

INDEX--RAI Version 2.0 Manual

Accidents MDS, J-4 3--145
Accuracy,RAI 1-25
Triggering RAPs Appendix C
Activities of Daily Living,
Function, change in MDS, G-9 3-117
Self Performance MDS, G(1) (A) 3-76
Scoring ADL Self Performance 3-80
Support Provided MDS, G(1) (B) 3-91
Activities,
General Preferences MDS, N-4 3-173
Pursuit Patterns MDS N 3-169
Setting Preference MDS N-3 3-172
Admitted From, at Entry MDS, AB-2 3-13
Advanced Directives MDS, A-10 3-37
Annual Reassessment, Timing 2-5
Anxiety, (Depression, Sad Mood) MDS, E-1 3-61
Appliances and Programs,
Continence MDS, H-3 3-124
Applicability of RAI to Facility Resident 1-14
Assessment,
Information MDS, R 3-210
Participation in MDS, R-1 3-210
Problem Identification Model 1-2
Reference Date MDS, A-3 3-29
Return Stay/Readmission 2-15
Timing 2-3
Type 2-5
Avoidable Decline 4-29

Background Information,
Date Complete MDS, AB-11 3-21
Face Sheet MDS, (AB), (AC), (AD) 3-12
Balance, Test for MDS, G-3 3-102
Bathing MDS, G-2 3-100
Behavior Intervention Program MDS, P-2 3-190
Behavioral Symptoms, MDS, E-4 3-66
Change in Behavior Symptoms MDS, E-5 3-69
Birthdate MDS, AA-3 3-6
Bowel Elimination Pattern MDS, H-2 3-122
Broad Screen Triggers 4-8
Care Plan,
Avoidable Declines 4-29

Care Planning Areas in Long-Term Care 4-33
Completing/Timing 2-22
Evaluation 4-30
Goal Statement 4-30
Initial 4-29
Interdisciplinary Team and 4-31
Linkage to RAPs 4-18
Measurable Outcomes 4-30
Outcome Objectives 4-30
Overview of RAI and Care Planning 4-26
Problem Statement 4-8
Processes of Care Planning 4-18
Revision 4-16
Risk Management 4-30
Care Planning,
Direct Care Staff 4-32
Problem Solving Model 1-2
Process, General 4-29
Components 4-18
Certification of Accuracy 1-25
Change, Overall, in Care Needs MDS, Q-2 3-209
CMS-RAI,
Content of the RAI for NFs 1-3
Approval, State RAIs 1-8
Coding Conventions, MDS 3-4
Cognitive Loss Intervention Program MDS, P-2 3-190
Cognitive Patterns MDS, B 3-41
Cognitive Skills Daily Decision-Making MDS, B-4 3-46
Cognitive Performance Scale Appendix F
Cognitive Status, change in MDS, B-6 3-50
Comatose MDS, B-1 3-42
Commonly Prescribed Medications Appendix E
Communication,
Communication/hearing, change in MDS, C-7 3-56
Devices/Techniques MDS, C-2 3-58
Direct Care Staff (MDS source) 1-21
Family (MDS source) 1-22
Licensed Professionals (MDS source) 1-22
Physician (MDS source) 1-22
Resident (MDS source) 1-21
Completeness of Assessment 2-17
Comprehensive Assessment 2-1
Conditions,
Problem MDS, I-1 3-127
Stability of MDS, J-5 3-147
Confidentiality of Records 1-9

Continence,
Appliances and Programs MDS, H-3 3-124
Self Control Categories MDS, H-1 3-119
Coordinator, RN 1-17
Copy, Paper 1-27
Corrections, of MDS 1-26
Current Payment Source MDS, A-7 3-33
Customary Routine MDS, AC-1 3-22

Daily Routine, Preference for change in MDS, N-5 3-175
Date of Entry MDS, AB-1 3-12
Date of Reentry MDS, A-4 3-31
Decision-making,
Based on RAP Review 4-10
Problem Solving Model (Step2) 4-9
Delirium, Indicators of MDS, B-5 3-47
Demographic Information MDS, AB 3-12
Dental Status MDS, L-1 3-158
Depression (Anxiety, Sad Mood) MDS, E-1 3-61
Devices and Restraints MDS, P-4 3-198
Direct Care Staff,
Care Planning Process 4-26
MDS Information source 1-21
Care Planning 4-26
Overall Status MDS, Q 3-207
Discharge Tracking Form 1-29
Diseases MDS, I-1 3--127

Education MDS, AB7 3-18
Electronic Clinical Record 1-27
Emergency Room Visits MDS, P-6 3-203
Enteral Intake MDS, K-6 3-154
Evaluation,
Care Plan 4-30
Problem Solving Model 1-2
Expression, Modes of MDS, C-3 3-53

Face Sheet MDS, AB, AC, AD 3-12
Face Sheet Signatures MDS, AD 3-27
Facility Provider Number MDS, AA-6 3-8
Family,
Care Planning Process 4-31
Communication as MDS source 1-19

Federal Regulation, Timing of Assessments 1-7,24
Federal Requirements Appendix G
Foot Problems and Care MDS, M-6 3-168
Forms, Mandated 1-29
F-Tags, Care Planning 4-29
Functional,
Assessment MDS, A-R 3-28
Care Plan Category 4-33
Status, Decline in 4-29

Gender MDS, AA-2 3-6
Goals, Care Plan 4-2
Guardian, Legal MDS, A-9 3-36
Guidelines, RAP Section III 4-3

Health Conditions MDS, J 3-138
Health Maintenance 4-18
Hearing MDS, C-1 3-51
Height (Weight) MDS, K-2 3-150
Change 3-150
Holistic Approach, Interdisciplinary Team 1-1
Hospice Resident, RAI Applicability 1-15
Hospital Stay(s) MDS, P-5 3-202

ICD-9-CM Codes MDS, I-1 3-130
Identification Information MDS, AA 3-6
Implementation of Care Plan,
Problem Solving 4-26
Infections MDS, I-2 3-135
Initiative/Involvement MDS, F-1 3-71
Injections MDS, O-3 3-178
Institute of Medicine 1-3
Interdisciplinary, Team
Assessment Process 1-6, 17
Care Planning 4-1, 4
Intervention Programs,
Mood, Behavior, Cognitive Loss MDS, P-2 3-190
Interviewing Resident, Guidelines Appendix D
Key-RAP Key Section IV Appendix C 4-4

Lab Values, Abnormal MDS, P-9 3-206
Legal Guardian MDS, A-9 3-36

Language MDS, AB-8 3-19
Lesions MDS, M-4 3-165
Licensed Professionals, as MDS source 1-19
Linkage of MDS/Care Plan 4-2
Lived Alone MDS, AB-3 3-15
Locomotion, Modes of MDS, G-5 3-111

Maintenance of Records 1-27
Making Self Understood MDS, C-4 3-54
Mandated Assessment and Associated Forms 1-7
Manual, Suggestions for use 1-6
Marital Status MDS, A-5 3-33
Medicaid number MDS, AA-7 3-8
Medical Record Number MDS, A-6 3-33
Medication,
Care Plan Category 4-43
Days Received MDS, O-4 3-179
New MDS, O-2 3-178
Number MDS, O-1 3-176
Memory MDS, B-2 3-43
Memory/Recall Ability MDS, B-3 3-45
Mental Health History MDS, AB-9 3-20
Mental Retardation (MR/DD Status) MDS, AB-10 3-20
Minimum Data Set (MDS)
Additional Uses 1-4
Component of Comprehensive Assessment 1-11
Component of RAI 1-2
Definition of MDS 174
Familiarizing Self with MDS 3-2
Forms Chapter 1
Sections,
AA. Identification Information 3-6
AB. Demographic Information 3-12
AC. Customary Routine 3-22
AD. Face Sheet Signatures 3-27
A. Identification/Background Information 3-28
B. Cognitive Patterns 3-41
C. Communication/Hearing 3-51
D. Vision Patterns 3-58
E. Mood and Behavior Patterns 3-60
F. Psychosocial Well-Being 3-71
G. Physical Function/Structural Problems 3-76
H. Continence in Last 14 Days 3-119
I. Disease Diagnoses 3-127
J. Health Conditions 3-138

K. Oral/Nutritional Status 3-149
L. Oral/Dental Status 3-158
M. Skin Condition 3-159
N. Activity Pursuit Patterns 3-169
O. Medications 3-176
P. Special Treatments and Procedures 3-182
Q. Discharge Potential/Overall Status 3-207
R. Assessment Information 3-210
S. State Defined Section 3-214
*T. Supplemental Items for MDS 2.0/
Case Mix and Quality Demonstration States 3-214*
U. Medications (NHCMQ) 3-223
MDS, Supplemental Items Section S, T 3-214
Modes of Expression MDS, C-3 3-53
Mood,
Change in MDS, E-3 3-64
Intervention Program MDS, P-2 3-190
Persistence MDS, E-2 3-64
Sad (Depression, Anxiety) MDS, E-1 3-61

Needs, Overall Change in Care MDS, Q-2 3-209
Non-Certified Units, RAI Applicability 1-16
Nursing Rehabilitation/Restorative Care MDS, P-3 3-191
Nutritional Approaches MDS, K-5 3-153
Nutritional Problems MDS, K-4 3-152

OBRA 1987 Preface 1
Observation of Resident as MDS source 1-21
Occupation, Lifetime MDS, AB-6 3-18
Oral/Nutritional Status MDS, K 3-149
Oral Problems MDS, K-1 3-149

Pain,
Site MDS, I-3 3-144
Symptoms MDS, I-2 3-140
Parental/Enteral Intake MDS, K-6 3-154
Pediatric Resident, RAI Applicability 1-15
Physician,
Orders MDS, P-8 3-205
Participation in RAI 1-18
Source for MDS 1-18
Visits MDS, P-7 3-204
Potential Problem, Type of Trigger 4-8

Prevention of Problems Type of Trigger 4-8
Problem, RAP Section I 4-3
Problem Solving Identification,
Model 1-2
Process 1-2
Nursing Process 1-1
Resident Assessment Instrument 1-1
Provider Number MDS, AA-6 3-8

Quarterly Assessment (Review),
Definition 2-15
Form-Optional Chapter 1
Form-Standard Chapter 1
Key Mandated Items 2-15
Timing 2-2

Race/Ethnicity MDS, AA-4 3-6
Range of Motion,
Functional Limitation MDS, G4-(A) 3-107
Loss of Voluntary Movement MDS, G4-(B) 3-110
Readmission Assessment 2-27
Reason for Assessment MDS, AA-8 3-9
MDS, A-8 3-34
Record,
Maintenance of MDS in Record 1-27
Record as Source of Information 1-19
Reentry,
Information, minimum 2-26
Tracking form 2-23
Refusal of Services/Treatment 4-30
Regulatory, Basis for RAI 1-7, Appendix G
Rehabilitation Potential,
ADL Function MDS, G-8 3-115
Type of Trigger 4-9
Rehabilitation/Restorative Nursing, MDS, P-3 3-191
Relationships, unsettled MDS, F-2 3-73
Reproducible, Assessment 1-7
Reproduction, of the RAI 1-27
Resident,
Individualized Care 1-2
Holistic View 4-27
Name MDS, AA 3-6
Name MDS, A-1 3-28
Representative, care planning team 3-7

Strengths, care plan 4-31
Resident Assessment Instrument (RAI)
Applicability to Facility Residents 4-30
Components 1-3
Process, understanding 1-2
Regulatory Basis 1-7
System 5-1
Resident Assessment Protocols (RAPs),
Care Plan Linkage 4-1
Completion with each full assessment 4-1
Component of Comprehensive Assessment 4-1
Component of RAI 1-4
Decision Facilitators 4-2
Definition 1-4
Documentation of RAP Findings 4-10
List of 18 RAPs 4-4
Organization 4-3
Process, Steps 4-4
Steps 4-5
Summary Form Appendix C
Timing for Completion 2-21
Resident Assessment Protocol Summary Form,
Care Plan Decision 4-5
Component of Comprehensive Assessment 2-2
Location and Date/
RAP Assessment Documentation 4-10
Trigger Identification 4-3, Appendix C
Residential History MDS, AB-5 3-17
Respite Resident-RAI Applicability 115-4
Responsibility/Legal Guardian MDS, A-9 3-36
Restraints and Devices MDS, P-4 3-198
RN Coordinator, Certification of Completeness 1-18
Roles, past MDS, F-3 3-75
Room Number MDS, A-2 3-28
Routine, Daily
Preference for Change MDS, N-5 3-175
Short-Term Resident, RAI Applicability 1-15
Signatures,
Accuracy/Completeness 1-25
MDS Portions 1-25
MDS Section AA-9 3-11
Others Completing MDS MDS, AD(b-g) 3-28
Persons Completing Assessment MDS, R-2 3-217
RN Coordinator MDS, AD(a) 3-27
Significant Change in Status Assessment,
Additional Comments 3-9

Condition when not required 2-10
Decline 2-8
Definition 2-7
Guidelines for Determination 2-9
Improvement 2-9
Timing 2-12
Skin,
Problems MDS, M-4 3-165
Treatments MDS, M-5 3-167
Speech Clarity MDS, C-5 3-55
Social Security and Medicare Numbers MDS, AA-5 3-7
Sources of Information, Completion of MDS 1-1
Standardized Assessment 1-3
State Agency Contacts Appendix B
State Operations Manual 1-4, 1-78
State RAIs, CMS Approval 1-8
Statutory Authority for RAI 1-7, Appendix G
Swing Bed, RAI Applicability 1-16

Task Segmentation MDS, G-7 3-113
Therapies, MDS, P1b 3-185
Ordered MDS, T-1(b) 3-215
Recreation MDS, T-1(a) 3-214
Time,
Awake MDS, N-1 3-170
Involved in Activities MDS, N-2 3-171
Timing (Timeframes) of Assessments 1-11
Tracking Form-Basic Assessment 2-23
Transfer, Modes of MDS, G-6 3-112
Treatments,
Special Procedures and Programs MDS, P-1 3-182
Trigger Legend,
Instructions for Use 4-6
Key 4-6, Appendix C
Triggers,
Component of Comprehensive Assessment 4-1
Definitions--Location 4-6
RAP- Section IV 4-3
Types 4-6

Ulcer, Cause MDS, M-1 3-159
History of Resolved, Cured MDS, M-3 3-165
Type MDS, M-2 3-161
Understand, others MDS, C-6 3-55

Understood, making self MDS, C-4 3-54
Urinary, Continence, change in MDS, H-4 3-126
Utilization Guidelines,
Component of Comprehensive Assessment 4-1
Component of RAI 1-14

Vision MDS, D-1 3-58
Visual,
Appliances MDS, D-3 3-60
Limitation/Difficulties MDS, D-2 3-59

Walking, when most self sufficient MDS, T-2 3-218
Weight, (Height) MDS, K-2 3-150
Change MDS, K-3 3-150

Zip Code MDS, AB-4 3-16