure in **last 30 days**; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes **a.** HT (in.) **b.** WT (lb.)

3.	WEIGHT CHANGE		
		a. Weight loss—5 % or more in **last 30 days**; or 10 % or more in **last 180 days** 0. No 1. Yes	
		b. Weight gain—5 % or more in **last 30 days**; or 10 % or more in **last 180 days** 0. No 1. Yes	

4.	NUTRI-TIONAL PROBLEMS				
		Complains about the taste of many foods	a.	Leaves 25% or more of food uneaten at most meals	c.
		Regular or repetitive complaints of hunger	b.	NONE OF ABOVE	d.

5.	NUTRI-TIONAL APPROACH-ES	(**Check all that apply** in **last 7 days**)			
		Parenteral/IV	a.	Dietary supplement between meals	f.
		Feeding tube	b.		
		Mechanically altered diet	c.	Plate guard, stabilized built-up utensil, etc.	g.
		Syringe (oral feeding)	d.	On a planned weight change program	h.
		Therapeutic diet	e.	NONE OF ABOVE	i.

6.	PARENTERAL OR ENTERAL INTAKE	(**Skip to Section L if neither 5a nor 5b is checked**)
		a. Code the proportion of **total calories** the resident received through parenteral or tube feedings in the **last 7 days** 0. None 3. 51% to 75% 1. 1% to 25% 4. 76% to 100% 2. 26% to 50%
		b. Code the average **fluid intake** per day by IV or tube in **last 7 days** 0. None 3. 1001 to 1500 cc/day 1. 1 to 500 cc/day 4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day 5. 2001 or more cc/day

SECTION L. ORAL/DENTAL STATUS

1.	ORAL STATUS AND DISEASE PREVENTION		
		Debris (soft, easily movable substances) present in mouth prior to going to bed at night	a.
		Has dentures or removable bridge	b.
		Some/all natural teeth lost—does not have or does not use dentures (or partial plates)	c.
		Broken, loose, or carious teeth	d.
		Inflamed gums (gingiva); swollen or bleeding gums; oral abcesses; ulcers or rashes	e.
		Daily cleaning of teeth/dentures or daily mouth care—by resident or staff	f.
		NONE OF ABOVE	g.

SECTION N. ACTIVITY PURSUIT PATTERNS

1.	TIME AWAKE	(**Check appropriate time periods over last 7 days**) Resident awake all or most of time (i.e., naps no more than one hour per time period) in the:			
		Morning	a.	Evening	c.
		Afternoon	b.	NONE OF ABOVE	d.

(If resident is comatose, skip to Section O)

2.	AVERAGE TIME INVOLVED IN ACTIVITIES	(**When awake and not receiving treatments or ADL care**) 0. Most—more than 2/3 of time 2. Little—less than 1/3 of time 1. Some—from 1/3 to 2/3 of time 3. None

3.	PREFERRED ACTIVITY SETTINGS	(**Check all settings** in which activities are **preferred**)			
		Own room	a.		
		Day/activity room	b.	Outside facility	d.
		Inside NH/off unit	c.	NONE OF ABOVE	e.

4.	GENERAL ACTIVITY PREFER-ENCES (adapted to resident's current abilities)	(**Check all PREFERENCES** whether or not activity is currently available to resident)			
		Cards/other games	a.	Trips/shopping	g.
		Crafts/arts	b.	Walking/wheeling outdoors	h.
		Exercise/sports	c.	Watching TV	i.
		Music	d.	Gardening or plants	j.
		Reading/writing	e.	Talking or conversing	k.
		Spiritual/religious activities	f.	Helping others	l.
				NONE OF ABOVE	m.

5.	PREFERS CHANGE IN DAILY ROUTINE	Code for resident preferences in daily routines	
		0. No change 1. Slight change 2. Major change	
		a. Type of activities in which resident is currently involved	
		b. Extent of resident involvement in activities	

SECTION O. MEDICATIONS

1.	NUMBER OF MEDICA-TIONS	(***Record the number of different*** medications used in the ***last 7 days***; enter "0" if none used)	
2.	NEW MEDICA-TIONS	(Resident currently receiving medications that were initiated during the **last 90 days**) 0. No 1. Yes	
3.	INJECTIONS	(***Record the number of DAYS*** injections of any type received during the **last 7 days**; enter "0" if none used)	
4.	DAYS RECEIVED THE FOLLOWING MEDICATION	(***Record the number of DAYS*** during **last 7 days**; enter "0" if not used. Note—enter "1" for long-acting meds used less than weekly)	

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

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

| 1. | SPECIAL TREAT-MENTS, PROCE-DURES, AND PROGRAMS | **a.** SPECIAL CARE—***Check*** treatments or programs received during the ***last 14 days*** | |

TREATMENTS				
		Ventilator or respirator	l.	
Chemotherapy	a.	**PROGRAMS**		
Dialysis	b.	Alcohol/drug treatment program	m.	
IV medication	c.	Alzheimer's/dementia special care unit	n.	
Intake/output	d.			
Monitoring acute medical condition	e.	Hospice care	o.	
Ostomy care	f.	Pediatric unit	p.	
Oxygen therapy	g.	Respite care	q.	
Radiation	h.	Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)	r.	
Suctioning	i.			
Tracheostomy care	j.			
Transfusions	k.	*NONE OF ABOVE*	s.	

b. THERAPIES - *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily)*
[Note—count only post admission therapies]
(A) = # of days administered for **15 minutes or more**
(B) = total # of minutes provided in last 7 days

	DAYS (A)	MIN (B)
a. Speech - language pathology and audiology services		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		
e. Psychological therapy (by any licensed mental health professional)		

| 2. | INTERVEN-TION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS | (***Check all interventions or strategies used in last 7 days***—no matter where received) | |

Special behavior symptom evaluation program	a.
Evaluation by a licensed mental health specialist in **last 90 days**	b.
Group therapy	c.
Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage	d.
Reorientation—e.g., cueing	e.
NONE OF ABOVE	f.

| 3. | NURSING REHABILITA-TION/RESTOR-ATIVE CARE | *Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was **provided to the resident for more than or equal to 15 minutes per day in the last 7 days** (Enter 0 if none or less than 15 min. daily.)* |

a. Range of motion (passive)		**f.** Walking	
b. Range of motion (active)		**g.** Dressing or grooming	
c. Splint or brace assistance		**h.** Eating or swallowing	
TRAINING AND SKILL PRACTICE IN:		**i.** Amputation/prosthesis care	
d. Bed mobility		**j.** Communication	
e. Transfer		**k.** Other	

| 4. | DEVICES AND RESTRAINTS | (*Use the following codes for last 7 days:*) 0. Not used 1. Used less than daily 2. Used daily | |

Bed rails		
a. — Full bed rails on all open sides of bed		
b. — Other types of side rails used (e.g., half rail, one side)		
c. Trunk restraint		
d. Limb restraint		
e. Chair prevents rising		

5.	HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no hospital admissions*)	
6.	EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay **in last 90 days** (or since last assessment if less than 90 days). (*Enter 0 if no ER visits*)	
7.	PHYSICIAN VISITS	In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (*Enter 0 if none*)	
8.	PHYSICIAN ORDERS	In the **LAST 14 DAYS** (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? *Do not include order renewals without change.* (*Enter 0 if none*)	
9.	ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the **last 90 days** (or since admission)? 0. No 1. Yes	

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

1.	DISCHARGE POTENTIAL	**a.** Resident expresses/indicates preference to return to the community 0. No 1. Yes	
		b. Resident has a support person who is positive towards discharge 0. No 1. Yes	
		c. Stay projected to be of a short duration— discharge projected **within 90 days** (do not include expected discharge due to death) 0. No 2. Within 31-90 days 1. Within 30 days 3. Discharge status uncertain	
2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall self sufficiency has changed significantly as compared to status of **90 days ago** (or since last assessment if less than 90 days) 0. No change 1. Improved—receives fewer supports, needs less restrictive level of care 2. Deteriorated—receives more support	

SECTION R. ASSESSMENT INFORMATION

1.	PARTICIPA-TION IN ASSESS-MENT	a. Resident: 0. No 1. Yes	
		b. Family: 0. No 1. Yes 2. No family	
		c. Significant other: 0. No 1. Yes 2. None	

2. SIGNATURE OF PERSON COORDINATING THE ASSESSMENT:

a. Signature of RN Assessment Coordinator (sign on above line)

b. Date RN Assessment Coordinator signed as complete

	Month		Day		Year	

SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

1.	SPECIAL TREAT-MENTS AND PROCE-DURES	**a. RECREATION THERAPY**—*Enter number of days and total minutes of recreation therapy administered (**for at least 15 minutes a day**) in the last 7 days* (*Enter 0 if none*)		

			DAYS	MIN
			(A)	(B)
		(A) = # **of days** administered for 15 minutes or more (B) = **total # of minutes** provided in last 7 days		

Skip unless this is a Medicare 5 day or Medicare readmission/ return assessment.

b. ORDERED THERAPIES—*Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service*?
0. No   1. Yes

If not ordered, skip to item 2

c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.

d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?

2.	WALKING WHEN MOST SELF SUFFICIENT

Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0,1,2, or 3 AND at least one of the following are present:
- Resident received physical therapy involving gait training (P.1.b.c)
- Physical therapy was ordered for the resident involving gait training (T.1.b)
- Resident received nursing rehabilitation for walking (P.3.f)
- Physical therapy involving walking has been discontinued within the past 180 days

Skip to item 3 if resident did not walk in last 7 days

(*FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.*)

a. Furthest distance walked without sitting down during this episode.

0. 150+ feet	3. 10-25 feet
1. 51-149 feet	4. Less than 10 feet
2. 26-50 feet	

b. Time walked without sitting down during this episode.

0. 1-2 minutes	3. 11-15 minutes
1. 3-4 minutes	4. 16-30 minutes
2. 5-10 minutes	5. 31+ minutes

c. Self-Performance in walking during this episode.

0. *INDEPENDENT*—No help or oversight
1. *SUPERVISION*—Oversight, encouragement or cueing provided
2. *LIMITED ASSISTANCE*—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance
3. *EXTENSIVE ASSISTANCE*—Resident received weight bearing assistance while walking

d. Walking support provided associated with this episode (code regardless of resident's self-performance classification).

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist

e. Parallel bars used by resident in association with this episode.

0. No   1. Yes

3.	CASE MIX GROUP	Medicare					State				

MINIMUM DATA SET (MDS) - *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

SECTION W. SUPPLEMENTAL MDS ITEMS

1.	**National Provider ID**	Enter for all assessments and tracking forms, if available.	
		If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.	

2.	**Influenza Vaccine**	a . Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)?
		
		    0. No (If No, go to item W2b)
		    1. Yes (If Yes, go to item W3)
		
		b. If Influenza vaccine not received, state reason:
		    1. Not in facility during this year's flu season
		    2. Received outside of this facility
		    3. Not eligible
		    4. Offered and declined
		    5. Not offered
		    6. Inability to obtain vaccine	

3.	**Pneumo-coccal Vaccine**	a. Is the resident's PPV status up to date?
		    0. No (If No, go to item W3b)
		    1. Yes (If Yes, skip item W3b)
		
		b. If PPV not received, state reason:
		    1. Not eligible
		    2. Offered and declined
		    3. Not offered	

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

Resident's Name:	Medical Record No.:

1. Check if RAP is triggered.

2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.

   • Describe:
   — Nature of the condition (may include presence or lack of objective data and subjective complaints).
   — Complications and risk factors that affect your decision to proceed to care planning.
   — Factors that must be considered in developing individualized care plan interventions.
   — Need for referrals/further evaluation by appropriate health professionals.

   • Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.

   • Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).

3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.

4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

A. RAP PROBLEM AREA	(a) Check if triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision—check if addressed in care plan
1. DELIRIUM	☐		☐
2. COGNITIVE LOSS	☐		☐
3. VISUAL FUNCTION	☐		☐
4. COMMUNICATION	☐		☐
5. ADL FUNCTIONAL/ REHABILITATION POTENTIAL	☐		☐
6. URINARY INCONTINENCE AND INDWELLING CATHETER	☐		☐
7. PSYCHOSOCIAL WELL-BEING	☐		☐
8. MOOD STATE	☐		☐
9. BEHAVIORAL SYMPTOMS	☐		☐
10. ACTIVITIES	☐		☐
11. FALLS	☐		☐
12. NUTRITIONAL STATUS	☐		☐
13. FEEDING TUBES	☐		☐
14. DEHYDRATION/FLUID MAINTENANCE	☐		☐
15. DENTAL CARE	☐		☐
16. PRESSURE ULCERS	☐		☐
17. PSYCHOTROPIC DRUG USE	☐		☐
18. PHYSICAL RESTRAINTS	☐		☐

B.

1. Signature of RN Coordinator for RAP Assessment Process

2. ☐☐ — ☐☐ — ☐☐☐☐   Month   Day   Year

3. Signature of Person Completing Care Planning Decision

4. ☐☐ — ☐☐ — ☐☐☐☐   Month   Day   Year

MDS 2.0 September, 2000

HAIs in NICUs

NHSN Findings

From the NHSN Update on Antimicrobial Resistance, 2006-2007:
- NICUs represent 12.2% of reporting locations
- NICUs represent 20.5% of reported CLABSIs
- Other tabulated data do not provide results for NICUs

From the 2006 NHSN report:
- CLABSI rate for <750 g. (6.4 per 1000 central line days) is higher than any other location except Burn ICUs (6.8 per 1000 central line days)
- CLABSI rate for > 2500 g. (3.1 per 1000 central line days) is similar to the CLABSI rate for medical ICUs (2.9 per 1000 central line days)

Table 5. Pooled means and key percentiles of the distribution of central line-associated BSI rates and central line utilization ratios for level III NICUs, DA module, 2006

Birth-weight category	No. of units	No. of CLAB	Central line-days	Pooled mean	Percentile				
					10%	25%	50% (median)	75%	90%
Central line-associated BSI rate*									
≤750 g	42	118	18,458	6.4	0.0	2.5	5.2	11.0	15.6
751-1000 g	44	83	18,781	4.4	0.0	0.0	3.8	8.7	10.2
1001-1500 g	42	87	17,968	4.8	0.0	0.0	3.6	7.5	14.0
1501-2500 g	36	68	16,208	4.2	0.0	0.0	0.0	4.1	8.5
>2500 g	32	50	16,131	3.1	0.0	0.0	0.0	1.9	5.3

Summaries of Literature Abstracts

Am J Infect Control. 2005 Jun;33(5):268-75.
- Review
- Highest NICU HAI rates reported in facilities treating the largest proportion of neonates with birth weights less than 1000 grams

Infect Control Hosp Epidemiol. 2006 Jun;27(6):581-5. Epub 2006 May 25.
- MRSA outbreak caused by a NICU healthcare worker who was colonized

J Perinatol. 2006 Mar;26(3):176-9.
- Evaluated effectiveness of a NICU infection control program
- Included implementing a nursing team for central venous catheter care
- Reduction in HAIs sustained for three years post-intervention

Am J Infect Control. 2008 Aug;36(6):430-5.
- Evaluated a hand hygiene intervention in an Italian NICU
- Substantially reduced central venous catheter colonization
- Estimated to prevent ten infections per year

A Second Look at the Vermont Oxford Network

VLBW Database
Eligibility
- Birth weight 401-1500 grams
- Gestational age 22 weeks 0 days to 29 weeks 6 days
- Follow up until discharged home, age one year, or expired
- Submit data electronically or submit paper forms

Expanded Database
Eligibility
- All infants eligible for VLBW Database
- Birth weight over 1500 grams and admitted to NICU by age 28 days
- Birth weight over 1500 grams and expires by age 28 days without ever discharging home
- Follow up until discharged home, age one year, or expired
- Submit data electronically

Requirements
- Membership application
- Membership agreement
- Fee ($4000 for 2008)

Reports
- Quarterly reports
- Annual NICU quality management report
- Annual network database summary for public distribution
- Access to web-based reporting system to produce customized tabular and graphical output

Considerations
- No new reporting burdens
- Membership fee is not trivial
- Very limited potential for HAI reporting
  - Item 35: Sepsis and/or meningitis late (after age 3 days), prior to discharge or transfer
    - Item 35a: cultured bacterial pathogen is listed in an appendix (yes/no/not applicable)
    - Item 35b: cultured pathogen is coagulase negative staph AND infant has symptoms of infection AND infant is treated with IV antibiotics (yes/no/not applicable)
    - Item 35c: cultured fungal pathogen (yes/no/not applicable)

Facility	ZIP	City	cath	uti	flu long	pna long	flu short	pna short
_Oregon			0.08	0.11	0.81	0.79	0.64	0.72
_US			0.06	0.09	0.88	0.87	0.77	0.79
Avamere at Three Fountains	97504	Medford	0.08	0.08	0.87	0.8	0.87	0.95
Avamere Court at Keizer	97303	Keizer	0.04	0.11	0.87	0.92	0.97	0.82
Avamere Crestview of Portland	97201	Portland	0.1	0.17	0.88	0.61	0.91	0.81
Avamere Heart of the Valley Rehab	97330	Corvallis	0.09	0.1	0.77	0.83	0.58	0.79
Avamere Rehab of Beaverton	97008	Beaverton	0.06	0.1	0.7	0.86	0.48	0.81
Avamere Rehab of Clackamas	97027	Gladstone	.s	.s	0.73	0.72	0.82	0.85
Avamere Rehab of Coos Bay	97420	Coos Bay	0.13	0.25	0.8	0.79	0.58	0.66
Avamere Rehab of Eugene	97405	Eugene	0.06	0.11	0.67	0.79	0.74	0.86
Avamere Rehab of Hillsboro	97123	Hillsboro	0.19	0.09	0.72	0.91	0.71	0.93
Avamere Rehab of Junction City	97448	Junction City	0.12	0.06	0.87	0.94	0.94	0.88
Avamere Rehab of King City	97224	Tigard	0.04	0.17	0.88	0.99	0.99	0.92
Avamere Rehab of Lebanon	97355	Lebanon	0.02	0.07	0.94	0.94	0.87	0.97
Avamere Rehab of Newport	97365	Newport	0.05	0.13	0.62	0.98	0.47	0.98
Avamere Rehab of Oregon City	97045	Oregon City	.m	.m	0.89	.m	1	0.86
Avamere Rehab of Salem	97302	Salem	0.13	0.15	0.78	0.75	0.42	0.8
Avamere Riverpark of Eugene	97401	Eugene	0.2	0.21	0.91	0.93	0.88	0.95
Avamere Twin Oaks of Sweet Home	97386	Sweet Home	.s	.s	0.95	0.95	0.92	0.79
Baycrest Health Center	97459	North Bend	.s	.s	0.89	0.98	0.86	0.89
Blue Mountain Nursing Home	97869	Prairie City	.s	.s	1	1	.m	.m
Camelot Care Center	97116	Forest Grove	0.09	0.1	0.92	0.94	.s	0.74
Care Center East Hlth	97220	Portland	0.07	0.11	0.37	0.62	0.35	0.63
Cascade Terrace	97236	Portland	0.07	0.04	0.65	0.64	0.79	0.59
Cascade View Nursing Home	97702	Bend	0.2	0.06	0.97	0.7	.m	.m
Chehalem Health and Rehab	97132	Newberg	0.03	0.02	0.81	0.81	0.87	0.83
Clatsop Care Center	97103	Astoria	0.06	0.13	0.93	0.96	0.74	0.93
Coast Fork Nursing Center	97424	Cottage Grove	0.08	0.1	0.85	0.66	0.7	0.45
Columbia Basin Care Facility	97058	The Dalles	0.11	0.13	0.95	0.94	0.88	0.93
Columbia Care Center	97056	Scappoose	.s	.s	.s	.s	.s	.s
Cornerstone Care Option	97236	Portland	0	0.03	1	1	.m	.m
Corvallis Manor	97330	Corvallis	0.07	0.06	0.57	0.55	0.34	0.43
Creswell Care Center	97426	Creswell	0.08	0.05	0.89	0.85	0.86	0.8
Dallas Retirement Village Care Center	97338	Dallas	0.05	0.05	0.86	0.94	0.83	0.95
Evergreen Health and Rehab Center	97850	La Grande	.s	0.19	0.77	0.9	0.7	0.77
Evergreen Hillsboro Hlth	97124	Hillsboro	0.09	0.07	0.75	0.81	0.75	0.89
Evergreen Independence Health and Rehab	97351	Independence	0.04	0.05	0.92	0.93	.s	0.93
Evergreen Milton Freewater	97862	Milton Freewater	0.06	0.09	0.93	0.95	0.63	0.9
Evergreen Portland H&R Center	97233	Portland	0.17	0.04	0.53	0.22	0.09	0.55
Evergreen The Dalles Health	97058	The Dalles	.s	.s	0.91	0.8	.s	0.8
Evergreen Vista Health Center	97850	La Grande	0	0.19	0.88	0.75	.s	.s
Evergreen Windsor Health & Rehab Center	97301	Salem	0.03	0.08	0.48	0.22	0.45	0.45
Fairview Transitional Health Center	97526	Grants Pass	0.11	0.14	0.83	0.86	0.69	0.73
Fernhill Estates	97211	Portland	.s	0.07	0.63	0.88	.s	.s
French Prairie Nursing and Rehab Center	97071	Woodburn	0.07	0.13	0.69	0.72	0.42	0.61
Friendship Health Center	97202	Portland	.s	.s	0.25	0.11	0.29	0.12
Gateway Care and Retirement	97220	Portland	0.08	0.09	1	0.64	0.93	0.57
Glisan Care Center	97220	Portland	0.08	0.12	0.54	0.22	0.51	0.18
Good Samaritan Society - Curry Village	97415	Brookings	0.11	0.09	0.92	0.41	0.6	0.22
Good Samaritan Society - Eugene Village	97405	Eugene	.s	.s	0.47	0.35	0.1	0.29
Good Samaritan Society - Fairlawn Village	97030	Gresham	0.17	0.2	0.83	0.96	0.87	0.96
Gracelen Terrace NF	97266	Portland	0.07	0.14	0.91	0.82	.m	.m
Green Valley Rehab Health Center	97401	Eugene	0.08	0.1	0.52	0.67	0.3	0.5
Gresham Rehab and Specialty Care	97030	Gresham	0.08	0.12	0.87	0.78	0.66	0.77
Harbor Care Reedwood	97202	Portland	0.05	0.06	0.98	0.96	.s	.s
Harmony House Nursing Home	97701	Bend	.s	.s	0.95	1	0.66	0.97
Healthcare at Foster Creek	97236	Portland	0	0.13	0.86	0.29	.m	.m
Hearthstone Manor	97504	Medford	0.03	0.1	0.87	0.97	0.84	1
Highland House	97526	Grants Pass	0.1	0.14	0.95	0.96	0.86	0.97
Hillside Heights Rehab Ctr	97405	Eugene	0.02	0.08	0.66	0.7	0.07	0.46
Holliday Park Plaza	97232	Portland	.s	.s	0.82	0.98	0.38	1
Hood River Care Center	97031	Hood River	0.03	0.06	0.67	0.6	0.03	0.3

Name	Zip	City						
Lake District Long Term Care	97630	Lakeview	.s	.s	0.97	.s	.s	.s
Laurel Hill and Rehab Center	97526	Grants Pass	0	0.15	0.84	0.7	.s	0.27
Laurelhurst Village	97214	Portland	0.15	0.1	0.7	0.75	0.67	0.85
Lawrence Convalscent Ctr	97215	Portland	0.07	0.05	0.98	1	.m	.m
Life Care Center of Coos Bay	97420	Coos Bay	0.1	0.08	0.91	0.82	0.87	0.87
Life Care Center of McMinnville	97128	McMinnville	0.06	0.22	0.93	0.95	0.77	0.88
Lincoln City Rehab Center	97367	Lincoln City	.s	0.13	0.69	0.63	0.39	0.32
Linda Vista Nursing & Rehab Center	97520	Ashland	0.19	0.09	0.89	0.76	0.61	0.82
Lower Umpqua Hospital	97467	Reedsport	.s	.s	.s	0.92	.s	.s
Marian Estates	97385	Sublimity	0.04	0.18	0.85	0.88	0.81	0.73
Marquis Care at Autumn Hills	97225	Portland	0	0.03	0.95	0.93	.m	.m
Marquis Care at Centennial	97233	Portland	0.02	0.11	0.83	0.93	0.93	1
Marquis Care at Forest Grove	97116	Forest Grove	0.04	0.1	0.83	0.78	0.71	0.71
Marquis Care at Hope Village	97013	Canby	.s	0.19	0.52	0.84	0.36	0.85
Marquis Care at Mt Tabor	97215	Portland	0.06	0.11	0.81	0.89	0.78	0.93
Marquis Care at Oregon City	97045	Oregon City	0.02	0.1	0.99	0.78	0.81	0.66
Marquis Care at Piedmont	97211	Portland	0.06	0.1	0.64	0.65	0.49	0.7
Marquis Care at Plum Ridge	97601	Klamath Falls	0.11	0.11	0.74	0.86	0.61	0.8
Marquis Care at Powellhurst	97236	Portland	0.26	0.1	0.81	1	.s	.s
Marquis Care at Silver Gardens	97381	Silverton	.s	.s	0.97	0.66	.s	0.55
Marquis Care at Springfield	97477	Springfield	0.1	0.17	0.99	0.94	0.94	0.94
Marquis Care at Vermont Hills	97221	Portland	0.02	0.06	0.9	0.91	1	0.94
Marquis Care at Wilsonville	97070	Wilsonville	.s	.s	0.39	0.51	0.16	0.44
Mary's Woods at Marylhurst	97034	Lake Oswego	.s	.s	.s	.s	0.81	0.82
Maryville Nursing Home	97007	Beaverton	0.06	0.04	0.93	0.84	0.93	0.83
Meadow Park Health and Specialty	97051	Saint Helens	0.03	0.13	0.52	0.74	0.2	0.27
Medford Rehab and Healthcare	97504	Medford	0.03	0.14	0.74	0.31	0.71	0.52
Menlo Park Health Care	97230	Portland	0.04	0.05	0.82	0.97	0.82	0.97
Mennonite Home	97321	Albany	0.04	0.12	0.87	0.66	0.84	0.28
Milwaukie Convalescent Ctr	97222	Milwaukie	0.08	0.1	0.81	0.64	0.56	0.65
Molalla Manor Care Center	97038	Molalla	0.2	0.18	0.91	0.78	0.85	0.86
Mountain View Living Center	97741	Madras	.s	.s	.s	.s	0.79	.s
Myrtle Point Care Center	97458	Myrtle Point	.s	.s	.s	.s	.s	.s
Nehalem Valley Care Center	97147	Wheeler	0.05	0.08	0.81	0.96	0.58	0.81
Newberg Care Home	97132	Newberg	0.08	0.1	1	0.92	0.95	0.93
Oakwood Country Place	97128	McMinnville	.s	0.17	0.85	0.89	0.77	0.93
Ochoco Health Care Center	97754	Prineville	0.03	0.17	0.92	0.95	.s	.s
Oregon City Health Care Center	97045	Oregon City	.s	.s	0.63	0.75	.s	0.76
Oregon Veterans Home	97058	The Dalles	0.08	0.07	0.95	0.93	0.88	0.94
Pacific Health and Rehab	97224	Tigard	0.19	0.05	0.76	0.65	0.43	0.52
Park Forest Care Center	97220	Portland	0.03	0.06	0.65	0.57	.s	.s
Pearl at Kruse Way, The	97035	Lake Oswego	.m	.m	.s	.m	0.62	0.79
Pilot Butte Rehab Center	97701	Bend	.s	.s	.m	0.97	0.21	0.71
Pioneer Nursing Home	97918	Vale	.s	.s	.m	0.78	.m	.m
Porthaven Healthcare Center	97218	Portland	0.07	0.15	0.96	0.94	0.8	0.88
Presbyterian Community Care Ctr	97914	Ontario	0	0	0.98	1	0.88	0.99
Providence Benedictine NC	97362	Mt Angel	0.08	0.2	0.96	0.95	0.9	0.96
Providence Child Center	97213	Portland	0	0.02	0.99	1	.m	.m
Providence Seaside Hospital	97138	Seaside	.s	.s	.s	.s	.s	.s
Redmond Health Care Center	97756	Redmond	.s	.s	0.66	0.65	0.5	0.8
Regency Albany	97321	Albany	0.21	0.1	0.75	0.81	0.7	0.37
Regency Florence	97439	Florence	.s	.s	0.92	0.97	0.87	0.89
Regency Gresham Nursing & Rehab Ctr	97080	Gresham	0.32	0.12	0.91	0.85	0.59	.s
Regency Hermiston Nursing and Rehab Ctr	97838	Hermiston	0.15	0.18	0.83	0.8	0.6	0.52
Robison Jewish Health Center	97221	Portland	0.1	0.14	0.76	0.83	0.69	0.49
Rogue Valley Manor	97504	Medford	0.14	0.09	0.22	0.58	0.47	0.02
Rose City Nursing Home	97232	Portland	.s	.s	.s	.s	.m	.m
Rose Haven Nursing Center	97470	Roseburg	0.03	0.19	0.86	0.78	0.53	0.31
Rose Linn Care Center	97068	West Linn	0.01	0.05	0.99	0.94	.m	.m
Royale Gardens	97526	Grants Pass	0.05	0.1	0.68	0.85	0.62	0.93
Sheridan Care Center	97378	Sheridan	0	0.11	1	0.76	.m	.m
Sherwood Park Nursing and Rehab Ctr	97303	Keizer	0.17	0.07	0.58	0.6	0.55	0.54
South Hills Rehab Ctr	97403	Eugene	0.14	0.1	0.51	0.72	0.22	0.62
St Elizabeth Health Services	97814	Baker City	0.05	0.09	0.93	0.8	.m	.m

Name	ZIP	City	cath	uti	flu long	pna long	flu short	pna short
Sunnyside Care Center	97302	Salem	0.12	0.11	0.63	0.38	0.44	0.5
Tierra Rose Care Center	97301	Salem	0.08	0.07	0.86	0.76	.m	.m
Timberview Care Center	97321	Albany	0.08	0.07	0.8	0.74	0.69	0.44
Town Center Village	97266	Portland	.s	.s	0.97	0.92	0.89	0.92
Trinity Mission Health & Rehab of Portland	97266	Portland	0.04	0.15	0.89	0.95	.s	.s
Umpqua Valley Nursing and Rehab Ctr	97470	Roseburg	0.1	0.15	0.82	0.83	0.11	0.44
Valley West Health Care	97405	Eugene	0.04	0.11	0.8	0.99	.m	0.99
Village at Hillside	97128	McMinnville	.m	.m	.m	.m	0.08	0.98
Village Health Care	97030	Gresham	0.08	0.1	0.93	0.79	0.96	0.84
Village Manor	97060	Troutdale	0	0.06	0.95	0.34	.s	.m
Wallowa Valley Care Center	97828	Enterprise	.s	.s	0.97	0.95	.s	.m
West Hills Health and Rehab Center	97219	Portland	0.03	0.19	0.58	0.68	0.35	0.28
Willamette View Health Center	97222	Milwaukie	.m	.m	.m	.m	.s	.s
Willowbrook Terrace	97801	Pendleton	0.1	0.03	0.61	0.48	0.26	0.25

Definitions

.s = suppressed
.m = missing
cath = pct of pts with a urinary catheter
uti = pct of pts with a UTI
flu long = pct of long-term residents receiving fluvax
pna long = pct of long-term residents receiving pneumovax
flu short = pct of short-term residents receiving fluvax
pna short = pct of short-term residents receiving pneumovax

Source: Centers for Medicare and Medicaid
Services. Nursing Home ComparePage Last
Updated: January 15, 2009