

INDEX--RAI Version 2.0 Manual

<i>Accidents</i>	<i>MDS, J-4</i>	<i>3--145</i>
<i>Accuracy,RAI</i>		<i>1-25</i>
<i>Triggering RAPs</i>		<i>Appendix C</i>
<i>Activities of Daily Living,</i>		
<i>Function, change in</i>	<i>MDS, G-9</i>	<i>3-117</i>
<i>Self Performance</i>	<i>MDS, G(1) (A)</i>	<i>3-76</i>
<i>Scoring ADL Self Performance</i>		<i>3-80</i>
<i>Support Provided</i>	<i>MDS, G(1) (B)</i>	<i>3-91</i>
<i>Activities,</i>		
<i>General Preferences</i>	<i>MDS, N-4</i>	<i>3-173</i>
<i>Pursuit Patterns</i>	<i>MDS N</i>	<i>3-169</i>
<i>Setting Preference</i>	<i>MDS N-3</i>	<i>3-172</i>
<i>Admitted From, at Entry</i>	<i>MDS, AB-2</i>	<i>3-13</i>
<i>Advanced Directives</i>	<i>MDS, A-10</i>	<i>3-37</i>
<i>Annual Reassessment, Timing</i>		<i>2-5</i>
<i>Anxiety, (Depression, Sad Mood)</i>	<i>MDS, E-1</i>	<i>3-61</i>
<i>Appliances and Programs,</i>		
<i>Continence</i>	<i>MDS, H-3</i>	<i>3-124</i>
<i>Applicability of RAI to Facility Resident</i>		<i>1-14</i>
<i>Assessment,</i>		
<i>Information</i>	<i>MDS, R</i>	<i>3-210</i>
<i>Participation in</i>	<i>MDS, R-1</i>	<i>3-210</i>
<i>Problem Identification Model</i>		<i>1-2</i>
<i>Reference Date</i>	<i>MDS, A-3</i>	<i>3-29</i>
<i>Return Stay/Readmission</i>		<i>2-15</i>
<i>Timing</i>		<i>2-3</i>
<i>Type</i>		<i>2-5</i>
<i>Avoidable Decline</i>		<i>4-29</i>
<i>Background Information,</i>		
<i>Date Complete</i>	<i>MDS, AB-11</i>	<i>3-21</i>
<i>Face Sheet</i>	<i>MDS, (AB), (AC), (AD)</i>	<i>3-12</i>
<i>Balance, Test for</i>	<i>MDS, G-3</i>	<i>3-102</i>
<i>Bathing</i>	<i>MDS, G-2</i>	<i>3-100</i>
<i>Behavior Intervention Program</i>	<i>MDS, P-2</i>	<i>3-190</i>
<i>Behavioral Symptoms,</i>	<i>MDS, E-4</i>	<i>3-66</i>
<i>Change in Behavior Symptoms</i>	<i>MDS, E-5</i>	<i>3-69</i>
<i>Birthdate</i>	<i>MDS, AA-3</i>	<i>3-6</i>
<i>Bowel Elimination Pattern</i>	<i>MDS, H-2</i>	<i>3-122</i>
<i>Broad Screen Triggers</i>		<i>4-8</i>

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

<i>Conditions,</i>		
<i>Problem</i>	<i>MDS, I-1</i>	3-127
<i>Stability of</i>	<i>MDS, J-5</i>	3-147
<i>Confidentiality of Records</i>		1-9
<i>Continence,</i>		
<i>Appliances and Programs</i>	<i>MDS, H-3</i>	3-124
<i>Self Control Categories</i>	<i>MDS, H-1</i>	3-119
<i>Coordinator, RN</i>		1-17
<i>Copy, Paper</i>		1-27
<i>Corrections, of MDS</i>		1-26
<i>Current Payment Source</i>	<i>MDS, A-7</i>	3-33
<i>Customary Routine</i>	<i>MDS, AC-1</i>	3-22
<i>Daily Routine, Preference for change in</i>	<i>MDS, N-5</i>	3-175
<i>Date of Entry</i>	<i>MDS, AB-1</i>	3-12
<i>Date of Reentry</i>	<i>MDS, A-4</i>	3-31
<i>Decision-making,</i>		
<i>Based on RAP Review</i>		4-10
<i>Problem Solving Model (Step2)</i>		4-9
<i>Delirium, Indicators of</i>	<i>MDS, B-5</i>	3-47
<i>Demographic Information</i>	<i>MDS, AB</i>	3-12
<i>Dental Status</i>	<i>MDS, L-1</i>	3-158
<i>Depression (Anxiety, Sad Mood)</i>	<i>MDS, E-1</i>	3-61
<i>Devices and Restraints</i>	<i>MDS, P-4</i>	3-198
<i>Direct Care Staff,</i>		
<i>Care Planning Process</i>		4-26
<i>MDS Information source</i>		1-21
<i>Care Planning</i>		4-26
<i>Overall Status</i>	<i>MDS, Q</i>	3-207
<i>Discharge Tracking Form</i>		1-29
<i>Diseases</i>	<i>MDS, I-1</i>	3--127
<i>Education</i>	<i>MDS, AB7</i>	3-18
<i>Electronic Clinical Record</i>		1-27
<i>Emergency Room Visits</i>	<i>MDS, P-6</i>	3-203
<i>Enteral Intake</i>	<i>MDS, K-6</i>	3-154
<i>Evaluation,</i>		
<i>Care Plan</i>		4-30
<i>Problem Solving Model</i>		1-2
<i>Expression, Modes of</i>	<i>MDS, C-3</i>	3-53
<i>Face Sheet</i>	<i>MDS, AB, AC, AD</i>	3-12
<i>Face Sheet Signatures</i>	<i>MDS, AD</i>	3-27
<i>Facility Provider Number</i>	<i>MDS, AA-6</i>	3-8

<i>Family,</i>		
<i>Care Planning Process</i>		4-31
<i>Communication as MDS source</i>		1-19
<i>Federal Regulation, Timing of Assessments</i>		1-7,24
<i>Federal Requirements</i>		Appendix G
<i>Foot Problems and Care</i>	<i>MDS, M-6</i>	3-168
<i>Forms, Mandated</i>		1-29
<i>F-Tags, Care Planning</i>		4-29
<i>Functional,</i>		
<i>Assessment</i>	<i>MDS, A-R</i>	3-28
<i>Care Plan Category</i>		4-33
<i>Status, Decline in</i>		4-29
<i>Gender</i>	<i>MDS, AA-2</i>	3-6
<i>Goals, Care Plan</i>		4-2
<i>Guardian, Legal</i>	<i>MDS, A-9</i>	3-36
<i>Guidelines, RAP Section III</i>		4-3
<i>Health Conditions</i>	<i>MDS, J</i>	3-138
<i>Health Maintenance</i>		4-18
<i>Hearing</i>	<i>MDS, C-1</i>	3-51
<i>Height (Weight)</i>	<i>MDS, K-2</i>	3-150
<i>Change</i>		3-150
<i>Holistic Approach, Interdisciplinary Team</i>		1-1
<i>Hospice Resident, RAI Applicability</i>		1-15
<i>Hospital Stay(s)</i>	<i>MDS, P-5</i>	3-202
<i>ICD-9-CM Codes</i>	<i>MDS, I-1</i>	3-130
<i>Identification Information</i>	<i>MDS, AA</i>	3-6
<i>Implementation of Care Plan,</i>		
<i>Problem Solving</i>		4-26
<i>Infections</i>	<i>MDS, I-2</i>	3-135
<i>Initiative/Involvement</i>	<i>MDS, F-1</i>	3-71
<i>Injections</i>	<i>MDS, O-3</i>	3-178
<i>Institute of Medicine</i>		1-3
<i>Interdisciplinary, Team</i>		
<i>Assessment Process</i>		1-6, 17
<i>Care Planning</i>		4-1, 4
<i>Intervention Programs,</i>		
<i>Mood, Behavior, Cognitive Loss</i>	<i>MDS, P-2</i>	3-190
<i>Interviewing Resident, Guidelines</i>		Appendix D

<i>Key-RAP Key Section IV</i>	<i>Appendix C</i>	<i>4-4</i>
<i>Lab Values, Abnormal</i>	<i>MDS, P-9</i>	<i>3-206</i>
<i>Legal Guardian</i>	<i>MDS, A-9</i>	<i>3-36</i>
<i>Language</i>	<i>MDS, AB-8</i>	<i>3-19</i>
<i>Lesions</i>	<i>MDS, M-4</i>	<i>3-165</i>
<i>Licensed Professionals, as MDS source</i>		<i>1-19</i>
<i>Linkage of MDS/Care Plan</i>		<i>4-2</i>
<i>Lived Alone</i>	<i>MDS, AB-3</i>	<i>3-15</i>
<i>Locomotion, Modes of</i>	<i>MDS, G-5</i>	<i>3-111</i>
<i>Maintenance of Records</i>		<i>1-27</i>
<i>Making Self Understood</i>	<i>MDS, C-4</i>	<i>3-54</i>
<i>Mandated Assessment and Associated Forms</i>		<i>1-7</i>
<i>Manual, Suggestions for use</i>		<i>1-6</i>
<i>Marital Status</i>	<i>MDS, A-5</i>	<i>3-33</i>
<i>Medicaid number</i>	<i>MDS, AA-7</i>	<i>3-8</i>
<i>Medical Record Number</i>	<i>MDS, A-6</i>	<i>3-33</i>
<i>Medication,</i>		
<i>Care Plan Category</i>		<i>4-43</i>
<i>Days Received</i>	<i>MDS, O-4</i>	<i>3-179</i>
<i>New</i>	<i>MDS, O-2</i>	<i>3-178</i>
<i>Number</i>	<i>MDS, O-1</i>	<i>3-176</i>
<i>Memory</i>	<i>MDS, B-2</i>	<i>3-43</i>
<i>Memory/Recall Ability</i>	<i>MDS, B-3</i>	<i>3-45</i>
<i>Mental Health History</i>	<i>MDS, AB-9</i>	<i>3-20</i>
<i>Mental Retardation (MR/DD Status)</i>	<i>MDS, AB-10</i>	<i>3-20</i>
<i>Minimum Data Set (MDS)</i>		
<i>Additional Uses</i>		<i>1-4</i>
<i>Component of Comprehensive Assessment</i>		<i>1-11</i>
<i>Component of RAI</i>		<i>1-2</i>
<i>Definition of MDS</i>		<i>174</i>
<i>Familiarizing Self with MDS</i>		<i>3-2</i>
<i>Forms</i>		<i>Chapter 1</i>
<i>Sections,</i>		
<i>AA. Identification Information</i>		<i>3-6</i>
<i>AB. Demographic Information</i>		<i>3-12</i>
<i>AC. Customary Routine</i>		<i>3-22</i>
<i>AD. Face Sheet Signatures</i>		<i>3-27</i>
<i>A. Identification/Background Information</i>		<i>3-28</i>
<i>B. Cognitive Patterns</i>		<i>3-41</i>
<i>C. Communication/Hearing</i>		<i>3-51</i>
<i>D. Vision Patterns</i>		<i>3-58</i>
<i>E. Mood and Behavior Patterns</i>		<i>3-60</i>
<i>F. Psychosocial Well-Being</i>		<i>3-71</i>

<i>G. Physical Function/Structural Problems</i>		3-76
<i>H. Continence in Last 14 Days</i>		3-119
<i>I. Disease Diagnoses</i>		3-127
<i>J. Health Conditions</i>		3-138
<i>K. Oral/Nutritional Status</i>		3-149
<i>L. Oral/Dental Status</i>		3-158
<i>M. Skin Condition</i>		3-159
<i>N. Activity Pursuit Patterns</i>		3-169
<i>O. Medications</i>		3-176
<i>P. Special Treatments and Procedures</i>		3-182
<i>Q. Discharge Potential/Overall Status</i>		3-207
<i>R. Assessment Information</i>		3-210
<i>S. State Defined Section</i>		3-214
<i>T. Supplemental Items for</i>	<i>MDS 2.0/</i>	
<i>Case Mix and Quality Demonstration States</i>		3-214
<i>U. Medications (NHCMQ)</i>		3-223
<i>MDS, Supplemental Items Section S, T</i>		3-214
<i>Modes of Expression</i>	<i>MDS, C-3</i>	3-53
<i>Mood,</i>		
<i>Change in</i>	<i>MDS, E-3</i>	3-64
<i>Intervention Program</i>	<i>MDS, P-2</i>	3-190
<i>Persistence</i>	<i>MDS, E-2</i>	3-64
<i>Sad (Depression, Anxiety)</i>	<i>MDS, E-1</i>	3-61
<i>Needs, Overall Change in Care</i>	<i>MDS, Q-2</i>	3-209
<i>Non-Certified Units, RAI Applicability</i>		1-16
<i>Nursing Rehabilitation/Restorative Care</i>	<i>MDS, P-3</i>	3-191
<i>Nutritional Approaches</i>	<i>MDS, K-5</i>	3-153
<i>Nutritional Problems</i>	<i>MDS, K-4</i>	3-152
<i>OBRA 1987</i>		<i>Preface 1</i>
<i>Observation of Resident as MDS source</i>		1-21
<i>Occupation, Lifetime</i>	<i>MDS, AB-6</i>	3-18
<i>Oral/Nutritional Status</i>	<i>MDS, K</i>	3-149
<i>Oral Problems</i>	<i>MDS, K-1</i>	3-149
<i>Pain,</i>		
<i>Site</i>	<i>MDS, I-3</i>	3-144
<i>Symptoms</i>	<i>MDS, I-2</i>	3-140
<i>Parental/Enteral Intake</i>	<i>MDS, K-6</i>	3-154
<i>Pediatric Resident, RAI Applicability</i>		1-15

<i>Physician,</i>		
<i>Orders</i>	<i>MDS, P-8</i>	3-205
<i>Participation in RAI</i>		1-18
<i>Source for MDS</i>		1-18
<i>Visits</i>	<i>MDS, P-7</i>	3-204
<i>Potential Problem, Type of Trigger</i>		4-8
<i>Prevention of Problems Type of Trigger</i>		4-8
<i>Problem, RAP Section I</i>		4-3
<i>Problem Solving Identification,</i>		
<i>Model</i>		1-2
<i>Process</i>		1-2
<i>Nursing Process</i>		1-1
<i>Resident Assessment Instrument</i>		1-1
<i>Provider Number</i>	<i>MDS, AA-6</i>	3-8
<i>Quarterly Assessment (Review),</i>		
<i>Definition</i>		2-15
<i>Form-Optional</i>		Chapter 1
<i>Form-Standard</i>		Chapter 1
<i>Key Mandated Items</i>		2-15
<i>Timing</i>		2-2
<i>Race/Ethnicity</i>	<i>MDS, AA-4</i>	3-6
<i>Range of Motion,</i>		
<i>Functional Limitation</i>	<i>MDS, G4-(A)</i>	3-107
<i>Loss of Voluntary Movement</i>	<i>MDS, G4-(B)</i>	3-110
<i>Readmission Assessment</i>		2-27
<i>Reason for Assessment</i>	<i>MDS, AA-8</i>	3-9
	<i>MDS, A-8</i>	3-34
<i>Record,</i>		
<i>Maintenance of MDS in Record</i>		1-27
<i>Record as Source of Information</i>		1-19
<i>Reentry,</i>		
<i>Information, minimum</i>		2-26
<i>Tracking form</i>		2-23
<i>Refusal of Services/Treatment</i>		4-30
<i>Regulatory, Basis for RAI</i>		1-7, Appendix G
<i>Rehabilitation Potential,</i>		
<i>ADL Function</i>	<i>MDS, G-8</i>	3-115
<i>Type of Trigger</i>		4-9
<i>Rehabilitation/Restorative Nursing,</i>	<i>MDS, P-3</i>	3-191
<i>Relationships, unsettled</i>	<i>MDS, F-2</i>	3-73
<i>Reproducible, Assessment</i>		1-7
<i>Reproduction, of the RAI</i>		1-27

<i>Resident,</i>		
<i>Individualized Care</i>		1-2
<i>Holistic View</i>		4-27
<i>Name</i>	<i>MDS, AA</i>	3-6
<i>Name</i>	<i>MDS, A-1</i>	3-28
<i>Representative, care planning team</i>		3-7
<i>Strengths, care plan</i>		4-31
<i>Resident Assessment Instrument (RAI)</i>		
<i>Applicability to Facility Residents</i>		4-30
<i>Components</i>		1-3
<i>Process, understanding</i>		1-2
<i>Regulatory Basis</i>		1-7
<i>System</i>		5-1
<i>Resident Assessment Protocols (RAPs),</i>		
<i>Care Plan Linkage</i>		4-1
<i>Completion with each full assessment</i>		4-1
<i>Component of Comprehensive Assessment</i>		4-1
<i>Component of RAI</i>		1-4
<i>Decision Facilitators</i>		4-2
<i>Definition</i>		1-4
<i>Documentation of RAP Findings</i>		4-10
<i>List of 18 RAPs</i>		4-4
<i>Organization</i>		4-3
<i>Process, Steps</i>		4-4
<i>Steps</i>		4-5
<i>Summary Form</i>		Appendix C
<i>Timing for Completion</i>		2-21
<i>Resident Assessment Protocol Summary Form,</i>		
<i>Care Plan Decision</i>		4-5
<i>Component of Comprehensive Assessment</i>		2-2
<i>Location and Date/</i>		
<i>RAP Assessment Documentation</i>		4-10
<i>Trigger Identification</i>		4-3, Appendix C
<i>Residential History</i>	<i>MDS, AB-5</i>	3-17
<i>Respite Resident-RAI Applicability</i>		115-4
<i>Responsibility/Legal Guardian</i>	<i>MDS, A-9</i>	3-36
<i>Restraints and Devices</i>	<i>MDS, P-4</i>	3-198
<i>RN Coordinator, Certification of Completeness</i>		1-18
<i>Roles, past</i>	<i>MDS, F-3</i>	3-75
<i>Room Number</i>	<i>MDS, A-2</i>	3-28
<i>Routine, Daily</i>		
<i>Preference for Change</i>	<i>MDS, N-5</i>	3-175

<i>Short-Term Resident, RAI Applicability</i>		1-15
<i>Signatures,</i>		
<i>Accuracy/Completeness</i>		1-25
<i>MDS Portions</i>		1-25
<i>MDS Section AA-9</i>		3-11
<i>Others Completing MDS</i>	<i>MDS, AD(b-g)</i>	3-28
<i>Persons Completing Assessment</i>	<i>MDS, R-2</i>	3-217
<i>RN Coordinator</i>	<i>MDS, AD(a)</i>	3-27
<i>Significant Change in Status Assessment,</i>		
<i>Additional Comments</i>		3-9
<i>Condition when <u>not</u> required</i>		2-10
<i>Decline</i>		2-8
<i>Definition</i>		2-7
<i>Guidelines for Determination</i>		2-9
<i>Improvement</i>		2-9
<i>Timing</i>		2-12
<i>Skin,</i>		
<i>Problems</i>	<i>MDS, M-4</i>	3-165
<i>Treatments</i>	<i>MDS, M-5</i>	3-167
<i>Speech Clarity</i>	<i>MDS, C-5</i>	3-55
<i>Social Security and Medicare Numbers</i>	<i>MDS, AA-5</i>	3-7
<i>Sources of Information, Completion of MDS</i>		1-1
<i>Standardized Assessment</i>		1-3
<i>State Agency Contacts</i>		<i>Appendix B</i>
<i>State Operations Manual</i>		1-4, 1-78
<i>State RAIs, CMS Approval</i>		1-8
<i>Statutory Authority for RAI</i>		1-7, <i>Appendix G</i>
<i>Swing Bed, RAI Applicability</i>		1-16
<i>Task Segmentation</i>	<i>MDS, G-7</i>	3-113
<i>Therapies,</i>	<i>MDS, P1b</i>	3-185
<i>Ordered</i>	<i>MDS, T-1(b)</i>	3-215
<i>Recreation</i>	<i>MDS, T-1(a)</i>	3-214
<i>Time,</i>		
<i>Awake</i>	<i>MDS, N-1</i>	3-170
<i>Involved in Activities</i>	<i>MDS, N-2</i>	3-171
<i>Timing (Timeframes) of Assessments</i>		1-11
<i>Tracking Form-Basic Assessment</i>		2-23
<i>Transfer, Modes of</i>	<i>MDS, G-6</i>	3-112
<i>Treatments,</i>		
<i>Special Procedures and Programs</i>	<i>MDS, P-1</i>	3-182
<i>Trigger Legend,</i>		
<i>Instructions for Use</i>		4-6
<i>Key</i>		4-6, <i>Appendix C</i>

<i>Triggers,</i>		
<i>Component of Comprehensive Assessment</i>		4-1
<i>Definitions--Location</i>		4-6
<i>RAP- Section IV</i>		4-3
<i>Types</i>		4-6
<i>Ulcer, Cause</i>	<i>MDS, M-1</i>	3-159
<i>History of Resolved, Cured</i>	<i>MDS, M-3</i>	3-165
<i>Type</i>	<i>MDS, M-2</i>	3-161
<i>Understand, others</i>	<i>MDS, C-6</i>	3-55
<i>Understood, making self</i>	<i>MDS, C-4</i>	3-54
<i>Urinary, Continence, change in</i>	<i>MDS, H-4</i>	3-126
<i>Utilization Guidelines,</i>		
<i>Component of Comprehensive Assessment</i>		4-1
<i>Component of RAI</i>		1-14
<i>Vision</i>	<i>MDS, D-1</i>	3-58
<i>Visual,</i>		
<i>Appliances</i>	<i>MDS, D-3</i>	3-60
<i>Limitation/Difficulties</i>	<i>MDS, D-2</i>	3-59
<i>Walking, when most self sufficient</i>	<i>MDS, T-2</i>	3-218
<i>Weight, (Height)</i>	<i>MDS, K-2</i>	3-150
<i>Change</i>	<i>MDS, K-3</i>	3-150
<i>Zip Code</i>	<i>MDS, AB-4</i>	3-16