

(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.

- 1 - Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
- 2 - Diabetes Mellitus (DM)

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

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

inches

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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.)

pounds

INTEGUMENTARY STATUS

(M1300) Pressure Ulcer Assessment: Was this patient assessed for Risk of Developing Pressure Ulcers?																					
Enter Code <input type="checkbox"/>	0 No assessment conducted [<i>Go to M1306</i>] 1 Yes, based on an evaluation of clinical factors (for example, mobility, incontinence, nutrition) without use of standardized tool 2 Yes, using a standardized, validated tool (for example, Braden Scale, Norton Scale)																				
(M1302) Does this patient have a Risk of Developing Pressure Ulcers?																					
Enter Code <input type="checkbox"/>	0 No 1 Yes																				
(M1306) Does this patient have at least one Unhealed Pressure Ulcer at Stage 2 or Higher or designated as Unstageable? (Excludes Stage 1 pressure ulcers and healed Stage 2 pressure ulcers)																					
Enter Code <input type="checkbox"/>	0 No [<i>Go to M1322</i>] 1 Yes																				
(M1307) The Oldest Stage 2 Pressure Ulcer that is present at discharge: (Excludes healed Stage 2 Pressure Ulcers)																					
Enter Code <input type="checkbox"/>	1 Was present at the most recent SOC/ROC assessment 2 Developed since the most recent SOC/ROC assessment. Record date pressure ulcer first identified: <div style="text-align: center; margin: 5px 0;"> <table style="display: inline-table; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-size: 1.2em; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="font-size: 1.2em; padding: 0 5px;">/</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: 0.8em;">month</td> <td></td> <td></td> <td style="text-align: center; font-size: 0.8em;">day</td> <td></td> <td></td> <td style="text-align: center; font-size: 0.8em;">year</td> <td></td> <td></td> <td></td> </tr> </table> </div> NA No Stage 2 pressure ulcers are present at discharge			/			/					month			day			year			
		/			/																
month			day			year															

(M1311) Current Number of Unhealed Pressure Ulcers at Each Stage	Enter Number
<p>A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red pink wound bed, without slough. May also present as an intact or open/ruptured blister. Number of Stage 2 pressure ulcers [If 0 at FU/DC Go to M1311B1]</p> <p>A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC</p>	<input type="text"/> <input type="text"/>
<p>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 [If 0 at FU/DC Go to M1311C1]</p> <p>B2. Number of <u>these</u> Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC</p>	<input type="text"/> <input type="text"/>
<p>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 [If 0 at FU/DC Go to M1311D1]</p> <p>C2. Number of <u>these</u> Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC</p>	<input type="text"/> <input type="text"/>
<p>D1. Unstageable: Non-removable dressing: Known but not stageable due to non-removable dressing/device Number of unstageable pressure ulcers due to non-removable dressing/device [If 0 at FU/DC Go to M1311E1]</p> <p>D2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC</p>	<input type="text"/> <input type="text"/>
<p>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 [If 0 at FU/DC Go to M1311F1]</p> <p>E2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC</p>	<input type="text"/> <input type="text"/>
<p>F1. Unstageable: Deep tissue injury: Suspected deep tissue injury in evolution Number of unstageable pressure ulcers with suspected deep tissue injury in evolution [If 0 - Go to M1322 (at Follow up), Go to M1313 (at Discharge)]</p> <p>F2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC</p>	<input type="text"/> <input type="text"/>

(M1313) Worsening in Pressure Ulcer Status since SOC/ROC:

Instructions for a-c: Indicate the number of current pressure ulcers that were not present or were at a lesser stage at the most recent SOC/ROC. If no current pressure ulcer at a given stage, enter 0.	
	Enter Number
a. Stage 2	<input type="text"/>
b. Stage 3	<input type="text"/>
c. Stage 4	<input type="text"/>
Instructions for e: For pressure ulcers that are Unstageable due to slough/eschar, report the number that are new or were at a Stage 1 or 2 at the most recent SOC/ROC.	
d. Unstageable – Known or likely but Unstageable due to non-removable dressing.	<input type="text"/>
e. Unstageable – Known or likely but Unstageable due to coverage of wound bed by slough and/or eschar.	<input type="text"/>
f. Unstageable – Suspected deep tissue injury in evolution.	<input type="text"/>

(M1320) Status of Most Problematic Pressure Ulcer that is Observable: (Excludes pressure ulcer that cannot be observed due to a non-removable dressing/device)

Enter Code	<input type="text"/>	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing NA No observable pressure ulcer
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(M1322) Current Number of Stage 1 Pressure Ulcers: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer, or cooler as compared to adjacent tissue. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.

Enter Code	<input type="text"/>	0 1 2 3 4 or more
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(M1324) Stage of Most Problematic Unhealed Pressure Ulcer that is Stageable: (Excludes pressure ulcer that cannot be staged due to a non-removable dressing/device, coverage of wound bed by slough and/or eschar, or suspected deep tissue injury.)

Enter Code	<input type="text"/>	1 Stage 1 2 Stage 2 3 Stage 3 4 Stage 4 NA Patient has no pressure ulcers or no stageable pressure ulcers
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(M1330) Does this patient have a Stasis Ulcer?

Enter Code	<input type="text"/>	0 No [<i>Go to M1340</i>] 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) [<i>Go to M1340</i>]
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(M1332) Current Number of Stasis Ulcer(s) that are Observable:	
Enter Code <input type="checkbox"/>	1 One 2 Two 3 Three 4 Four or more
(M1334) Status of Most Problematic Stasis Ulcer that is Observable:	
Enter Code <input type="checkbox"/>	1 Fully granulating 2 Early/partial granulation 3 Not healing
(M1340) Does this patient have a Surgical Wound?	
Enter Code <input type="checkbox"/>	0 No [<i>At SOC/ROC, go to M1350 ; At FU//DC, go to M1400</i>] 1 Yes, patient has at least one observable surgical wound 2 Surgical wound known but not observable due to non-removable dressing/device [<i>At SOC/ROC, go to M1350 ; At FU//DC, go to M1400</i>]
(M1342) Status of Most Problematic Surgical Wound that is Observable	
Enter Code <input type="checkbox"/>	0 Newly epithelialized 1 Fully granulating 2 Early/partial granulation 3 Not healing
(M1350) Does this patient have a Skin Lesion or Open Wound (excluding bowel ostomy), other than those described above, that is receiving intervention by the home health agency?	
Enter Code <input type="checkbox"/>	0 No 1 Yes

Section GG: FUNCTIONAL ABILITIES and GOALS – SOC/ROC

(GG0170C) Mobility						
<p>Code the patient's usual performance at the SOC/ROC using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason.</p> <p>Code the patient's discharge goal using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal.</p>						
<p>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. <i>Activity may be completed with or without assistive devices.</i></p> <p>06 Independent – Patient completes the activity by him/herself with no assistance from a helper.</p> <p>05 Setup or clean-up assistance – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity.</p> <p>04 Supervision or touching assistance – Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>If activity was not attempted, code reason:</p> <p>07 Patient refused</p> <p>09 Not applicable</p> <p>88 Not attempted due to medical condition or safety concerns</p>	<p>1. SOC/ROC Performance</p>	<p>2. Discharge Goal</p>				
	<p>↓Enter Codes in Boxes↓</p>		<p>Lying to Sitting on Side of Bed: The ability to safely 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.</p>			
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