Demographics

Time In: 12:45 **Time Out:** 02:00 **Visit Date:** 04/03/2019

(M0020) Patient ID Number:

(M0030) Start of Care Date: 04/03/2019

(M0032) Resumption of Care Date:
✓ NA - Not Applicable

Episode Start Date: 04/03/2019

(M0040) Patient Name:
(Last) (Suffix) (First)

(M0064) Social Security Number:
✓ UK - Unknown or Not Available

Patient Street Address City

(M0050) Patient State of Residence: CO

(M0060) Patient ZIP Code: 80222

(M0063) Medicare Number: (including suffix)
✓ NA - No Medicare

(M0065) Medicaid Number:
✓ NA - No Medicaid

(M0066) Birth Date: 03/08/1927

(M0069) Gender:
◉ Male ○ Female

Physician
Schnell, Benjamin

Emergency Contact Name

Relationship
wife

Contact Address

Contact Phone

Secondary Physician's Name

Secondary Physician Phone
( ) - -

(M0080) Discipline of Person Completing Assessment:
○ 1 - RN ◉ 2 - PT ○ 3 - SLP/ST ○ 4 - OT

(M0090) Date Assessment Completed: 04/03/2019

(M0100) This Assessment is Currently Being Completed for the Following Reason

Start/Resumption of Care
◉ 1- Start of care - further visits planned
○ 3 - Resumption of care (after inpatient stay)

Follow-Up
○ 4 - Recertification (follow-up) reassessment **[Go to M0110]**
○ 5 - Other follow-up **[Go to M0110]**

Transfer to an Inpatient Facility
○ 6 - Transferred to an inpatient facility - patient not discharged from agency **[Go to M1041]**
○ 7 - Transferred to an inpatient facility - patient discharge from agency **[Go to M1041]**

Discharge from Agency – Not to an Inpatient Facility
○ 8 - Death at home **[Go to M2005]**
○ 9 - Discharged from agency **[Go to M1041]**

(M0102) 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.
[Go to M0110, if date entered]
✓ NA - No specific SOC date ordered by physician
Comments:

(M0104) Date of Referral: Indicate the date that the written or verbal referral for initiation or resumption of care was received by the HHA.
04/02/2019
Comments:

(M0110) 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?
◉ 1 - Early
○ 2 - Later
○ UK - Unknown
○ NA - Not Applicable: No Medicare case mix group to be defined by this assessment

(M0140) Race/Ethnicity: ***(Mark all that apply)***
☐ 1 - American Indian or Alaska Native
☐ 2 - Asian
☐ 3 - Black or African American
☐ 4 - Hispanic or Latino
☐ 5 - Native Hawaiian or Pacific Islander
✓ 6 - White

(M0150) Current Payment Sources for Home Care: ***(Mark all that apply)***
☐ 0 - None - No charge for current services
☐ 1 - Medicare (traditional fee-for-service)
☐ 2 - Medicare (HMO/Managed Care/Advantage plan)
☐ 3 - Medicaid (traditional fee-for-service)
☐ 4 - Medicaid (HMO/Managed Care)
☐ 5 - Worker's compensation
☐ 6 - Title programs (for example, Title III, V, or XX)
✓ 7 - Other government (for example, TriCare, VA)
☐ 8 - Private Insurance
☐ 9 - Private HMO/managed care
☐ 10 - Self-pay
☐ 11 - Other (specify)
☐ UK - Unknown

Patient History and Diagnoses

Vital Signs

Pulse: Apical: ○ (Reg) ○ (Irreg)
Radial: 69 ◉ (Reg) ○ (Irreg)

Temp: Resp:

Height: 74
Weight: 194
○ Actual ◉ Stated

BP	Lying	Sitting	Standing
Left		130/68	
Right			

Notify physician of:

Temperature greater than (>)	101	or less than (<)	96
Pulse greater than (>)	100	or less than (<)	60
Respirations greater than (>)	28	or less than (<)	12
Systolic BP greater than (>)	160	or less than (<)	100
Diastolic BP greater than (>)	100	or less than (<)	60
O2 Sat less than (<)	88 %		
Fasting blood sugar greater than (>)		or less than (<)	
Random blood sugar greater than (>)		or less than (<)	
Weight greater than (>)		lbs or less than (<)	lbs

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

☐ 1 - Long-term nursing facility (NF)
☐ 2 - Skilled nursing facility (SNF / TCU)
☐ 3 - Short-stay acute hospital (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 **[Go to M1021]**

(M1005) Inpatient Discharge Date: (most recent): ☐ UK - Unknown

Indicate events leading to, and reasons for, inpatient stay:

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):

Inpatient Facility Diagnosis	ICD-10-C M Code
a.	
b.	
c.	
d.	
e.	
f.	

Other Procedures	Procedure Code	Date
a.		
b.		
c.		
d.		

✓ NA - Not applicable ☐ UK - Unknown

Past Medical History *(Mark all that apply)*

☐ CHF ☐ Cardiomyopathy ☐ Arrhythmia ☐ Chest Pain ☐ MI ☐ CAD ☐ HTN ☐ PVD ☐ Murmur

☐ Cancer *(specify type)* In remission? ○ Y ○ N

☐ Osteoarthritis/DJD *(specify sites affected)*

☐ Rheumatoid Arthritis ☐ Gait Problems ☐ Fractures ☐ Falls

☐ Joint Replacement *(specify joint)*

☐ CVA ☐ TIA ☐ MS ☐ Hemiplegia ☐ Seizures ☐ Headaches ☐ Dizziness/Vertigo

☐ IBS ☐ Crohn's Disease ☐ Diverticulitis/Diverticulosis ☐ Constipation ☐ Diarrhea ☐ Fecal Incontinence

☐ Liver/Gallbladder Problems *(specify)*

☐ Depression ☐ Anxiety ☐ Dementia ☐ Alzheimer's

☐ Substance Abuse *(specify)*

☐ Mental Disorder *(specify)*

☐ Pressure Ulcer ☐ Stasis Ulcer ✓ Diabetic Ulcer ☐ Trauma Wound
☐ Other *(specify)*

☐ Chronic Kidney Disease ☐ Renal Failure ☐ Dialysis

☐ Anemia ☐ Abnormal Coagulation ☐ Blood Clots

☐ Diabetes ☐ Thyroid Problems

☐ COPD ☐ Asthma ☐ Chronic Obstructive Bronchitis ☐ Emphysema ☐ Chronic Obstructive Asthma

☐ Urinary Incontinence ☐ Urinary Retention ☐ BPH ☐ Recent/Frequent UTI

☐ Tuberculosis ☐ Hepatitis *(specify)*

☐ Infectious Disease *(specify)*

☐ Tobacco Dependence Type: Amount: Length of Time Used:

✓ Vision Problems ✓ Hearing Loss

✓ Other: GERD

✓ Past Surgical History: LLE femoral fracture and resultant L foot drop with AFO

(M1021/1023)

Diagnoses and Symptom Control:

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

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

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

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

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

0 - Asymptomatic, no treatment needed at this time

1 - Symptoms well controlled with current therapy

2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring

3 - Symptoms poorly controlled; patient needs frequent adjustment in treatment and dose monitoring

4 - Symptoms poorly controlled; history of re-hospitalizations

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

((M1021) Primary Diagnosis & (M1023) Other Diagnoses)	
Column 1	Column 2
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-10-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses.
Descriptions	ICD-10-C M / Symptom Control Rating
(M1021) Primary Diagnosis **a.** `Difficulty in walking, not elsewhere classified` **O/E:** `Exacerbation` **Date:** `04/02/2019`	V, W, X, Y codes NOT allowed `R26.2` **Severity:** `2`
(M1023) Other Diagnosis **b.** **O/E:** **Date:**	All ICD-10-C M codes allowed **Severity:**
(M1023) Other Diagnosis **c.** **O/E:** **Date:**	All ICD-10-C M codes allowed **Severity:**
(M1023) Other Diagnosis **d.** **O/E:** **Date:**	All ICD-10-C M codes allowed **Severity:**
(M1023) Other Diagnosis **e.** **O/E:** **Date:**	All ICD-10-C M codes allowed **Severity:**
(M1023) Other Diagnosis **f.** **O/E:** **Date:**	All ICD-10-C M codes allowed **Severity:**

((M1021) Primary Diagnosis & (M1023) Other Diagnoses)	
Column 1	Column 2
Diagnoses (Sequencing of diagnoses should reflect the seriousness of each condition and support the disciplines and services provided.)	ICD-10-C M and symptom control rating for each condition. Note that the sequencing of these ratings may not match the sequencing of the diagnoses.
Descriptions	ICD-10-C M / Symptom Control Rating
(M1023) Other Diagnosis **g.** **O/E:** **Date:**	All ICD-10-C M codes allowed **Severity:**
(M1023) Other Diagnosis **h.** **O/E:** **Date:**	All ICD-10-C M codes allowed **Severity:**
(M1023) Other Diagnosis **i.** **O/E:** **Date:**	All ICD-10-C M codes allowed **Severity:**
(M1023) Other Diagnosis **j.** **O/E:** **Date:**	All ICD-10-C M codes allowed **Severity:**

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

- [x] 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
  - [ ] Not assessed / No information
- [ ] 2 - Diabetes Mellitus (DM)
  - [ ] Not assessed / No information
- [ ] 3 - None of the above
  - [ ] Not assessed / No information

(M1030) Therapies 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)
- [x] 4 - None of the above

Risk Assessment

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

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

Comments:

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

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

- [ ] - Not assessed (no information)

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

- [ ] - Not assessed (no information)

HHVBP: Herpes Zoster (Shingles) Vaccine

Has the patient ever received the shingles vaccine?

☐ Yes ☐ No

Most Recent Immunizations				
Pneumonia	◉ Yes	○ No	○ Unknown	Date: 10/02/2018
Flu	◉ Yes	○ No	○ Unknown	Date: 10/02/2018
Tetanus	○ Yes	○ No	◉ Unknown	Date:
TB	○ Yes	◉ No	○ Unknown	Date:
TB Exposure	○ Yes	◉ No	○ Unknown	Date:
Hepatitis B	○ Yes	○ No	◉ Unknown	Date:
Additional Immunizations				
	○ Yes	○ No	○ Unknown	Date:
	○ Yes	○ No	○ Unknown	Date:

Comments:

Health Screening	
Last Cholesterol Level:	
Last Mammogram:	
Does patient perform monthly self breast exams?	○ Yes ○ No
Last Pap Smear:	
Last PSA:	
Last Prostate Exam:	
Last Colonoscopy:	

Interventions

Additional Orders:

Goals

Additional Goals:

Prognosis

Advance Directives

Patient has Advance Directives? (•) Yes ( ) No
Advance Directives
Check all that apply
☑ Do Not Resuscitate (DNR)
☑ Living Will
☑ Medical Power of Attorney Name:
☐ Other
Copies on file at agency? (•) Yes ( ) No
Has surrogate? ( ) Yes (•) No Name: Phone: ( )
Patient was provided written and verbal information on Advance Directives? (•) Yes ( ) No

Has an advance care plan been documented in the Home Health record?
☐ Yes ☐ No
Has a surrogate decision maker been documented in the Home Health record?
☐ Yes ☐ No

Prognosis:
( ) Guarded ( ) Poor ( ) Fair (•) Good ( ) Excellent

Is the Patient DNR (Do Not Resuscitate)?
(•) Yes ( ) No

Functional Limitations

☐ Amputation	☐ Paralysis	☐ Legally Blind	☐ Bowel/Bladder Incontinence	☑ Endurance
☐ Dyspnea	☐ Contracture	☐ Ambulation	☑ Hearing	☐ Speech

☐ Other

Supportive Assistance

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

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

Type of Assistance Patient Receives - other than from home health agency staff
(Select all that apply)

Type of Assistance	Family/Friends	Provider Services	Paid Caregiver	Volunteer Organizations
ADL (bathing, dressing, toileting, bowel/bladder, eating/feeding)	✓	☐	☐	☐
IADL (meds, meals, housekeeping, laundry, telephone, shopping, finances)	✓	☐	☐	☐
Psychosocial Support	✓	☐	☐	☐
Assistance with Medical Appointments, Delivery of Medications	✓	☐	☐	☐
Management of Finances	✓	☐	☐	☐

Comments:
ILF

Supportive Assistance: Names of organizations providing assistance
Patient lives in ILF with wife

Community Agencies/Social Service Screening	Yes	No
Community resource info needed to manage care	○	◉
Altered affect, e.g., expressed sadness or anxiety, grief	○	◉
Suicidal ideation	○	◉
Suspected Abuse/Neglect: ☐ Unexplained bruises ☐ Inadequate food ☐ Fearful of family member ☐ Exploitation of funds ☐ Sexual abuse ☐ Neglect ☐ Left unattended if constant supervision is needed		
MSW referral indicated for:	○	○
Coordinator notified	○	○

Ability of patient to handle finances:
○ Independent ○ Dependent ◉ Needs assistance

Comments:

Safety/Sanitation Hazards affecting patient: *(Select all that apply)*

☑ No hazards identified

☐ Stairs	☐ Narrow or obstructed walkway	☐ No gas/electric appliance
☐ No running water, plumbing	☐ Insect/rodent infestation	☐ Cluttered/soiled living area
☐ Inadequate lighting, heating and cooling	☐ Lack of fire safety devices	Other: *(specify)*

Comments:
no concerns noted in ILF

Fire Assessment for Patients with Oxygen.

☐ Patient not using oxygen

Does patient have No Smoking signs posted? ◉ Y ○ N
☑ Patient ☐ Caregiver educated

Does patient or anyone in the home smoke with oxygen in use? ○ Y ◉ N
☑ Patient ☐ Caregiver educated

Are smoke detectors present and working properly? ◉ Y ○ N
☑ Patient ☐ Caregiver educated

Does patient have a properly functioning fire extinguisher? ◉ Y ○ N
☑ Patient ☐ Caregiver educated

Are oxygen cylinders stored properly? ◉ Y ○ N
☑ Patient ☐ Caregiver educated

Are all electrical cords near oxygen intact and free from fraying? ◉ Y ○ N
☑ Patient ☐ Caregiver educated

Does patient have an evacuation plan in case of fire? ◉ Y ○ N
☑ Patient ☐ Caregiver educated

Are all cleaning fluids and aerosols stored away from oxygen, and not used while oxygen is in use? ◉ Y ○ N
☑ Patient ☐ Caregiver educated

Does patient refrain from using petroleum products around oxygen? ◉ Y ○ N
☑ Patient ☐ Caregiver educated

Does patient only use water-based body and lip moisturizers? ◉ Y ○ N
☑ Patient ☐ Caregiver educated

Comments:
safety signs throughout ILF, O2 only at night

Safety Measures

☐ Anticoagulant Precautions	☑ Emergency Plan Developed	☑ Fall Precautions
☐ Keep Pathway Clear	☐ Keep Side Rails Up	☐ Neutropenic Precautions
☑ O2 Precautions	☐ Proper Position During Meals	☐ Safety in ADLs
☐ Seizure Precautions	☐ Sharps Safety	☐ Slow Position Change
☑ Standard Precautions/Infection Control	☑ Support During Transfer and Ambulation	☑ Use of Assistive Devices
Other *(specify)*:		
☐ Instructed on safe utilities management	☑ Instructed on mobility safety	☑ Instructed on DME & electrical safety
☐ Instructed on sharps container	☐ Instructed on medical gas	☑ Instructed on disaster/emergency plan
☑ Instructed on safety measures	☐ Instructed on proper handling of biohazard waste	
Triage/Risk Code: 3	**Disaster Code:** 3	

Comments:

Cultural

English Other(*specify*):

Does patient have cultural practices that influence health care? ○ Yes ◉ No

If yes, please explain:

Is religion important to the patient? ◉ Yes ○ No

Patient's religious preference? protestant

Use of interpreter *(select patient preferences)*: ☐ Family ☐ Friend ☐ Professional ☐ Other

Patient's primary source of emotional support:

OASIS-D Start of Care (PT):

Homebound? ○ No ○ Yes

- ☐ Residual weakness
- ☐ Requires max assistance/taxing effort to leave home
- ☐ Severe SOB or SOB upon exertion
- ☐ Need assistance for all activities
- ☒ Unable to safely leave home unassisted
- ☐ Confusion, unsafe to go out of home alone
- ☒ Other 1 person assist x 4WW

Sensory Status

Sensory Status

Eyes:
- ☐ WNL (Within Normal Limits)
- ☐ Glasses
- ☐ Contacts Left
- ☐ Contacts Right
- ☐ Blurred Vision
- ☐ Glaucoma
- ☐ Cataracts
- ☑ Macular Degeneration
- ☐ Redness
- ☐ Drainage
- ☐ Itching
- ☐ Watering
- ☐ Other

Date of Last Eye Exam:

Ears:
- ☐ WNL (Within Normal Limits)
- ☑ Hearing Impaired ☑ Left ☑ Right
- ☐ Deaf
- ☐ Drainage
- ☐ Pain
- ☑ Hearing Aids ☑ Left ☑ Right

Nose:
- ☑ WNL (Within Normal Limits)
- ☐ Congestion
- ☐ Loss of Smell
- ☐ Nose Bleeds *How often?*
- ☐ Other

(M1200) Vision (with corrective lenses if the patient usually wears them):

○ 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.

◉ 1 - Partially impaired: cannot see medication labels or newsprint, 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.

Interventions

Additional Orders:

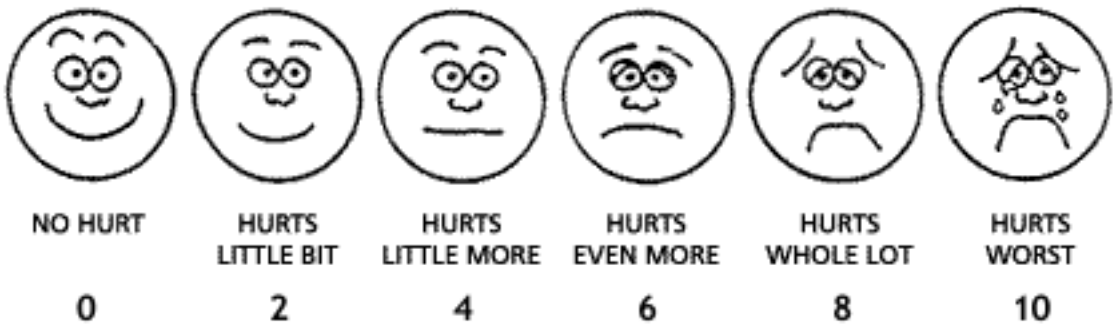
Goals

Additional Goals:

(OASIS-D/2019)

Pain

Pain Scale	
Onset Date: 04/03/2019	Location of Pain: NA



From Hockenberry MJ, Wilson D: Wong's essentials of pediatric nursing, ed. 8, St. Louis, 2009, Mosby. Used with permission. Copyright Mosby.

Intensity of pain:	0
Duration:	no pain
Quality:	NA
What makes pain worse:	NA
What makes pain better:	NA
Relief rating of pain, i.e., pain level after medications:	0
Medications patient takes for pain:	NA
Medication effectiveness:	NA
Medication adverse side effects:	NA
Patient's pain goal:	NA

(M1242) 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

Interventions	
☐	Therapist to assess pain level and effectiveness of pain medications and current pain management therapy every visit
☐	Therapist to instruct patient to take pain medication before pain becomes severe to achieve better pain control
☐	Therapist to instruct patient on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and/or hot/cold packs
☐	Therapist to assess patient's willingness to take pain medications and/or barriers to compliance, e.g., patient is unable to tolerate side effects such as drowsiness, dizziness, constipation
☐	Therapist to report to physician if patient experiences pain level not acceptable to patient, pain level greater than , pain medications not effective, patient unable to tolerate pain medications, pain affecting ability to perform patient's normal activities

Additional Orders:

Goals	
☐	Patient will verbalize understanding of proper use of pain medication by
☐	Patient will achieve pain level less than within weeks

Additional Goals:

Integumentary Status

Braden Scale
for Predicting Pressure Sore Risk in Home Care

SENSORY PERCEPTION ability to respond meaningfully to pressure-related discomfort	**1. Completely Limited** Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation **OR** limited ability to feel pain over most of body.	**2. Very Limited** Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness **OR** has a sensory impairment which limits the ability to feel pain or discomfort over 1/2 of body.	**3. Slightly Limited** Responds to verbal commands, but cannot always communicate discomfort or the need to be turned **OR** has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	**4. No Impairment** Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.	2
MOISTURE degree to which skin is exposed to moisture	**1. Constantly Moist** Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	**2. Often Moist** Skin is often, but not always moist. Linen must be changed as often as 3 times in 24 hours.	**3. Occasionally Moist** Skin is occasionally moist, requiring an extra linen change approximately once a day.	**4. Rarely Moist** Skin is usually dry; Linen only requires changing at routine intervals.	4
ACTIVITY degree of physical activity	**1. Bedfast** Confined to bed.	**2. Chairfast** Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	**3. Walks Occasionally** Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of day in bed or chair.	**4. Walks Frequently** Walks outside bedroom twice a day and inside room at least once every two hours during waking hours.	4
MOBILITY ability to change and control body position	**1. Completely Immobile** Does not make even slight changes in body or extremity position without assistance.	**2. Very Limited** Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	**3. Slightly Limited** Makes frequent though slight changes in body or extremity position independently.	**4. No Limitation** Makes major and frequent changes in position without assistance.	3
NUTRITION usual food intake pattern	**1. Very Poor** Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement **OR** is NPO and/or maintained on clear liquids or IVs for more than 5 days.	**2. Probably Inadequate** Rarely eats a complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement **OR** receives less than optimum amount of liquid diet or tube feeding.	**3. Adequate** Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) per day. Occasionally will refuse a meal, but will usually take a supplement when offered **OR** is on a tube feeding or TPN regimen which probably meets most of nutritional needs.	**4. Excellent** Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.	4
FRICTION & SHEAR	**1. Problem** Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures or agitation leads to almost constant friction.	**2. Potential Problem** Moves feebly or requires minimum assistance. During a move skin probably slides to some extent against sheets, chair, restraints or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	**3. No Apparent Problem** Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair.		3
				Total:	20

Braden Scale Scoring: Risk of developing pressure ulcers: ***15-18:*** *At risk;* ***13-14:*** *Moderate risk;* ***10-12:*** *High risk;* ***9 or below:*** *Very high risk*

(OASIS-D/2019)

Integumentary Status

Skin Turgor: ◉ Good ○ Fair ○ Poor

Skin Color: ✓ Pink/WNL ☐ Pale ☐ Jaundice ☐ Cyanotic

Skin: ✓ Dry ☐ Diaphoretic ☐ Warm ☐ Cool ✓ Wound
☐ Ulcer ☐ Incision ☐ Rash ☐ Ostomy ☐ Other

Instructed on measures to control infections? ◉ Yes ○ No

Nails: ◉ Good ○ Problems

Is patient using pressure-relieving device(s)? ○ **Yes** ◉ **No**
Type:

Comments:
PVD with ulcer with scar noted on LLE, RN notified

(M1306) Does this patient have at least one **Unhealed Pressure Ulcer/Injury at Stage 2 or Higher** or designated as Unstageable? (Excludes Stage 1 pressure injuries and all healed pressure ulcers/injuries)
◉ 0 - No ○ 1 - Yes

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage

A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister.
Number of Stage 2 pressure ulcers

B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
Number of Stage 3 pressure ulcers

C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling.
Number of Stage 4 pressure ulcers

D1. Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device.
Number of unstageable pressure ulcers/injuries due to non-removable dressing/device

E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar.
Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar

F1. Unstageable: Deep tissue injury:
Number of unstageable pressure ulcers with deep tissue injury in evolution

(M1322) Current Number of Stage 1 Pressure Injuries: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.
○ 0 ◉ 1 ○ 2 ○ 3 ○ 4 or more

(M1324) Stage of Most Problematic Unhealed Pressure Ulcer/Injury that is Stageable: (Excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or deep tissue injury.)
◉ 1 - Stage 1 ○ 2 - Stage 2 ○ 3 - Stage 3 ○ 4 - Stage 4
○ N/A - Patient has no pressure ulcers/injuries or no stageable pressure ulcers/injuries

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

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

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

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

(M1342) Status of Most Problematic Surgical Wound that is Observable:
○ 0 - Newly epithelialized ○ 1 - Fully granulating ○ 2 - Early/partial granulation ○ 3 - Not healing

(OASIS-D/2019)

Interventions		
☐	Therapist to instruct the `Patient/Caregiver`	on turning/repositioning every 2 hours
☑	Therapist to instruct the `Patient/Caregiver`	to float heels
☐	Therapist to instruct the `Patient/Caregiver`	on methods to reduce friction and shear
☐	Therapist to instruct the `Patient/Caregiver`	on proper use of moisture barrier
☐	Therapist to instruct the `Patient/Caregiver`	to pad all bony prominences
Additional Orders:		

Goals	
☑	Patient skin integrity will remain intact during this episode
Additional Goals:	

(OASIS-D/2019)

Respiratory Status

Respiratory

☑ **WNL (Within Normal Limits)**

☐ **Lung Sounds:**
- ☐ CTA
- ☐ Rales
- ☐ Rhonchi
- ☐ Wheezes
- ☐ Crackles
- ☐ Diminished
- ☐ Absent
- ☐ Stridor

☐ **Sputum:**
Enter amount:

Describe color, consistency, and odor:

☑ **02 At:** 1.5L at night NC
LPM via:

☑ **02 Sat:** 95%

☐ **Nebulizer:**

☐ **Cough:**

Comments:

(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 (for example, while dressing, using commode or bedpan, walking distances less than 20 feet)
- ○ 3 - With minimal exertion (for example, while eating, talking, or performing other ADLs) or with agitation
- ○ 4 - At rest (during day or night)

Interventions

Additional Orders:

Goals

Additional Goals:

(OASIS-D/2019)

Endocrine

Endocrine

- [x] WNL (Within Normal Limits)

Is patient diabetic?	○ Y	○ N	
Insulin dependent?	○ Y	○ N	For how long?
Is patient independently able to draw up correct dose of insulin?	○ Y	○ N	
Is patient able to properly administer own insulin?	○ Y	○ N	
Is patient taking oral hypoglycemic agent?	○ Y	○ N	
Is patient independent with glucometer use?	○ Y	○ N	
Is caregiver able to correctly draw up and administer insulin?	○ Y	○ N	○ N/A, no caregiver
Is caregiver independent with glucometer use?	○ Y	○ N	○ N/A, no caregiver
Does patient or caregiver routinely perform inspection of the patient's lower extremities?	○ Y	○ N	

Does patient have any of the following?

- ☐ Polyuria
- ☐ Polydipsia
- ☐ Polyphagia
- ☐ Neuropathy
- ☐ Radiculopathy
- ☐ Thyroid problems

Blood Sugar ○ Random ○ Fasting ○ 2 Hours PP

Blood sugar checked by:
Site:

Comments:
Patient has peripheral neuropathy from PVD, no history of DM

Interventions

☑	Therapist to instruct Patient/Caregiver to inspect patient's feet daily and report any skin or nail problems immediately
☐	SN needed for evaluation for patient due to knowledge deficit related to diabetic foot care
☐	Therapist to instruct Patient/Caregiver to wash patient's feet in warm (not hot) water. Wash feet gently and pat dry thoroughly making sure to dry between toes
☑	Therapist to instruct Patient/Caregiver to use moisturizer daily but avoid getting between toes
☑	Therapist to instruct patient to wear clean, dry, properly-fitted socks and change them every day
☑	Therapist to instruct Patient/Caregiver on appropriate nail care as follows: trim nails straight across and file rough edges with nail file
☑	Therapist to instruct Patient/Caregiver that patient should never walk barefoot
☑	Therapist to instruct Patient/Caregiver that patient should elevate feet when sitting
☑	Therapist to instruct Patient/Caregiver to protect patient's feet from extreme heat or cold
☐	Therapist to instruct Patient/Caregiver never to try to cut off corns, calluses, or any other lesions from lower extremities

Additional Orders:

Goals

Additional Goals:
Patient will maintain skin integrity and learn to check his feet on a regular basis for possible skin breakdown from PVD

(OASIS-D/2019)

Cardiac Status

Cardiovascular

☑ WNL (Within Normal Limits)	☐ Dizziness:
☐ Chest Pain:	☑ Edema: BLE 1+ ☐ Dependent Edema: ☑ Pitting ☐ Nonpitting
☐ Heart Sounds: ☐ Murmur ☐ Gallop ☐ Click ☐ Irregular	☐ Neck Vein Distention:
☐ Peripheral Pulses:	☐ Cap Refill: ○ <3 sec ○ >3 sec
Pacemaker: (Insertion date)	AICD: (Insertion date)

Comments:
Cardiac evaluation WNL

Interventions

Additional Orders:

Goals

Additional Goals:

(OASIS-D/2019)

Elimination Status

GU	Digestive
✓ WNL (Within Normal Limits) ☐ Incontinence ☐ Bladder Distention ☐ Burning ☐ Frequency ☐ Dysuria ☐ Retention ☐ Urgency ☐ Urostomy ☐ Catheter: Last Changed Fr cc ☐ Urine: ☐ Cloudy ☐ Odorous ☐ Sediment ☐ Hematuria ☐ Other ☐ External Genitalia: ○ Normal ○ Abnormal As per: ○ Clinician Assessment ○ Pt/CG Report	✓ WNL ☐ Nausea/Vomiting ☐ NPO ☐ Reflux/Indigestion ☐ Diarrhea ☐ Constipation ☐ Bowel Incontinence ☐ Bowel Sounds: ○ Hyperactive ○ Hypoactive ○ Normal ☐ Abd Girth: ☐ Last BM: As per: ○ Clinician Assessment ○ Pt/CG Report ☐ WNL ☐ Abnormal Stool: ☐ Gray ☐ Tarry ☐ Fresh Blood ☐ Black ☐ Constipation: ○ Chronic ○ Acute ○ Occasional ☐ Lax/Enema Use: ☐ Hemorrhoids: ○ *Internal* ○ *External* ☐ Ostomy: Ostomy Type(s): ☐ Stoma Appearance: ☐ Stool Appearance: ☐ Surrounding Skin: ☐ Intact

Comments:

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

◉ 0 - No ○ 1 - Yes ○ NA - Patient on prophylactic treatment ○ UK - Unknown

(M1610) Urinary Incontinence or Urinary Catheter Presence:

◉ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage)
○ 1 - Patient is incontinent
○ 2 - Patient requires a urinary catheter (specifically: external, indwelling, intermittent, suprapubic)

(M1620) Bowel Incontinence Frequency:

◉ 0 - Very rarely or never has bowel incontinence
○ 1 - Less than once weekly
○ 2 - One to three times weekly
○ 3 - Four to six times weekly
○ 4 - On a daily basis
○ 5 - More often than once daily
○ NA - Patient has ostomy for bowel elimination
○ UK - Unknown

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

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

Is patient on dialysis? ○ Y ◉ N

☐ Hemodialysis
☐ AV Graft / Fistula Site:
☐ Central Venous Catheter Access Site:
☐ Peritoneal Dialysis
☐ CCPD (Continuous Cyclic Peritoneal Dialysis)
☐ IPD (Intermittent Peritoneal Dialysis)
☐ CAPD (Continuous Ambulatory Peritoneal Dialysis)
☐ Catheter site free from signs and symptoms of infection
☐ Other:

Dialysis Center:
Phone Number:
Contact Person:

Interventions

☐ No blood pressure in arm

Additional Orders:

Goals

Additional Goals:

(OASIS-D/2019)

Nutrition

Nutrition

- [x] WNL (Within Normal Limits)
- [ ] Dysphagia
- [ ] Decreased Appetite
- [ ] Weight Loss/Gain ○ Loss ○ Gain Amount: in: *(how long)*
- [ ] Meals Prepared Appropriately
- [x] Diet ◉ Adequate ○ Inadequate ☐ NG ☐ PEG ☐ Dobhoff ☐ Tube Placement Checked
- [ ] Residual Checked, Amount: cc
  - [ ] Throat problems? [ ] Sore throat? [ ] Dentures? [ ] Other:
  - [ ] Hoarseness? [ ] Dental problems? [ ] Problems chewing?

Comments:
regular diet

Nutritional Health Screen	Yes
☐ Without reason, has lost more than 10 lbs, in the last 3 months	15
☐ Has an illness or condition that made pt change the type and/or amount of food eaten	10
☐ Has open decubitus, ulcer, burn or wound	10
☐ Eats fewer than 2 meals a day	10
☐ Has a tooth/mouth problem that makes it hard to eat	10
☐ Has 3 or more drinks of beer, liquor or wine almost every day	10
☐ Does not always have enough money to buy foods needed	10
☐ Eats few fruits or vegetables, or milk products	5
☐ Eats alone most of the time	5
☐ Takes 3 or more prescribed or OTC medications a day	5
☑ Is not always physically able to cook and/or feed self and has no caregiver to assist	5
☐ Frequently has diarrhea or constipation	5

Score

- [x] **Good Nutritional Status (Score 0 - 25)**
- [ ] **Moderate Nutritional Risk (Score 25 - 55)**
- [ ] **High Nutritional Risk (Score 55 - 100)**

Nutritional Status Comments:
Good, no concerns

- [ ] **Non-compliant with prescribed diet**
- [ ] **Over/under weight by 10%**

Meals prepared by:
ILF for lunch and dinner, breakfast provided by patient or spouse to include simple items such as toast or cereal.

Enter Physician's Orders or Diet Requirements

- [ ] Sodium
- [ ] No Added Salt
- [ ] Calorie ADA Diet
- [x] Regular
- [ ] High Protein
- [ ] Low Protein
- [ ] Carbohydrate ○ Low ○ High
- [ ] Mechanical Soft
- [ ] High Fiber
- [ ] Supplement:
- [ ] Renal Diet
- [ ] Coumadin Diet
- [ ] Fluid Restriction cc/24 hours
- [ ] Other:

- [ ] No Concentrated Sweets
- [ ] Heart Healthy
- [ ] Low Cholesterol
- [ ] Low Fat
- [ ] Enteral Nutrition (formula)
  Amount cc/day via
  - [ ] Pump [ ] Gravity
  - [ ] PEG [ ] NG [ ] Dobhoff
  - [ ] Continuous [ ] Bolus
- [ ] TPN @cc/hr
  via

Interventions

Additional Orders:

Goals

Additional Goals:

Neuro/Emotional/Behavioral Status

Neuro/Emotional/Behavioral Status

Neurological	Psychosocial
Oriented to: ☑ Person ☑ Place ☑ Time ☐ Disoriented ☐ Forgetful ☐ PERRL ☐ Seizures ☐ Tremors Location(s)	☑ WNL (Within Normal Limits) ☐ Poor Home Environment ☐ Poor Coping Skills ☐ Agitated ☐ Depressed Mood ☐ Impaired Decision Making ☐ Demonstrated/Expressed Anxiety ☐ Inappropriate Behavior ☐ Irritability

Comments:

(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 (for example, on all tasks involving shifting of attention) or consistently requires low stimulus environment due to distractibility
○ 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time
○ 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium

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

◉ 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, validated 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?"

PHQ-2©	Not at all 0 - 1 day	Several days 2 - 6 days	More than half of the days 7 - 11 days	Nearly every day 12 - 14 days	N/A Unable to respond
a)Little interest or pleasure in doing things?	◉ 0	○ 1	○ 2	○ 3	○ na
b)Feeling down, depressed, or hopeless?	◉ 0	○ 1	○ 2	○ 3	○ na

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

(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 (for example), hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects
☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
☐ 6 - Delusional, hallucinatory, or paranoid behavior
☑ 7 - None of the above behaviors demonstrated

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

◉ 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

Interventions	
☐	***Notify SN or Physician that this patient was screened for depression using the PHQ-2 scale and meets criteria for further evaluation for depression**
☐	SN to evaluate patient for signs and symptoms of depression
☐	MSW: ○ 1-2 OR ○ visits, every 60 days for provider services
☐	MSW: ○ 1-2 OR ○ visits, every 60 days for long term planning
☐	MSW: ○ 1-2 OR ○ visits, every 60 days for community resource assistance

Additional Orders:

Goals	
☐	Patient's community resource needs will be met with the assistance of social worker

Additional Goals:

Mental Status			
✓ Oriented	☐ Comatose	☐ Forgetful	☐ Agitated
☐ Depressed	☐ Disoriented	☐ Lethargic	Other *(specify)*:

Additional Orders *(specify)*:

ADL/IADLs

Activities Permitted			
☐ Complete bed rest	✓ Up as tolerated	✓ Exercise prescribed	✓ Independent at home
☐ Cane	✓ Walker	☐ Bed rest with BRP	☐ Transfer bed-chair
☐ Partial weight bearing	☐ Crutches	☐ Wheelchair	Other (specify):

Musculoskeletal

☐ WNL (Within Normal Limits)
✓ Weakness
✓ Ambulation Difficulty
☐ Limited Mobility/ROM
☐ Joint Pain/Stiffness
✓ Poor Balance
✓ Grip Strength
- ◉ Equal
- ○ Unequal

☐ Bedbound
☐ Chairbound
☐ Contracture:
☐ Paralysis:
- ○ Dominant
- ○ Nondominant

☐ Assistive Device:

Comments:
Notable ataxic like movement with MMT for strength testing

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

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

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

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

(M1820) Current **Ability to Dress Lower Body** safely (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

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

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

○ 0 - Able to bathe self in shower or tub independently, including getting in and out of tub/shower
◉ 1 - With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower
○ 2 - Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, 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.
○ 6 - Unable to participate effectively in bathing and is bathed totally by another person

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

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

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

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

(OASIS-D/2019)

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

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

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

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

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

- ◉ 0 - Able to independently feed self
- ○ 1 - Able to feed self independently but requires:
  (a) meal set-up; 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

(OASIS-D/2019)

Interventions	
☐	HHA (Freq) assistance with ADLs/IADLs
Additional Orders:	

Goals	
☐	Patient's ADL/IADL needs will be met with assistance of HHA
Additional Goals::	

(OASIS-D/2019)

MAHC 10 - Fall Risk Assessment Tool

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

Ref: The Missouri Alliance for Home Care

Fall Risk Assessment: Timed Get Up and Go

Observe patient for postural stability, steppage, stride length, and sway.

Patient performed the above once for practice. Then repeated the exercise while being timed.

Score 20 seconds

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

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

Interventions	
✓	Therapist to instruct the patient to wear proper footwear when ambulating
✓	Therapist to instruct the patient to used prescribed assistive device when ambulating
☐	Therapist to instruct the patient to change positions slowly
☐	Therapist to instruct the `Patient/Caregiver` to remove throw rugs or use double-sided tape to secure rug in place
☐	Therapist to instruct the `Patient/Caregiver` to remove clutter from patient's path such as clothes, books, shoes, electrical cords, or other items that may cause patient to trip
☐	Therapist to instruct the `Patient/Caregiver` to contact agency for increased dizziness or problems with balance
☐	Therapist to instruct the patient to use non-skid mats in tub/shower
☐	Therapist to instruct the `Patient/Caregiver` on importance of adequate lighting in patient area
☐	Therapist to instruct the `Patient/Caregiver` to contact agency to report any fall with or without minor injury and to call 911 for fall resulting in serious injury or causing severe pain or immobility
☐	Therapist to request Physical Therapy Evaluation order from physician
Additional Orders:	

Goals	
✓	The patient will be free from falls during the certification period
✓	The patient will be free from injury during the certification period
☐	The `Patient/Caregiver` will remove all clutter from patient's path, such as clothes, books, shoes, electrical cords, and other items, that may cause patient to trip by:
☐	The `Patient/Caregiver` will remove throw rugs or secure them with double-sided tape by:
Additional Goals:	

DME				
☐ Bedside Commode	☐ Cane	☐ Elevated Toilet Seat	☐ Grab Bars	☐ Hospital Bed
☐ Nebulizer	✓ Oxygen	✓ Tub/Shower Bench	✓ Walker	☐ Wheelchair
Other:				

Supplies				
☐ ABDs	☐ Ace Wrap	✓ Alcohol Pads	☐ Chux/Underpads	☐ Diabetic Supplies
☐ Drainage Bag	☐ Dressing Supplies	☐ Duoderm	✓ Exam Gloves	☐ Foley Catheter
☐ Gauze Pads	☐ Insertion Kit	☐ Irrigation Set	☐ Irrigation Solution	☐ Kerlix Rolls
☐ Leg Bag	☐ Needles	☐ NG Tube	☐ Probe Covers	☐ Sharps Container
☐ Sterile Gloves	☐ Syringe	☐ Tape		
Other:				

DME Provider

Information for company (other than home health agency) that provides supplies/DME:
Name:
Address:
Phone Number:
Supplies/DME
Provided:

(OASIS-D/2019)

Functional Abilities and Goals

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

Coding: Enter Code in Boxes		
3. **Independent** - Patient completed the activities by him/herself, with or without an assistive device, with no assistance from a helper. 2. **Needed Some Help** - Patient needed partial assistance from another person to complete activities. 1. **Dependent** - A helper completed the activities for the patient. 8. **Unknown** 9. **Not Applicable** - **Not Assessed/No Information**	3	**A. Self Care:** Code the patient's need for assistance with bathing, dressing, using the toilet, or eating prior to the current illness, exacerbation, or injury.
	3	**B. Indoor Mobility (Ambulation):** Code the patient's need for assistance with walking from room to room (with or without a device such as a cane, crutch or walker) prior to the current illness, exacerbation or injury.
	3	**C. Stairs:** Code the patient's need for assistance with internal or external stairs (with or without a device such as a cane, crutch or walker) prior to the current illness, exacerbation or injury.
	3	**D. Functional Cognition:** Code the patient's need for assistance with planning regular tasks, such as shopping or remembering to take medication prior to the current illness, exacerbation or injury.

(GG0110) Prior Device Use

Indicate devices and aids used by the patient prior to the current illness, exacerbation, or injury. Check all that apply.

☐ **A. Manual Wheelchair**	✓ **D. Walker**	☐ **Not Assessed/No Information**
☐ **B. Motorized wheelchair and/or scooter**	☐ **E. Orthotics/Prosthetics**	
☐ **C. Mechanical lift**	☐ **Z. None of the above**	

(GG0130) Self Care

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

Coding:

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

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07. **Patient refused**
09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical conditions or safety concerns**
- **Not Assessed/No Information**

1. SOC/ROC Performance	2. Discharge Goal	
Enter Codes in Boxes		
06	06	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.
06	06	**B. Oral Hygiene:** The ability to use suitable items to clean teeth. Dentures (if applicable): The ability to remove and replace dentures from and to the mouth, and manage equipment for soaking and rinsing them.
06	06	**C. Toileting Hygiene:** The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment.
06	06	**E. Shower/bathe self:** The ability to bathe self, including washing, rinsing, and drying self (excludes washing of back and hair). Does not include transferring in/out of tub/shower.
06	06	**F. Upper body dressing:** The ability to dress and undress above the waist; including fasteners, if applicable.
06	05	**G. Lower body dressing:** The ability to dress and undress below the waist, including fasteners; does not include footwear.
06	05	**H. Putting on/taking off footwear:** The ability to put on and take off socks and shoes or other footwear that is appropriate for safe mobility; including fasteners, if applicable.

(OASIS-D/2019)

(GG0170) Mobility

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

Coding:

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

Activities may be completed with or without assistive devices.

06. **Independent** - Patient completes the activity by him/herself with no assistance from a helper.
05. **Setup or clean-up assistance** - Helper sets up or cleans up; patient completes activity. Helper assists only prior to or following the activity.
04. **Supervision or touching assistance** - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.
03. **Partial/moderate assistance** - Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort.
02. **Substantial/maximal assistance** - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.
01. **Dependent** - Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity.

If activity was not attempted, code reason:

07. **Patient refused**
09. **Not applicable** - Not attempted and the patient did not perform this activity prior to the current illness, exacerbation or injury.
10. **Not attempted due to environmental limitations** (e.g., lack of equipment, weather constraints)
88. **Not attempted due to medical conditions or safety concerns**
- **Not Assessed/No Information**

1. SOC/ROC Performance	2. Discharge Goal	
Enter Codes in Boxes		
06	06	**A. Roll left and right:** The ability to roll from lying on back to left and right side, and return to lying on back on the bed.
06	06	**B. Sit to lying:** The ability to move from sitting on side of bed to lying flat on the bed.
06	06	**C. Lying to sitting on side of bed:** The ability to move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.
06	05	**D. Sit to stand:** The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed.
06	05	**E. Chair/bed-to-chair transfer:** The ability to transfer to and from a bed to a chair (or wheelchair).
06	06	**F. Toilet transfer:** The ability to get on and off a toilet or commode.
06	06	**G. Car Transfer:** The ability to transfer in and out of a car or van on the passenger side. Does not include the ability to open/close door or fasten seat belt.
06	05	**I. Walk 10 feet:** Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170M, 1 step (curb).*
06	05	**J. Walk 50 feet with two turns:** Once standing, the ability to walk 50 feet and make two turns.
06	05	**K. Walk 150 feet:** Once standing, the ability to walk at least 150 feet in a corridor or similar space.
88	88	**L. Walking 10 feet on uneven surfaces:** The ability to walk 10 feet on uneven or sloping surfaces (indoor or outdoor), such as turf or gravel.
06	88	**M. 1 step (curb):** The ability to go up and down a curb and/or up and down one step. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*
88	88	**N. 4 steps:** The ability to go up and down four steps with or without a rail. *If SOC/ROC performance is coded 07, 09, 10 or 88, skip to GG0170P, Picking up object.*
	88	**O. 12 steps:** The ability to go up and down 12 steps with or without a rail.
06	04	**P. Picking up object:** The ability to bend/stoop from a standing position to pick up a small object, such as a spoon, from the floor.
		0 **Q. Does patient use wheelchair and/or scooter?** **0. No** > Skip GG0170R, GG0170RR1, GG0170S, and GG0170SS1 **1. Yes** > Continue to GG0170R, Wheel 50 feet with two turns. **- Not Assessed/No Information**
		R. Wheel 50 feet with two turns: Once seated in wheelchair/scooter, the ability to wheel at least 50 feet and make two turns.
		RR1. Indicate the type of wheelchair or scooter used **1. Manual** **2. Motorized** **- Not Assessed/No Information**
		S. Wheel 150 feet: Once seated in wheelchair/scooter, the ability to wheel at least 150 feet in a corridor or similar space.
		SS1. Indicate the type of wheelchair or scooter used **1. Manual** **2. Motorized** **- Not Assessed/No Information**

Medications

Medication Administration Record

Time in: Time out: Date:

Time:

Medication 1

Medication **Dose** **Route**
Frequency **PRN Reason**
Location **Patient Response**
Comment
Legend

IM Location		***SQ Location***	
LD/RD	Left / Right Deltoid	**LA**	Left Arm
LVG/RVG	Left / Right Ventrogluteal	**RA**	Right Arm
LDG/RDG	Left / Right Dorsogluteal	**ABD**	Abdomen
LV/RV	Left / Right Vastus Lateralis	**LT**	Left Thigh
		RT	Right Thigh

Patient Responses

NB	No Bleeding/Bruising
NC	No Complaint
NN	See Narrative

(M2001) Drug Regimen Review: Did a complete drug regimen review identify potential clinically significant medication issues?

- (•) 0 No - No issues found during review **[Go to M2010]**
- ( ) 1 Yes - Issues found during review
- ( ) 9 NA - Patient is not taking any medications **[Go to M2102]**

Does patient have IV access? ( ) Y (•) N
Type:
Date of Insertion:
Date of Last Dressing Change:

(M2003) Medication Follow-up: Did the Agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

( ) 0 - No ( ) 1 - Yes

(M2010) Patient/Caregiver High Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc) and how and when to report problems that may occur?

- ( ) 0 - No
- ( ) 1 - Yes
- (•) NA - Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

- (•) 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times
- ( ) 1 - Able to take medication(s) at the correct times if:
  (a) individual dosages are prepared in advance by another person; OR
  (b) another person develops a drug diary or chart
- ( ) 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
- ( ) 3 - Unable to take medication unless administered by another person
- ( ) NA - No oral medications prescribed

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

- ( ) 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times
- ( ) 1 - Able to take injectable medication(s) at the correct times if:
  (a) individual syringes are prepared in advance by another person; OR
  (b) another person develops a drug diary or chart
- ( ) 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection
- ( ) 3 - Unable to take injectable medication unless administered by another person
- (•) NA - No injectable medications prescribed

Interventions

- [ ] SN to evaluate due to exhibited `Patient/Caregiver` medication regimen knowledge deficits

Additional Orders:

Goals

Additional Goals:

(OASIS-D/2019)

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.)

Type of Assistance	No assistance needed - patient is independent or does not have needs in this area	Non-agency caregiver(s) currently provide assistance	Non-agency caregiver(s) need training/supportive services to provide assistance	Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance	Assistance needed, but no non-agency caregiver(s) available
f. **Supervision and safety** (for example, due to cognitive impairment)	◉ 0	○ 1	○ 2	○ 3	○ 4

(OASIS-D/2019)

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.)**

006 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

(OASIS-D/2019)

Orders for Discipline and Treatments

Orders for Discipline and Treatments	
SN	
PT	1w6
OT	
ST	
MSW	
HHA	
Dietitian	

Additional Orders:
VO not needed, per VA and Dr. Schnell patient can receive up to 6 visits in the certification period for HH

Rehab Potential

- ☑ Good to achieve stated goals with skilled intervention and patient's compliance with the plan of care
- ☐ Fair to achieve stated goals with skilled intervention and patient's compliance with the plan of care
- ☐ Poor to achieve stated goals with skilled intervention and patient's compliance with the plan of care

Other rehab potential:

Discharge Plans

- ☑ Discharge when medical condition is stable and patient is no longer in need of skilled services
- ☐ Discharge to care of physician
- ☐ Discharge when patient independent with help
- ☐ Discharge to caregiver
- ☑ Discharge patient to self care
- ☐ Discharge when caregiver willing and able to manage all aspects of patient's care
- ☐ Discharge when goals met/maximum potential is reached

Additional discharge plans:

Patient Strengths		
☑ Motivated Learner	☑ Strong Support System	☐ Absence of Multiple Diagnosis
☑ Enhanced Socioeconomic Status	Other:	

Skilled Intervention

Assessment/Instruction/Performance:
see PT evaluation

☑ **Tolerated Well**

☑ **Response to Skilled Intervention**

Verbalized Understanding	☐ Pt	%	☐ CG	%
Return Demonstration	☐ Pt	%	☐ CG	%
Require Further Teaching	☐ Pt	☐ CG		
Comments:				

Title of Teaching Tool Used/Given:	Vestibular habituation tech and tools
Progress To Goals:	
Conferenced With:	SN
Name:	Sanji
Regarding:	Patient's diabetic ulcer on LLE just L of the anterior tibialis muscle
Physician Contacted Re:	
Order Changes:	PT orders per VA and Dr. Schnell
Plans for Next Visit:	plan to focus on strength training and endurance training with neuro re-education tech
Next Physician Visit:	
Discharge Planning:	
	☐ Written notice of discharge provided to patient. Discharge scheduled for:

Refer to last page for patient goal and intervention documentation.

OASIS-D Addendum Page : 04/03/2019

Goals and Interventions:

There was an internal error retrieving goals and interventions information for this document. Please contact support if the problem persists.

PT Evaluation

Diagnosis/History

Medical Diagnosis: difficulty with ambulation — Exacerbation — 04/01/2019

PT Diagnosis: generalized weakness, increased risk for falls — Exacerbation — 04/03/2019

Relevant Medical History:
GERD, PVD with severe peripheral neuropathy BLE, L > R, L femoral fracture 10years ago with L foot drop as a result, macular degeneration

Prior Level of Functioning:
independent with 4WW and more steady with gait per patient report

Patient's Goals:
To reach PLOF and max functional independence, decrease risk of falls and be able to walk better.

Precautions: peripheral neuropathy, risk for ulcers

Homebound? ☑ Yes ☐ No

- ☐ Residual Weakness
- ☑ Needs assistance for all activities
- ☑ Requires max assistance / taxing effort to leave home
- ☑ Unable to safely leave home unattended
- ☐ Severe SOB or SOB upon exertion
- ☐ Confusion, unsafe to go out of home alone

Other:
1 person assist with 4WW

Social Support/Safety Hazards

Evaluation of Living Situation, Supports, and Hazards
Patient lives in a one floor apartment, 2 bedroom, at an ILF with his wife

Subjective Information

Patient states he just doesn't feel as steady as he used too.

(OASIS-D/2019)

Physical Assessment

	Level	Functional Impact
Orientation:	Within normal limits.	
Speech:	Within normal limits.	
Vision:	Impairment present.	Macular degeneration
Hearing:	Impairment present.	HOH, 2 hearing aides in R and L ears
Skin:	Impairment present.	peripheral neuropathy BLE and notable skin discoloration, risk for ulcers
Muscle Tone:	Impairment present but not impacting functional ability.	4-/5 gross strength with some ataxic like movements noted during exam
Coordination:	Impairment present but not impacting functional ability.	some ataxic like motion with BLE and BUE L>R
Sensation:	Impairment present.	decreased sensation to monofilament testing and proprioception
Endurance:	Impairment present but not impacting functional ability.	decreased endurance at this time per patient report
Posture:	Impairment present but not impacting functional ability.	

Edema

☐ **Absent** ☐ **Dependent**

☑ **Present** ☑ **Pitting** +1

Location:

BLE

Circumferential Measurements:

(OASIS-D/2019)

ROM / Strength

		ROM		Strength	
Part	***Action***	***Right***	***Left***	***Right***	***Left***
Shoulder	Flexion	WFL	WFL	4-/5	4-/5
	Extension	WFL	WFL	4-/5	4-/5
	Abduction	WFL	WFL	4-/5	4-/5
	Adduction	WFL	WFL	4-/5	4-/5
	Int Rot	WFL	WFL	4-/5	4-/5
	Ext Rot	WFL	WFL	4-/5	4-/5
Elbow	Flexion	WFL	WFL	4-/5	4-/5
	Extension	WFL	WFL	4-/5	4-/5
Forearm	Pronation				
	Supination				
Finger	Flexion				
	Extension				
Wrist	Flexion				
	Extension				
Trunk	Extension				
	Rotation				
	Flexion				

		ROM		Strength	
Part	***Action***	***Right***	***Left***	***Right***	***Left***
Hip	Flexion	WFL	WFL	4-/5	4-/5
	Extension	WFL	WFL	4-/5	4-/5
	Abduction	WFL	WFL	4-/5	4-/5
	Adduction	WFL	WFL	4-/5	4-/5
	Int Rot	WFL	WFL	4-/5	4-/5
	Ext Rot	WFL	WFL	4-/5	4-/5
Knee	Flexion	WFL	WFL	3+/5	3+/5
	Extension	WFL	WFL	3+/5	3+/5
Ankle	Plantar Flexion	WFL	WFL	3/5	2/5
	Dorsiflexion	WFL	WFL	3/5	2/5
	Inversion	WFL	WFL	3/5	2/5
	Eversion	WFL	WFL	3/5	2/5
Neck	Flexion				
	Extension				
	Lat Flexion				
	Rotation				

Description of Functional Impact:
L foot drop >R, although strength is decreased with AROM on RLE as well

Functional Assessment

Independence Scale Key | **Dep** | **Max Assist** | **Mod Assist** | **Min Assist** | **CGA** | **SBA** | **Supervision** | **Ind with Equip** | **Indep**

Bed Mobility

	Assist Level	
Rolling	independent	☐ L ☐ R

	Assistive Device
Supine - Sit	independent
Sit - Supine	independent

Factors Contributing to Functional Impairment:
generalized weakness

Gait

	Assist Level	Distance / Amount	Assistive Device
Level	SBA	X 600	4WW
Unlevel	NT	X NT	NT
Steps / Stairs	NT	X NT	NT

Factors Contributing to Functional Impairment:
LOB noted with 4WW during ambulation

(OASIS-D/2019)

Wound Care Worksheet

Wounds Addressed on this Visit

WOUND 1 - Location: LLE, **Status:** Closed , **Onset Date:** 04/03/2019 , **Type:** Venous Ulcer , **Size:** Length: 12cm, Width: 10cm, Depth: 0cm , **Wound Bed:** Black , **Eschar:** 100% , **Wound Edges:** ✓ Attached , **Drainage:** None , **Surrounding Tissue:** ✓ Intact , ✓ Erythema
Treatment: Requesting RN visit to assess , **Patient Response To Treatment:** in agreement with plan
Additional Information: Patient will be evaluated by SN to ensure the wound is healing properly and does not require intervention

(OASIS-D/2019)

Transfer

	Assist Level	Assistive Device
Sit - Stand	CGA	4WW
Stand - Sit	CGA	4WW
Bed - Wheelchair	NA	NA
Wheelchair - Bed	NA	NA
Toilet or BSC	SBA	4WW and grab bars
Tub or Shower	SBA	grab bars and shower chair
Car / Van		

Factors Contributing to Functional Impairment:
generalized weakness, decreased sensation BLE and decreased visual input

Wheelchair Mobility

Assist Level	Assist Level	Assist Level
Level NA	Unlevel	Maneuver

Factors Contributing to Functional Impairment:
generalized weakness

Weight Bearing Status

FWB

Balance

- [x] Able to assume midline orientation
- [ ] Able to maintain midline orientation

Sitting:
Standing:

Fall Risk and Other Testing

	Test Used	Other	Test Results
Cognition		mini mental	WNL 4 points
Sensation	Monofilament Testing		decreased sensation and proprioception BLE
Endurance			
Balance	Other	Romberg, Balance Rxn, TUG	Romberg +, Balance Reaction + and TUG 20 sec
Gait			
Bal Confidence			

Clinical Statement of Assessment Findings and Recommendations

Homebound status Patient is still home bound because: Considerable and taxing effort to leave the home secondary to weakness, decreased balance, endurance to activity, decreased ability to transfer, and inability to drive. Evaluation: Initial evaluation completed today. Patient was involved in planning their own care, treatment and goal setting/expected outcomes. Patient was notified which disciplines will be providing care, and that their physician ordered these services for them and will be *(Continued)*

(OASIS-D/2019)

Treatment Goals

		Time Frame
1:	Patient will demo independence with HEP for progression between skilled PT visits	2 weeks
2:	Patient will ambulate 1000+ft with 4WW without demo of LOB to reach PLOF	4 weeks
3:	Patient will demonstrate negative Romberg test indicating static stance and balance is improved to decrease risk of falls	6 weeks
4:	Patient will increase generalized strength in BLE and BUE to 4/5 grossly for max functional independence	6 weeks
5:	Patient will demo TUG of 13 sec or less to indicate decreased risk of falls	6 weeks
6:		
7:		
8:		
9:		
10:		

Treatment Plan

- ☑ Thera Ex
- ☐ Hip Precaution Training
- ☑ Establish or Upgrade HEP
- ☐ Knee Precaution Training
- ☑ Transfer Training
- ☐ Pulmonary Physical Therapy
- ☑ Gait Training
- ☐ Range of Motion
- ☑ Balance Training
- ☑ Muscle Re-education
- ☐ Bed Mobility Training
- ☐ Ultrasound
- ☐ Prosthetic Training
- ☐ Electrotherapy
- ☑ Stairs / Steps Training
- ☑ O2 Sat Monitoring PRN
- ☑ Home Safety Training
- ☑ Assistive Device Training:

  4WW
- ☑ Modalities for Pain Control:

  ice, heat, MT and MTT as needed 10mins
- ☐ CPM:

Other:

Comments:

Care Coordination

Conference with:
☑ PT ☑ PTA ☐ OT ☐ COTA ☐ ST ☑ SN ☐ Aide ☐ Supervisor Other:

Name(s): Sanji, RN regarding wound evaluation; PTA regarding POC

Regarding: POC with DC planning

☑ Physician Notified Re: Plan of Care, Goals, Frequency, Duration and Direction

Other Discipline Recommendations: ☐ OT ☐ ST ☐ MSW ☐ Aide Other:

Reason: VO not required as VA and Dr. Schnell have pre-approved 6 visits for the certification period for HH PT

Treatment / Skilled Intervention This Visit

- ☑ Completion of the evaluation and development of the plan of care
- ☐ Other

Signature/Discipline and Date (Jayme Holcombe)
Digitally Signed by: Jayme Holcombe , 04/03/2019

(OASIS-D/2019)

PT Evaluation Addendum Page : 04/03/2019

Clinical Statement of Assessment Findings and Recommendations

notified of the treatment plans and expected outcomes. Patient was involved in determining the frequency of patient visits during the certification period and their anticipated discharge date. Patient has been informed of the benefits and risks of rehab services and acknowledges non-compliance of stated treatment plan that may result in decline. Patient was involved in developing POC and goals. Patient diagnosis: difficulty with ambulation Precautions/WB status/Fall Risk: High fall risk as seen in TUG score, Romberg and Balance reaction scores Pain Assessment: NA Vitals (HR, RR, BP, O2): WNL with no change in positions Objective: Patient is a 92yo male with a PMH to include GERD, macular degeneration, PVD with significant peripheral neuropathy, O2 at night for pulmonary support per patient report, and a L femoral fracture 10years ago resulting in L foot drop. Patient presented to MD office on 4/1/19 with c/o weakness and difficulty walking. Patient was referred to HH PT for evaluation and treat. Evaluation findings are as follows: TUG 20sec with 4WW with notable instability, Romberg (+), Balance Reaction (+), therefore patient is at a very high risk for falls at this time. ADL management requires some assistance for placing socks and shoes on LLE specifically due to decreased ROM at the L hip and knee. Transfers are CONTACT GUARD ASSIST to SBA for safety as patient tends to plop into chairs rather than create a smooth transition sit to stand. Bed mobility WNL. Ambulation with 4WW noted to be unstable with LOB at times while walking 500ft today during evaluation, with notable hyper flexion of the L hip for foot clearance with L AFO. MMT revealed weakness in BLE and BUE, more significantly noted in Dorsiflexion and plantar flexion of B feet, L>R. ROM generally WFL, although noted to flex at hips bilaterally with gait. Somatosensory- sensation to light touch LE and proprioception both impaired via monofilament testing and proprioceptive testing. Skin assessment on bilateral feet is WNL, although skin is discolored, dry and flaking in areas, with one region of concern located on LLE just interiorly of the anterior tibialis. RN notified for skin assessment. Cerebellar Tests: VORc (unable to test due to visual impairment and inability to see pen light), Dysdiadochokinesis (-), Finger to nose (+ for tremors BUE L>R). Vestibulocular exam WNL with no overshoots noted, no dizziness or vertigo noted/reported. Patient denies depression. PT performed and observed Therapeutic exercise for static balance activities to include standing with feet wide, 4WW locked, hands hovering 4WW, and gently moving head side to side 10x and up and down 10x with eyes open and closed. Written HEP provided. Neuromuscular re-education discussed for smooth gait and safety with transfers. Edu provided for balance, as balance comes from your eyes, ears and feet. Patients deficits are within his visual capacity, as well as his sensory and proprioceptive sensory in BLE. Balance will be a challenge for this patient until habituation tech are implemented, as well as generalized strengthening tech in patients building gym. Patient responded well to teaching at todays assessment. Functional Deficits: balance, deconditioning, difficulty walking, difficulty with transfers, decreased ROM bilateral hips Assessment: Pt demonstrates global functional and physical deficits, most notably inability to ambulate safely and independently, as well as having poor balance, activity tolerance, and fatigue. Pt will benefit from HH PT services to promote independence within the home and improve overall physical function. Plan: PT to provide skilled intervention to address functional deficits and improve overall condition with a progressive POC and HEP. Interdisciplinary communication occurred with (MD, RN, PTA, Patient, Caregiver). Continue to work on ther ex, gait training, balance program, transfer training, Modalities (MT, MTT, ice, heat 10mins to BLE as needed for pain), neurological re-education, PVD foot care education, balance habituation tech, and HEP.