
CHAPTER 43
(RESERVED)

Authority

N.J.S.A. 26:2H-1 et seq., specifically as amended by P.L. 1998, c.43.

Chapter Historical Note

Chapter 43, Boarding Homes for Sheltered Care, was adopted as R.1974 d.319, effective November 19, 1974. See: 6 N.J.R. 396(c), 6 N.J.R. 472(e). Chapter 43 was renamed Residential Health Care Facilities by R.1980 d.366, effective August 8, 1980. See: 12 N.J.R. 394(b), 12 N.J.R. 518(d).

Pursuant to Executive Order No. 66(1978), Chapter 43, Residential Health Care Facilities, was readopted as R.1990 d.568, effective October 24, 1990. See: 22 N.J.R. 2499(a), 22 N.J.R. 3581(a).

Pursuant to Executive Order No. 66(1978), Chapter 43, Residential Health Care Facilities, was readopted as R.1992 d.502, effective November 19, 1992. See: 24 N.J.R. 2506(a), 25 N.J.R. 109(a).

Chapter 43, Residential Health Care Facilities, was repealed and Chapter 43, Standards for Licensure of Residential Health Care Facilities, was adopted as new rules by R.1993 d.473, effective October 4, 1993 (operative February 12, 1994). See: 25 N.J.R. 25(a), 25 N.J.R. 4631(a). Pursuant to Executive Order No. 66(1978), Chapter 43 expired on October 4, 1998.

Chapter 43, Standards for Licensure of Residential Health Care Facilities, was adopted as new rules by R.1998 d.579, effective December 7, 1998. See: 30 N.J.R. 3633(a), 30 N.J.R. 4221(b). Chapter 43, Standards for Licensure of Residential Health Care Facilities, expired on December 7, 2003.



APPENDIX C

Numeric Identifier _____

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

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1. RESIDENT NAME [Ⓞ]	_____			
	a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)
2. GENDER [Ⓞ]	1. Male 2. Female			
3. BIRTHDATE [Ⓞ]	<input type="text"/> — <input type="text"/> — <input type="text"/>			
	Month	Day	Year	
4. RACE/ [Ⓞ] ETHNICITY	1. American Indian/Alaskan Native		4. Hispanic	
	2. Asian/Pacific Islander		5. White, not of Hispanic origin	
5. SOCIAL SECURITY AND MEDICARE NUMBERS [Ⓞ] [C in 1 st box if non med. no.]	a. Social Security Number			
	<input type="text"/> — <input type="text"/> — <input type="text"/>			
	b. Medicare number (or comparable railroad insurance number)			
6. FACILITY PROVIDER NO. [Ⓞ]	a. State No.			
	<input type="text"/>			
7. MEDICAID NO. (* if pending, "N" if not a Medicaid recipient) [Ⓞ]	b. Federal No.			
	<input type="text"/>			
8. REASONS FOR ASSESSMENT	[Note—Other codes do not apply to this form]			
	a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior assessment 5. Quarterly review assessment 6. NONE OF ABOVE b. Special codes for use with supplemental assessment types in Case Mix demonstration states or other states where required 1. 5 day assessment 2. 30 day assessment 3. 60 day assessment 4. Quarterly assessment using full MDS form 5. Readmission/return assessment 6. Other state required assessment			
9. SIGNATURES OF PERSONS COMPLETING THESE ITEMS:				
a. Signatures	Title	Date		
b.		Date		

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

Ⓞ = Key items for computerized resident tracking

= When box blank, must enter number or letter = When letter in box, check if condition applies

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

(Status in last 7 days, unless other time frame indicated)

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2. ROOM NUMBER	
3. ASSESSMENT REFERENCE DATE	a. Last day of MDS observation period [] [] - [] [] - [] [] [] [] Month Day Year b. Original (O) or corrected copy of form (enter number of correction)
4a. DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) [] [] - [] [] - [] [] [] [] Month Day Year
5. MARITAL STATUS	1. Never married 3. Widowed 5. Divorced 2. Married 4. Separated
6. MEDICAL RECORD NO.	
7. CURRENT PAYMENT SOURCES FOR N.H. STAY	(Billing Office to indicate; check all that apply in last 30 days) Medicaid per diem VA per diem Medicare per diem Self or family pays for full per diem Medicare ancillary part A Medicaid resident liability or Medicare co-payment Medicare ancillary part B Private insurance per diem (including co-payment) CHAMPUS per diem Other per diem
8. REASONS FOR ASSESSMENT	a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior assessment 5. Quarterly review assessment 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment 9. Reentry 0. NONE OF ABOVE b. Special codes for use with supplemental assessment types in Case Mix demonstration states or other states where required 1. 5 day assessment 2. 30 day assessment 3. 60 day assessment 4. Quarterly assessment using full MDS form 5. Readmission/return assessment 6. Other state required assessment
9. RESPONSIBILITY/LEGAL GUARDIAN	(Check all that apply) Durable power attorney/financial Legal guardian a. Family member responsible Other legal oversight b. Patient responsible for self Durable power of attorney/health care c. NONE OF ABOVE
10. ADVANCED DIRECTIVES	(For those items with supporting documentation in the medical record, check all that apply) Living will a. Feeding restrictions Do not resuscitate b. Medication restrictions Do not hospitalize c. Other treatment restrictions Organ donation d. NONE OF ABOVE Autopsy request e.

SECTION B. COGNITIVE PATTERNS

1. COMATOSE	(Persistent vegetative state/no discernible consciousness) 0. No 1. Yes (If yes, skip to Section G)
2. MEMORY	(Recall of what was learned or known) a. Short-term memory OK—seems/appears to recall after 5 minutes 0. Memory OK 1. Memory problem b. Long-term memory OK—seems/appears to recall long past 0. Memory OK 1. Memory problem

3. MEMORY/RECALL ABILITY	(Check all that resident was normally able to recall during last 7 days) Current season a. That he/she is in a nursing home Location of own room b. NONE OF ABOVE are recalled Staff names/faces c.
4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING	(Made decisions regarding tasks of daily life) 0. INDEPENDENT—decisions consistent/reasonable 1. MODIFIED INDEPENDENCE—some difficulty in new situations only 2. MODERATELY IMPAIRED—decisions poor; cues/supervision required 3. SEVERELY IMPAIRED—never/rarely made decisions
5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/AWARENESS	(Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time]. 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening) a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked) b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out) e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)
6. CHANGE IN COGNITIVE STATUS	Resident's cognitive status, skills, or abilities have changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING	(With hearing appliance, if used) 0. HEARS ADEQUATELY—normal talk, TV, phone 1. MINIMAL DIFFICULTY when not in quiet setting 2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tonal quality and speak distinctly 3. HIGHLY IMPAIRED/absence of useful hearing
2. COMMUNICATION DEVICES/TECHNIQUES	(Check all that apply during last 7 days) Hearing aid, present and used Hearing aid, present and not used regularly Other receptive comm. techniques used (e.g., lip reading) NONE OF ABOVE
3. MODES OF EXPRESSION	(Check all used by resident to make needs known) Speech a. Signs/gestures/sounds Writing messages to express or clarify needs b. Communication board American sign language or Braille c. Other NONE OF ABOVE
4. MAKING SELF UNDERSTOOD	(Expressing information content—however able) 0. UNDERSTOOD 1. USUALLY UNDERSTOOD—difficulty finding words or finishing thoughts 2. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests 3. RARELY/NEVER UNDERSTOOD
5. SPEECH CLARITY	(Code for speech in the last 7 days) 0. CLEAR SPEECH—distinct, intelligible words 1. UNCLEAR SPEECH—sturred, mumbled words 2. NO SPEECH—absence of spoken words
6. ABILITY TO UNDERSTAND OTHERS	(Understanding verbal information content—however able) 0. UNDERSTANDS 1. USUALLY UNDERSTANDS—may miss some pertinent of message 2. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication 3. RARELY/NEVER UNDERSTANDS
7. CHANGE IN COMMUNICATION/HEARING	Resident's ability to express, understand, or hear information has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

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

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SECTION D. VISION PATTERNS

1. VISION	(Ability to see in adequate light and with glasses if used) 0. ADEQUATE —sees fine detail, including regular print in newspapers/books 1. IMPAIRED —sees large print, but not regular print in newspapers/books 2. MODERATELY IMPAIRED —limited vision; not able to see newspaper headlines, but can identify objects 3. HIGHLY IMPAIRED —object identification in question, but eyes appear to follow objects 4. SEVERELY IMPAIRED —no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
2. VISUAL LIMITATIONS/DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self) Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes NONE OF ABOVE	a. b. c.
3. VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	(Code for indicators observed in last 30 days, irrespective of the assumed cause) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week) VERBAL EXPRESSIONS OF DISTRESS a. Resident made negative statements—e.g., "Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die" b. Repetitive questions—e.g., "Where do I go; What do I do?" c. Repetitive verbalizations—e.g., calling out for help, ("God help me") d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received e. Self deprecation—e.g., "I am nothing; I am of no use to anyone" f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack SLEEP-CYCLE ISSUES j. Unpleasant mood in morning k. Insomnia/change in usual sleep pattern SAD, APATHETIC, ANXIOUS APPEARANCE l. Sad, pained, worried facial expressions—e.g., furrowed brows m. Crying, tearfulness n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking LOSS OF INTEREST o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends p. Reduced social interaction h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance regarding schedules, meals, laundry, clothing, relationship issues	
2. MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	
3. CHANGE IN MOOD	Resident's mood status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	
4. BEHAVIORAL SYMPTOMS	(A) Behavioral symptom frequency in last 7 days 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) Behavioral symptom alterability in last 7 days 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety) b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at) c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused) d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disturbing in public, smeared/throw food/feces, hoarding, rummaged through others' belongings) e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)	(A) (B)

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

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

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE—(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)	0. INDEPENDENT —No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days 1. SUPERVISION —Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days 2. LIMITED ASSISTANCE —Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days 3. EXTENSIVE ASSISTANCE —While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times: —Weight-bearing support —Full staff performance during part (but not all) of last 7 days 4. TOTAL DEPENDENCE —Full staff performance of activity during entire 7 days 8. ACTIVITY DID NOT OCCUR during entire 7 days	(A) (B)
(B) ADL SUPPORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)	0. No setup or physical help from staff 1. Setup help only 2. One person physical assist 3. Two+ persons physical assist 8. ADL activity itself did not occur during entire 7 days	SELF-PERF SUPPORT
a. BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed	
b. TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)	
c. WALK IN ROOM	How resident walks between locations in his/her room	
d. WALK IN CORRIDOR	How resident walks in corridor on unit	
e. LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	
f. LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	
g. DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis	
h. EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	
i. TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes	
j. PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)	

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Resident	
2. BATHING	How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) <i>Code for most dependent in self-performance and support.</i> (A) BATHING SELF-PERFORMANCE codes appear below 0. Independent—No help provided 1. Supervision—Oversight help only 2. Physical help limited to transfer only 3. Physical help in part of bathing activity 4. Total dependence 8. Activity itself did not occur during entire 7 days (Bathing support codes are as defined in Item 1, code B above)
3. TEST FOR BALANCE (see training manual)	(Code for ability during test in the last 7 days) 0. Maintained position as required in test 1. Unsteady, but able to rebalance self without physical support 2. Partial physical support during test; or stands (sits) but does not follow directions for test 3. Not able to attempt test without physical help a. Balance while standing b. Balance while sitting—position, trunk control
4. FUNCTIONAL LIMITATION IN RANGE OF MOTION (see training manual)	(Code for limitations during last 7 days that interfered with daily functions or placed resident at risk of injury) (A) RANGE OF MOTION (B) VOLUNTARY MOVEMENT 0. No limitation 1. Limitation on one side 2. Limitation on both sides a. Neck b. Arm—including shoulder or elbow c. Hand—including wrist or fingers d. Leg—including hip or knee e. Foot—including ankle or toes f. Other limitation or loss
5. MODES OF LOCOMOTION	(Check all that apply during last 7 days) Cane/walker/crutch Wheeled self Other person wheeled a. Wheelchair primary mode of locomotion b. NONE OF ABOVE
6. MODES OF TRANSFER	(Check all that apply during last 7 days) Bed/lift all or most of time Bed rails used for bed mobility or transfer Lifted manually a. Lifted mechanically b. Transfer aid (e.g., slide board, trapeze, cane, walker, brace) c. NONE OF ABOVE
TASK SEGMENTATION	Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them 0. No 1. Yes
8. ADL FUNCTIONAL REHABILITATION POTENTIAL	Resident believes he/she is capable of increased independence in at least some ADLs Direct care staff believe resident is capable of increased independence in at least some ADLs Resident able to perform tasks/activity but is very slow Difference in ADL Self-Performance or ADL Support, comparing mornings to evenings NONE OF ABOVE
9. CHANGE IN ADL FUNCTION	Resident's ADL self-performance status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

SECTION H. CONTINENCE IN LAST 14 DAYS

1. CONTINENCE SELF-CONTROL CATEGORIES (Code for resident's PERFORMANCE OVER ALL SHIFTS)	0. CONTINENT—Complete control (includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool) 1. USUALLY CONTINENT—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly 2. OCCASIONALLY INCONTINENT—BLADDER, 2 or more times a week but not daily; BOWEL, once a week 3. FREQUENTLY INCONTINENT—BLADDER, tended to be incontinent daily, but some control present (e.g., on day shift); BOWEL, 2-3 times a week 4. INCONTINENT—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time
a. BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed
b. BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., Foley) or continence programs, if employed
BOWEL ELIMINATION PATTERN	Bowel elimination pattern regular—at least one movement every three days a. Diarrhea b. Fecal impaction c. NONE OF ABOVE

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3. APPLIANCES AND PROGRAMS	Any scheduled toileting plan Bladder retraining program External (condom) catheter Indwelling catheter Intermittent catheter a. Did not use toilet room/commode/urinal b. Pads/briefs used c. Enemas/irrigation d. Ostomy present e. NONE OF ABOVE
4. CHANGE IN URINARY CONTINENCE	Resident's urinary continence has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated

SECTION I. DISEASE DIAGNOSES

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

1. DISEASES (If none apply, CHECK the NONE OF ABOVE box)	ENDOCRINE/METABOLIC/NUTRITIONAL Diabetes mellitus Hyperthyroidism Hypothyroidism HEART/CIRCULATION Arteriosclerotic heart disease (ASHD) Cardiac dysrhythmias Congestive heart failure Deep vein thrombosis Hypertension Hypotension Peripheral vascular disease Other cardiovascular disease MUSCULOSKELETAL Arthritis Hip fracture Missing limb (e.g., amputation) Osteoporosis Pathological bone fracture NEUROLOGICAL Alzheimer's disease Aphasia Cerebral palsy Cerebrovascular accident (stroke) Dementia other than Alzheimer's disease Hemiplegia/Hemiparesis Multiple sclerosis Paraplegia Parkinson's disease Quadriplegia Seizure disorder Transient ischemic attack (TIA) Traumatic brain injury PSYCHIATRIC/MOOD Anxiety disorder Depression Manic depression (bipolar disease) Schizophrenia PULMONARY Asthma Emphysema/COPD SENSORY Cataracts Diabetic retinopathy Glaucoma Macular degeneration OTHER Allergies Anemia Cancer Renal failure NONE OF ABOVE
2. INFECTIONS (If none apply, CHECK the NONE OF ABOVE box)	Antibiotic resistant infection (e.g., Methicillin resistant staph) Clostridium difficile (c. diff) Conjunctivitis HIV infection Pneumonia Respiratory infection Septicemia Sexually transmitted diseases Tuberculosis Urinary tract infection in last 30 days Viral hepatitis Wound infection NONE OF ABOVE
3. OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9 CODES	

SECTION J. HEALTH CONDITIONS

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

Numeric Identifier _____

2. PAIN SYMPTOMS	(Code the highest level of pain present in the last 7 days)		
a. FREQUENCY with which resident complains or shows evidence of pain	0. No pain (skip to J4) 1. Pain less than daily 2. Pain daily	b. INTENSITY of pain	1. Mild pain 2. Moderate pain 3. Times when pain is horrible or excruciating
3. PAIN SITE	(If pain present, check all sites that apply in last 7 days)		
Back pain	a.	Incisional pain	f.
Bone pain	b.	Joint pain (other than hip)	g.
Chest pain while doing usual activities	c.	Soft tissue pain (e.g., lesion, muscle)	h.
Headache	d.	Stomach pain	i.
Hip pain	e.	Other	j.
4. ACCIDENTS	(Check all that apply)		
Fell in past 30 days	a.	Hip fracture in last 180 days	c.
Fell in past 31-180 days	b.	Other fracture in last 180 days	d.
		NONE OF ABOVE	e.
5. STABILITY OF CONDITIONS	Conditions/diseases make resident's cognitive, ADL, mood or behavior patterns unstable—(fluctuating, precarious, or deteriorating)		a.
	Resident experiencing an acute episode or a flare-up of a recurrent or chronic problem		b.
	End-stage disease, 6 or fewer months to live		c.
	NONE OF ABOVE		d.

SECTION M. SKIN CONDITION

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

SECTION K. ORAL/NUTRITIONAL STATUS

1. ORAL PROBLEMS	Chewing problem	a.
	Swallowing problem	b.
	Mouth pain	c.
	NONE OF ABOVE	d.
2. HEIGHT AND WEIGHT	Record (a.) height in inches and (b.) weight in pounds. Base weight on most recent measure in last 30 days; measure weight consistently in accord with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes	
	a. HT (in.)	b. WT (lb.)
3. WEIGHT CHANGE	a. Weight loss—5% or more in last 30 days; or 10% or more in last 180 days	
	0. No 1. Yes	
	b. Weight gain—5% or more in last 30 days; or 10% or more in last 180 days	
	0. No 1. Yes	
4. NUTRITIONAL PROBLEMS	Complains about the taste of many foods	a.
	Regular or repetitive complaints of hunger	b.
	Leaves 25% or more of food uneaten at most meals	c.
	NONE OF ABOVE	d.
5. NUTRITIONAL APPROACHES	(Check all that apply in last 7 days)	
	Parenteral/IV	a.
	Feeding tube	b.
	Mechanically altered diet	c.
	Syringe (oral feeding)	d.
	Therapeutic diet	e.
	Dietary supplement between meals	f.
	Plate guard, stabilized built-up utensil, etc.	g.
	On a planned weight change program	h.
	NONE OF ABOVE	i.
6. PARENTERAL OR ENTERAL INTAKE	(Skip to Section L if neither 5a nor 5b is checked)	
	a. Code the proportion of total calories the resident received through parenteral or tube feedings in the last 7 days	
	0. None 1. 1% to 25% 2. 26% to 50% 3. 51% to 75% 4. 76% to 100%	
	b. Code the average fluid intake per day by IV or tube in last 7 days	
	0. None 1. 1 to 500 cc/day 2. 501 to 1000 cc/day 3. 1001 to 1500 cc/day 4. 1501 to 2000 cc/day 5. 2001 or more cc/day	

SECTION L. ORAL/DENTAL STATUS

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

SECTION N. ACTIVITY PURSUIT PATTERNS

1. TIME AWAKE	(Check appropriate time periods over last 7 days)	
	Resident awakes all or most of time (i.e., naps no more than one hour per time period) in the:	
	Morning	a.
	Evening	b.
	Afternoon	c.
	NONE OF ABOVE	d.
(If resident is comatose, skip to Section O)		
2. AVERAGE TIME INVOLVED IN ACTIVITIES	(When awake and not receiving treatments or ADL care)	
	0. Most—more than 2/3 of time 1. Some—from 1/3 to 2/3 of time 2. Little—less than 1/3 of time 3. None	
3. PREFERRED ACTIVITY SETTINGS	(Check all settings in which activities are preferred)	
	Own room	a.
	Day/activity room	b.
	Outside facility	c.
	Inside NH/Unit	d.
	NONE OF ABOVE	e.
4. GENERAL ACTIVITY PREFERENCES	(Check all PREFERENCES whether or not activity is currently available to resident)	
	Cards/other games	a.
	Crafts/arts	b.
	Exercise/sports	c.
	Music	d.
	Reading/writing	e.
	Spiritual/religious activities	f.
	Trips/shopping	g.
	Walking/wheeling outdoors	h.
	Watching TV	i.
	Gardening or plants	j.
	Talking or conversing	k.
	Helping others	l.
	NONE OF ABOVE	m.

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Resident _____

Numeric Identifier _____

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

SECTION O. MEDICATIONS

1. NUMBER OF MEDICATIONS	(Record the number of different medications used in the last 7 days; enter "0" if none used)	
NEW MEDICATIONS	(Resident currently receiving medications that were initiated during the last 90 days) 0. No 1. Yes	
3. INJECTIONS	(Record the number of DAYS injections of any type received during the last 7 days; enter "0" if none used)	
4. DAYS RECEIVED THE FOLLOWING MEDICATION	a. Antipsychotic	
	b. Antianxiety	
	c. Antidepressant	
	d. Hypnotic	
	e. Diuretic	

SECTION P. SPECIAL TREATMENTS AND PROCEDURES

1. SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS	a. SPECIAL CARE—Check treatments or programs received during the last 14 days		
	TREATMENTS	Ventilator or respirator	
	Chemotherapy	a. PROGRAMS	
	Dialysis	b. Alcohol/drug treatment program	
	IV medication	c. Alzheimer's/dementia special care unit	
	Intake/output	d. Hospice care	
	Monitoring acute medical condition	e. Pediatric unit	
	Ostomy care	f. Respite care	
	Oxygen therapy	g. Training in skills required to return to the community (e.g., taking medications, house work, shopping, transportation, ADLs)	
	Radiation	h. NONE OF ABOVE	
b. THERAPIES - Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day) in the last 7 calendar days (Enter 0 if none or less than 15 min. daily) [Note—count only post admission therapies]			
(A) = # of days administered for 15 minutes or more DAYS MIN			
(B) = total # of minutes provided in last 7 days (A) (B)			
a. Speech - language pathology and audiology services			
b. Occupational therapy			
c. Physical therapy			
d. Respiratory therapy			
e. Psychological therapy (by any licensed mental health professional)			
2. INTERVENTION PROGRAMS FOR MOOD, BEHAVIOR, COGNITIVE LOSS	(Check all interventions or strategies used in last 7 days—no matter where received)		
	Special behavior symptom evaluation program	a.	
	Evaluation by a licensed mental health specialist in last 90 days	b.	
	Group therapy	c.	
	Resident-specific deliberate changes in the environment to address mood/behavior patterns—e.g., providing bureau in which to rummage	d.	
	Reorientation—e.g., cueing	e.	
NONE OF ABOVE			
3. NURSING REHABILITATION/RESTORATIVE CARE	Record the NUMBER OF DAYS each of the following rehabilitation or restorative techniques or practices was provided to the resident for more than or equal to 15 minutes per day in the last 7 days (Enter 0 if none or less than 15 min. daily)		
	a. Range of motion (passive)	f. Walking	
	b. Range of motion (active)	g. Dressing or grooming	
	c. Splint or brace assistance	h. Eating or swallowing	
	TRAINING AND SKILL PRACTICE IN:		i. Amputation/prosthesis care
	d. Bed mobility	j. Communication	
	e. Transfer	k. Other	

4. DEVICES AND RESTRAINTS	(Use the following codes for last 7 days): 0. Not used 1. Used less than daily 2. Used daily
	Bed rails
	a. — Full bed rails on all open sides of bed
	b. — Other types of side rails used (e.g., half rail, one side)
	c. Trunk restraint d. Limb restraint e. Chair prevents rising
5. HOSPITAL STAY(S)	Record number of times resident was admitted to hospital with an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no hospital admissions)
6. EMERGENCY ROOM (ER) VISIT(S)	Record number of times resident visited ER without an overnight stay in last 90 days (or since last assessment if less than 90 days). (Enter 0 if no ER visits)
7. PHYSICIAN VISITS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter 0 if none)
8. PHYSICIAN ORDERS	In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter 0 if none)
9. ABNORMAL LAB VALUES	Has the resident had any abnormal lab values during the last 90 days (or since admission)?
	0. No 1. Yes

SECTION Q. DISCHARGE POTENTIAL AND OVERALL STATUS

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

SECTION R. ASSESSMENT INFORMATION

1. PARTICIPATION IN ASSESSMENT	a. Resident: 0. No 1. Yes
	b. Family: 0. No 1. Yes 2. No family
	c. Significant other: 0. No 1. Yes 2. None
2. SIGNATURES OF PERSONS COMPLETING THE ASSESSMENT:	
a. Signature of RN Assessment Coordinator (sign on above line)	
b. Date RN Assessment Coordinator signed as complete	
c. Other Signatures	
d.	
e.	
f.	
g.	
h.	

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

numeric identifier _____

Resident's Name:	Medical Record No.:
------------------	---------------------

1. Check if RAP is triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
 - Describe:
 - Nature of the condition (may include presence or lack of objective data and subjective complaints).
 - Complications and risk factors that affect your decision to proceed to care planning.
 - Factors that must be considered in developing individualized care plan interventions.
 - Need for referrals/further evaluation by appropriate health professionals.
 - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
 - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

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

B. _____
 1. Signature of RN Coordinator for RAP Assessment Process

2.

	—		—												
Month		Day		Year											

3. Signature of Person Completing Care Planning Decision

4.

	—		—												
Month		Day		Year											

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RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

Key:

- ⊙ = One item required to trigger
- ⊚ = Two items required to trigger
- * = One of these three items, plus at least one other item required to trigger
- ⓐ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

MDS ITEM	CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL - Rehabilitation Trigger A (ⓐ)	ADL - Maintenance Trigger B (ⓐ)	Urinary Incontinence and Involving Catheter	Psychosocial Well Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	
B2a	Short term memory	1	⊙																			B2a
B2b	Long term memory	1	⊙																			B2b
B4	Decision making	1,2,3	⊙																			B4
B4	Decision making	3					⊙															B4
B5a to B5f	Indicators of delirium	2	⊙																			B5a to B5f
B6	Change in cognitive status	2	⊙																			B6
C1	Hearing	1,2,3			⊙																	C1
C4	Understood by others	1,2,3			⊙																	C4
C6	Understand others	1,2,3			⊙																	C6
C7	Change in communication	2																				C7
D1	Vision	1,2,3			⊙																	D1
D2a	Sedation problem	1			⊙																	D2a
E1a to E1p	Indicators of depression, anxiety, sad mood	1,2																				E1a to E1p
E1r	Repetitive movements	1,2																				E1r
E1o	Withdrawal from activities	1,2																				E1o
E2	Need for assistance	1,2																				E2
E3	Change in Mood	2	⊙																			E3
E4a - E4aA	Wandering	1,2,3																				E4a - E4aA
E4aA - E4aA	Behavioral symptoms	1,2,3																				E4aA - E4aA
E5	Change in behavioral symptoms	1																				E5
E5	Change in behavioral symptoms	2	⊙																			E5
F1a	Established own goals	1																				F1a
F2a to F2d	Unsettled relationships	✓																				F2a to F2d
F3a	Struggle of past roles	✓																				F3a
F3b	Lost roles	✓																				F3b
F3c	Day routine different	✓																				F3c
G1aA - G1A	ADL self-performance	1,2,3,4				⊙																G1aA - G1A
G1AA	Self-feeding	2,3,4,5																				G1AA
G2A	Bathing	1,2,3,4				⊙																G2A
G3a	Basic self-care	1,2,3																				G3a
G6a	Bedrest	✓																				G6a
G6aA	Personnel staff in care capable	✓																				G6aA
H1a	Bowel incontinence	1,2,3,4																				H1a
H1b	Bladder incontinence	2,3,4																				H1b
H2b	Constipation	✓																				H2b
H2a	Fecal impaction	✓																				H2a
H3c,d,e	Catheter use	✓																				H3c,d,e
H3a	Use of pads/briefs	✓																				H3a
I1i	Hypertension	✓																				I1i
I1	Prophylactic Aspirin	✓																				I1
I1aa	Depression	✓																				I1aa
I1j	Earwax	✓																				I1j
I1k	Glaucoma	✓																				I1k
I2	UTI	✓																				I2
I3	Dehydration diagnosis	2,7,6,5																				I3
J1a	Weight fluctuations	✓																				J1a
J1c	Dehydrated	✓																				J1c
J1d	Insufficient fluid	✓																				J1d
J1f	Dizziness	✓																				J1f
J1h	Fever	✓																				J1h
J1i	Hallucinations	✓																				J1i
J1j	Incontinence	✓																				J1j
J1k	Using assistive	✓																				J1k
J1m	CS syringe	✓																				J1m

MDS 2.0 10-1994x

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

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Proceed to RAP Review once triggered

MDS ITEM	CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A ⊕	ADL-Maintenance Trigger B ⊕	Urinary Incontinence and Involving Catheter	Psychosocial Well-Being	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	
J1a	Unsteady gait	✓																	⊙	J1a	
J4a,b	Fall	✓										●							⊙	J4a,b	
J4c	Hx fracture	✓																	⊙	J4c	
K1b	Swallowing problem	✓																	⊙	K1b	
K1c	Mouth pain	✓														●				K1c	
K3a	Weight loss	✓											●							K3a	
K4a	Fastidatious	✓											●							K4a	
K4c	Leave 25% food	✓											●							K4c	
K5a	Parenteral/IV feeding	✓											●		⊕					K5a	
K5b	Feeding tube	✓											●		⊕					K5b	
K5c	Mechanical assist	✓											●		⊕					K5c	
K5d	Syringe feeding	✓											●		⊕					K5d	
K5e	Therapeutic diet	✓											●		⊕					K5e	
L1a,c,d,e	Dental	✓															⊕			L1a,c,d,e	
L1	Daily cleaning teeth	N/A																		L1	
M2a	Pressure ulcer	2,3,4											●							M2a	
M2c	Pressure ulcer	1,2,3,4																	⊕	M2c	
M3	Previous pressure ulcer	1																	⊕	M3	
M4a	Impaired tactile sense	✓																	⊕	M4a	
N1a	Awake morning	✓										⊙								N1a	
N2	Involved in activities	0										⊙								N2	
N2	Involved in activities	2,3										●								N2	
N2	Previous change in daily routine	1,2										●								N2	
O4a	Antipsychotics	1-7																	*	O4a	
O4b	Anticonvulsants	1-7											●						*	O4b	
O4c	Antidepressants	1-7											●						*	O4c	
O4d	Diuretic	1-7														●				O4d	
P4c	Trunk restraint	1,2											●							P4c	
P4c	Trunk restraint	2																		P4c	
P4d	Limb restraint	1,2																	⊕	P4d	
P4d	Limb restraint	2																		P4d	
P4e	Chemical restraint	1,2																		⊕	P4e
P4e	Chemical restraint	2																		P4e	

