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3701-17-15 Restraints.

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(A) For purposes of this rule:

(1) "Prone restraint" means all items or measures used to limit or control the movement or normal functioning of any portion, or all, of an individual's body while the individual is in a face-down position for an extended period of time. Prone restraint includes physical or mechanical restraints.

(2) "Transitional hold" means a brief physical positioning of an individual face-down for the purpose of quickly and effectively gaining physical control of that individual in order to prevent harm to self and others, or prior to transport to enable the individual to be transported safely.

(B) Except as provided in paragraph (F) of this rule for emergency situations, the nursing home shall not physically or chemically restrain a resident or subject a resident to prolonged isolation except on written order of a physician which shall include the date, means of restraint to be used, medical reason for restraint, and duration of restraint. Such written orders shall be made a part of the resident's record.

(1) The nursing home shall not use a physical or chemical restraint or isolation for punishment, incentive, or convenience.

(2) The use of prone restraints and transitional holds is prohibited in nursing homes.

(3) A nursing home's use of the following for the purposes stated in this paragraph shall not be construed as physically or chemically restraining a resident or subjecting a resident to prolonged isolation:

(a) Devices that assist a resident in the improvement of the resident's mental and physical functional status and that do not restrict freedom of movement or normal access to one's body;

(b) Medications that are standard treatment or a documented exception to standard treatment for the resident's medical or psychiatric condition which assist a resident in attaining or maintaining the resident's highest practicable physical, mental, and psycho-social well-being; and

(c) Placement of residents in a unit who are assessed to need specialized care that restricts their freedom of movement throughout the home if:

(i) The home has made the determination to place each resident in such unit in accordance with paragraph (C) of this rule;

(ii) Care and services are provided in accordance with each resident's individual needs and preferences, not for staff convenience;

(iii) The need for the resident to remain in the locked unit is reviewed during each periodic assessment required by paragraph (F) of rule [3701-17-10](#) of the Administrative Code and during the continuing care planning required by rule [3701-17-14](#) of the Administrative Code;

(iv) The locked unit meets the requirements of the state building and fire codes; and

(v) Residents who are not cognitively impaired are able to enter and exit the unit without assistance.

(C) Except as provided in this paragraph, and paragraph (F) of this rule for emergency situations, prior to authorizing the use of a physical or chemical restraint on any resident, the nursing home shall ensure that the attending physician:

(1) Makes a personal examination of the resident and an individualized determination of the need to use the restraint on that resident; and

(2) In conjunction with an interdisciplinary team of health professionals and other care givers, conducts an individualized comprehensive assessment of the resident. This assessment shall:

(a) Identify specific medical symptoms that warrant the use of the restraint;

(b) Determine the underlying cause of the medical symptom and whether that underlying cause can be mitigated;

(c) Investigate and determine if possible alternative interventions have been attempted and found unsuccessful. Determine the least restrictive device that is most appropriate to meet the needs of the resident, taking into consideration any contraindications;

(d) Discuss with the resident or authorized representative, and any other individual designated or authorized by the resident, the risks and benefits of the restraint; and

(e) Obtain written consent from the resident or the resident's authorized representative.

A nursing home may restrain or isolate a resident transferred from another health care facility based on the resident's transfer orders if such orders include restraint use or isolation authorization and the home complies with the provisions of this paragraph within twenty-four hours of the resident's admission or readmission to the home.

(D) If a physical restraint is ordered, the nursing home shall select the restraint appropriate for the physical build and characteristics of the resident and shall follow the manufacturer's instructions in applying the restraint. The nursing home shall ensure that correct application of the restraint is supervised by a nurse and that the restrained resident is monitored every thirty minutes. The visual monitoring of the restrained resident may be delegated as permitted under state law. Jackets, sheets, cuffs, belts, or mitts made with unprotected elements of materials such as heavy canvas, leather, or metal shall not be used as restraints.

(E) The attending physician or a staff physician may authorize continued use of physical or chemical restraints for a period not to exceed thirty days and, at the end of this period and any subsequent period, may extend the authorization for an additional period of not more than thirty days. The use of physical or chemical restraints shall not be continued without a personal examination of the resident and the written authorization of the attending physician stating the reasons for continuing the restraint.

(F) Physical or chemical restraints or isolation may be used in an emergency situation without authorization of, or personal examination by, the attending physician only to protect the resident from injury to self or others. Use of the physical or chemical restraint or isolation shall not be continued for more than twelve hours after the onset of the emergency without personal examination and authorization by the attending physician.

(G) When isolation or confinement is used, the nursing home shall ensure that:

(1) The resident is continually monitored and periodically reassessed for continued use and need of this method of intervention;

(2) The door is secured in such a way as to be readily opened in case of an emergency;

(3) The resident is isolated or confined for the least amount of time to achieve desired outcome.

(H) Members of the nursing home's quality assurance committee, required by rule [3701-17-06](#) of the Administrative Code, shall review monthly the use of restraints and isolation and any incidents that resulted from their use, as well as incidents which resulted in the use of restraints or isolation. The review shall identify any trends, increases, and problems, the need for additional training, consultations or corrective action which shall be discussed and reflected in the minutes of the next quality assurance committee meeting.

Replaces: 3701-17-15, 3701-17- 15.1

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Prior Effective Dates: 5/2/1966 10/20/01, 6/20/10

PHYSICAL RESTRAINTS

Ohio Department of Health
Division of Quality Assurance
Bureau of Long Term Care Quality

May 9, 2007



WHAT ARE PHYSICAL RESTRAINTS?

“Physical restraints” are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident’s body that the individual cannot remove easily, and that restricts freedom of movement or normal access to one’s body.

Many different devices or items can restrict residents’ freedom to the point they become physical restraints. These include items specifically designed as restraints and others that are not.

The determination that something is a restraint cannot be based on the object or device that is being used, but must always be based on the *effect* the object or device has on the *individual resident*.

REQUIREMENTS FOR RESTRAINTS

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms. There are extensive federal and state guidelines governing the use of restraints. Facilities should be familiar with the individualized process of determining the need for restraints. Nursing homes welcome and depend upon involvement of the resident and/or the resident’s surrogate or representative in this process. You are encouraged to talk to a nursing home representative about restraints at the time of admission or at any other time.

ARE RESTRAINTS EVER APPROPRIATE?

Yes. However, the decision to use a restraint must always be based on the individual needs of the resident. Restraints should be used only after safer and less restrictive alternatives have all been considered and deemed inefficient. Restraints may be appropriate to use in an emergency.

WHAT IS THE IMPACT OF RESTRAINTS ON RESIDENTS?

We all value our rights to self determination, independence and freedom. The need to protect these rights becomes stronger as we age. Restraints can limit an individual’s self determination and independence, and can be directly linked to loss of function.

While it is easy to see the obvious results of a fall, often the negative physical, mental and social effects of restraint use are less obvious.

The less obvious negative effects of restraint use may include:

- Feelings of isolation and dehumanization.
- Withdrawal, agitation and depression.
- Loss of appetite.
- Bowel and bladder problems.
- Decreased bone and muscle strength.
- Development of skin problems.
- Resignation to loss of freedom and dignity.
- Increased dependence.
- Loss of mobility.
- Increased risk of strangulation.
- Feeling of entrapment.

Sometimes it is easy to overlook the less obvious negative effects when we feel that we are protecting a loved one.

Even though resident safety is the reason most given for restraint use, studies show that there are many dangers associated with the use of restraints. Therefore, it is important that restraints are used appropriately and cautiously.

RESIDENT CHOICE

Many residents, regardless of age, are capable of making decisions about being restrained.

Residents deserve freedom to make informed choices to the best of their ability for all aspects of their care including the use of restraints. In fact, it is their right under law to do so.

In order for the resident to be fully informed, the facility must explain, in the context of the individual resident's condition and circumstances, the potential risks and benefits of all options under consideration including using a restraint, not using a restraint and alternatives to restraint use. Whenever restraint use is considered, the facility must explain to the resident how the use of the restraint would treat the resident's medical symptoms and assist the resident in attaining or maintaining his/her highest practicable level of physical and psychological well-being. In addition, the facility must also explain the potential negative outcomes of restraint use.

DECISION MAKING

Although an alert resident may request a restraint, as with any medical care, ***a restraint can be ordered only by a physician.*** The facility must ensure the use of the restraint complies with the regulatory requirements. Therefore, a resident may ask about restraints but cannot require that a restraint be used.

If a resident is incapable of making a decision, a surrogate or representative with durable power of attorney for health care decisions cannot require the use of a restraint in the absence of a medical symptom. Legally authorized persons have the authority to act on behalf of the resident to refuse treatment that has been offered. There is no corresponding right to authorize treatment that is not necessary to treat a medical symptom. Therefore, a surrogate or representative may ask about restraints but cannot require that a restraint be used. Restraints may never be used for the sake of convenience or discipline.

The federal regulations governing restraint use define “medical symptom” as an indication or characteristic of a physical or psychological condition.

ARE RESTRAINTS SAFETY DEVICES?

One of the most common reasons for restraint use is the belief that someone must be restrained to prevent them from falling. However, no reliable data exists to prove restrained residents are safer than those who are not restrained. In fact, research shows:

- Restraint reduction does not result in an increase in serious falls.
- Restrained residents are more likely to fall and suffer serious fall-related injury or fall-related fracture than unrestrained residents.
- Mortality rates increase for restrained residents.

WHAT ABOUT BED RAILS?

The use of bed rails as restraints is prohibited unless necessary to treat a resident’s medical symptoms. Residents who attempt to exit a bed through, between, over or around bed rails are at risk of injury or death. Bed rails used as restraints increase the risk of more significant injury from falling from a bed with raised bed rails than without bed rails. They also increase the likelihood that the resident will spend more time in bed and fall when attempting to transfer from bed. Entrapment between the bed rail and the bed can lead to death. Therefore, rigorous assessment should tend to avoid using a bed rail as a restraint. Other interventions that might be incorporated in the care plan include (but are not limited to):

- Providing frequent staff monitoring at night with periodic assisted toileting for residents attempting to rise to use the bathroom.
- Providing restorative care to enhance abilities to stand safely and to walk.
- A trapeze to increase bed mobility.
- Placing the bed lower to the floor and surrounding the bed with a soft mat.
- Equipping the resident with a device that monitors attempts to rise.
- Furnishing visual and verbal reminders to use the call bell for residents who are able to comprehend this information.

Assessments should also include a review of the resident's:

- Bed mobility (Ex. Would the use of the bed rail assist the resident to turn from side to side, or, is the resident totally immobile and unable to shift without assistance?).
- Ability to transfer between positions, to and from bed or chair, to stand and toilet (Ex. Can the resident transfer safely with no risk of falling? Moderate risk? High risk? Would using a bed rail add to or detract from that risk?).

It is expected that the restraint reduction process be done in a systematic, individualized and gradual manner. (Ex. Lessening the time the bed rail is used while increasing visual and verbal reminders to use the call bell.)

Bed rails can create a barrier and decrease socialization and interaction with others, **especially when padded**. The plan of care for a resident using bed rails should address these issues.

The same device may have the affect of restraining one individual but not another, depending on the individual resident's condition and circumstances. For example, partial rails may assist one resident to enter and exit the bed independently, but act as a restraint for another.

As a general practice, facilities should consider adding bed rails only when a resident's assessment indicates that a rail or rails would assist with mobility and transfers; bed rails should not automatically be applied to all beds. When bed rails are used, an assessment of the mattress and bed frame for gaps must be completed.

RESOURCE INFORMATION

Ohio Department of Health District Offices:

Akron (330) 643-1300
Cambridge (740) 432-3012
Columbus (614) 466-5357

Dayton (937) 285-6250
Toledo (419) 245-2840

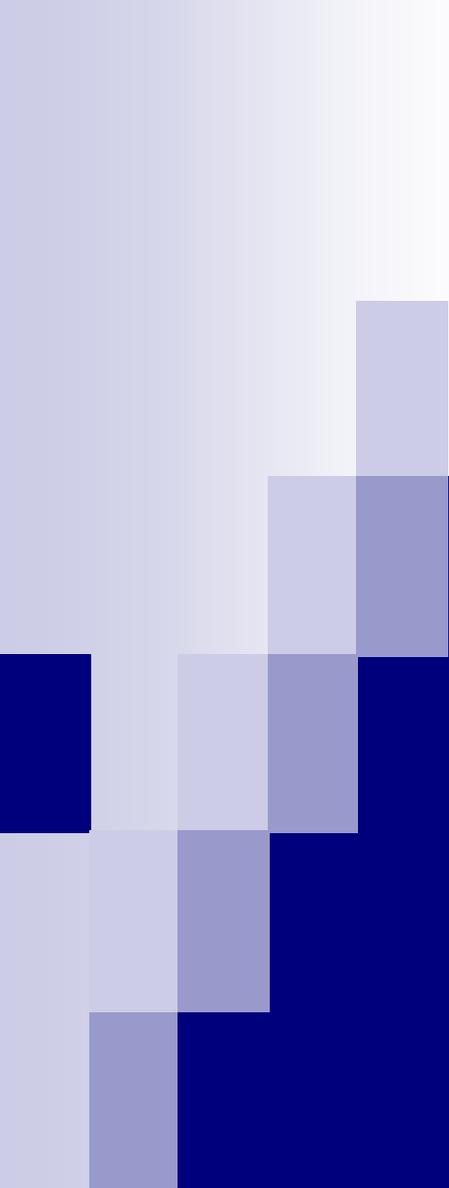
Complaint Hotline:

1-800-342-0553

State Long Term Care Ombudsman:

1-800-282-1206

Ohio Department of Health Web site: <http://www.odh.ohio.gov>



Restraints

Locked Units

Specialized Care
Units

LOCKED UNITS

Guidelines for Determining Compliance with Medicare/Medicaid Certification Requirements (Revised January 2010)

REGULATORY REQUIREMENTS

42 CFR 483.13(b) Tag F223: Locked units must be evaluated for compliance with standards for the prevention of abuse. Locked units are not considered restraints under the federal regulations but could subject residents to involuntary seclusion.

42 CFR 483.13(c) Tag F226: Facility must develop and implement policies and procedures to prevent abuse. Abuse includes unreasonable confinement, i.e., involuntary seclusion.

42 CFR 483.20 Tag F272: Facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

42 CFR 483.20(k) Tag F279: Facility must develop a comprehensive care plan for each resident.

42 CFR 483.20(k)(2) Tag F280: Facility must periodically review and revise the comprehensive care plan. The resident has the right to participate in planning care and treatment or changes in care and treatment.

FACT FINDING

Review of Secured Units: If the purpose of the secured unit is to provide specialized care for cognitively impaired residents then placement on the unit may not constitute involuntary seclusion if appropriate assessments are completed by the facility.

Determine whether there is a secured unit in the facility. A unit is considered secured if the unit restricts freedom of movement throughout the facility.

- A unit in which the doors have keypads or locks to which residents do not have the access code is a secured unit.
- A unit with a door that has a delayed-egress locking arrangement is not considered a secured unit.
- Note: The facility must comply with the requirements for use of a delayed-locking arrangement found in the National Fire Protection Association (NFPA) 101, Life Safety Code, 2000 Edition, Chapter 18 Section 2,22,2,4, Chapter 19 Section 2,2,22,4 and Chapter 7 Section 2,1,6.1, and State fire and Building Codes.

Determine the purpose of the unit including whether the unit provides specialized care for the cognitively impaired and if so the type of services provided. Specialized care includes but is not limited to special activities, increased staffing, environmental designs and other programs specifically designed for the care of cognitively impaired persons. If the sole purpose of the unit is to provide security then determine whether the cognitively impaired residents are at risk of elopement.

COMPLIANCE DETERMINATION

Review of Resident Assessments and Care Plan: Care and services are provided in accordance with each resident's individual needs, residents or representatives participate in the placement and there is continuing care planning to meet the resident's assessed care needs. Determine whether specific needs of the resident have been identified that require placement on the unit.

Tag F272 Assessment: Review the RAI, the history and physical, and other information such as physician orders, progress notes, nurses' notes, pharmacist reports, and any flow sheets or forms the facility uses to document the resident's history; including the assessment of the resident's overall condition. Determine if the facility assessment is consistent with or corroborated by documentation within the record and comprehensively reflects the status of the resident for placement on the locked unit.

Tag F279 Comprehensive Care Plan: Determine whether the facility developed a plan of care based on the resident's assessment. Determine whether the care plan addresses the needs identified in the comprehensive assessment for placement and retention on the secured unit.

Tag F280 Care Plan Revision: Look for evidence that the care plan was reviewed and revised as necessary. Look for evidence that the resident or representative was afforded the right to participate in care planning or was consulted about placement on the locked unit.

Review of Policies and Procedures: Determine whether the facility has developed and implemented policies and procedures to prevent abuse (involuntary seclusion).

Tag F226 Staff Treatment of Residents: Determine whether the facility has policies and procedures for placement and retention on the locked unit.

Review of Placement on the Locked Unit:

Tag F223 Abuse: A resident is not being subjected to involuntary seclusion as long as placement on the locked unit is necessary to provide the care and services identified in the resident's assessment and care plan. Additionally, the resident or representative must participate in the decision for the placement and retention on the locked unit.

Note: Compliance determinations are made at the time of survey.

SPECIALIZED CARE UNITS

Guidelines for Determining Compliance with State Nursing Home Licensing Requirements

(Revised January 2010)

REGULATORY REQUIREMENTS

Ohio Administrative Code rule 3701-17-01(AA): Physically restrained means that residents are confined or in the home in such a manner that the freedom for normal egress from the home is dependent upon the unlocking or unbolting by others of one or more doors or barriers, or the removal of physical restraints.

Ohio Administrative Code rule 3701-17-15(A)(2)(c): Specialized care units: This paragraph establishes the requirements such that a resident will not be considered to be physically restrained if the resident resides on a specialized care unit that restricts their freedom of movement throughout the home.

Ohio Administrative Code rule 3701-17-15(B): Establishes the requirements for use of a restraint, particularly the use of a specialized care unit that restricts a resident's freedom of movement throughout a facility.

FACT FINDING

Review of specialized care units: If the purpose of the unit is to provide specialized care for cognitively impaired residents the placement on the unit may not constitute the use of a restraint if requirements established under Ohio Administrative Code rule 3701-17-15(A)(2)(c) are met.

- Determine whether there is a specialized care unit that restricts freedom of movement throughout the facility.
- A unit in which the doors have keypads or locks in which residents do not have the access code would be a secured unit.
- A unit with a door that has a delayed-egress locking arrangement is not considered a secured unit.
- Note: The facility must comply with State Fire and Building Codes pertaining to the use of delayed-locking arrangements.

Determine the purpose of the unit including whether the unit provides specialized care for the cognitively impaired and if so the type of services provided. Specialized care includes but is not limited to special activities, increased staffing, environmental designs and other programs specifically designed for the care of cognitively impaired persons. If the sole purpose of the unit is to provide security then determine whether the cognitively impaired residents are at risk of elopement.

Determine whether requirements of Ohio Administrative Code rule 3701-17-15(A)(2)(c) are met.



COMPLIANCE DETERMINATION

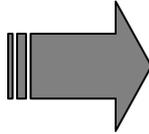
N Tag 215: If the requirements for placement on a unit that restricts freedom of movement throughout the home are not met then a resident is being physically restrained. Document which conditions for placement are not met including physician orders and an individualized comprehensive assessment. The assessment is to include identification of specific medical symptoms that warrant the use of the restraint, underlying cause of the medical symptom and whether that underlying cause can be mitigated, whether possible alternative interventions have been attempted and found unsuccessful, whether the risks and benefits of the restraint have been discussed with the resident or authorized representative, and whether written consent has been obtained.

Note: Compliance determinations are made at the time of survey.

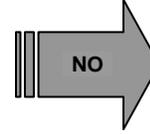
GUIDELINES FOR RESTRAINT USE

INITIAL ANALYSIS

- Determine the reason for device use in context of resident's condition, circumstances and environment
- Determine the medical symptoms creating the need for device use
- Determine the impact on the resident's function
- Begin risk/benefit analysis



Does the device restrict freedom of movement?

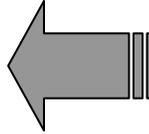


Document reason for use, add to POC, and revise periodically

YES

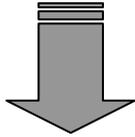


This meets the definition of a RESTRAINT – proceed with restraint protocol



RESTRAINT PROTOCOL

- #1 - May not be used for convenience or discipline
- #2 - Must be used to treat medical symptoms
- #3 - An alert resident who requests a restraint must be assessed following the protocol

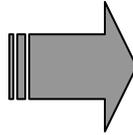


INDIVIDUALIZED COMPREHENSIVE ASSESSMENT

- Incorporates restraint and other relevant RAPs
- Identifies a specific medical symptom that warrants the use of the device
- Identifies the underlying cause of the medical symptom
- Rules out other possible interventions
- Involves resident and family in determining the risks and benefits
- Analyzes all information

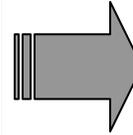
Information should include at minimum:

- ✓ What has happened /or is happening to the resident (medical symptom)
- ✓ When is the need occurring?
- ✓ What is the cause?
- ✓ What interventions have been tried?
- ✓ Why didn't alternative work?
- ✓ What is the least restrictive device?
- ✓ What is the time frame?
- ✓ Will it elevate the resident's quality of life?



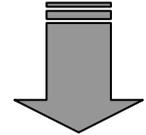
INTERDISCIPLINARY TEAM MEETING

- Evaluates relevant factors leading to the consideration of a device
- Determines that the residents' needs are being met and the need to use restraints is not the result of an unmet need
- Investigates alternatives to restraints and determines that alternative measures have been exhausted and found to be unsuccessful
- Weighs the risks and benefits of restraint use
- Develops measures to minimize risks and resident decline
- Makes decision that device is most appropriate



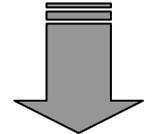
PHYSICIAN'S ORDER

- Specifies: type/reason/duration
- Physician makes a personal exam prior to use and every 30 days to document authorization for the restraint



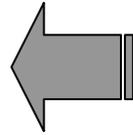
INFORMED CONSENT

Obtains written consent of resident or authorized representative prior to use (may honor orders in place on transfer from another healthcare facility x 24 hrs)



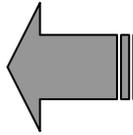
COMPREHENSIVE INDIVIDUALIZED PLAN OF CARE

- Developed with input from the resident and/or family
- Based on informed choice. Risks and benefits are identified and explained to family/resident
- Addresses medical symptoms
- Addresses safety issues as a result of restraint usage
- Identifies measures to minimize the risk of resident decline and maintain strength and mobility (including rehabilitative and restorative care)
- Specifies, at minimum, type of restraint to be used, when restraint is to be used, when it should be released
- Addresses meaningful activities and other psychosocial needs
- Ensures the restrained resident receives a nutritionally adequate diet
- Plan must be evaluated and revised as necessary

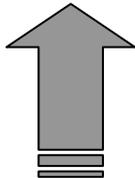


IMPLEMENTATION

- Correct application is supervised by a nurse
- Applied per manufacturers' instructions
- Resident is monitored at a minimum of every 30 minutes while restrained



Reassessment and reevaluation for reduction/elimination



EMERGENCY RESTRAINT USE: Physical restraints may be used in an emergency situation without authorization of, or personal examination by, the attending physician only to protect the resident from injury to self or others. Emergency use shall not be continued for more than 12 hours without personal examination and authorization by the attending physician.

F221 – §483.13 (a) The resident has the right to be free from physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptom.

ASSESSING/REASSESSING THE RESIDENT

- The determination of whether a device is or is not a restraint is based on an individualized comprehensive assessment of the particular resident. The assessment identifies the specific medical symptoms and evaluates the risks and benefits and the purpose being considered for the use of a device or practice. The determination must include whether the resident is capable of independently removing the device and whether the device restricts the resident's freedom of movement. The answer to this question will vary with the individual resident and situation.
- Facilities must assess the resident to determine their functional status. Determine what the level of function is, what is important to the resident to maintain, and what quality of life area will the use of the device improve, maintain or enhance. Improved functional status can be physical or emotional.
- **In the interpretive guidelines for F221, §483.13, medical symptom is defined as an indication or characteristic of a physical or psychological condition.**
 - The law and the statute prohibit the use of physical restraints except to treat medical symptoms. Evolving professional standards of practice continue to identify treatment options that tend to be more effective than restraints. When added to the strong association of restraint use with negative physical and psychological effects there are fewer reasons for justifying the use of restraints to treat medical symptoms than in the past.
 - Short term use of restraints may have some benefits, for example:
 - Restraints used to prevent a severely dehydrated and confused person from pulling out a lifesaving I.V. Restrain only to the extent necessary to protect the I.V.
 - Restraints used to allow a doctor or nurse to examine a delirious person to find the cause of their symptoms.
 - A confused, disoriented resident returns from the hospital after undergoing a surgical procedure. Restraints used for a limited time to prevent the resident from pulling out stitches, tubes or dislocating a hip or knee replacement would constitute medical justification.
 - **The medical symptom for the restraint will be the reason the device is required to improve the resident's functional status.**
 - **If a facility has residents who need to be restrained, the facility must have an ongoing systemic gradual restraint reduction program in place.**
 - **If a restraint is used, it must be the least restrictive for the least amount of time – consider short-term or time-limited orders.**

RESIDENT CHOICE AND RESTRAINT USE

- An alert resident may request and have a restraint – but the restraint protocol must still be followed.
- In order for the resident to be fully informed, the facility must explain, in the context of the individual resident's condition and circumstances, the potential risks and benefits of all options under consideration including using a restraint, and alternatives to restraint use. Whenever restraint use is considered, the facility must explain to the resident how the use of the restraints would treat the resident's medical symptoms and assist the resident in attaining or maintaining his/her highest practicable level of physical and psychological well-being. In addition, the facility must also explain the potential negative outcomes of restraint use which include, but are not limited to, declines in the resident's physical functioning (e.g., ability to ambulate) and muscle condition, contractures, increased incidence of infections and development of pressure sores/ulcers, delirium, agitation, and incontinence. Moreover, restraint use may constitute an accident hazard. Restraints have been found in some cases to increase the incidence of falls or head trauma due to falls and other accidents (e.g. strangulation, entrapment). Finally, residents who are restrained may face a loss of autonomy, dignity and self-respect, and may show symptoms of withdrawal, depression, or reduced social contact. In effect, restraints can reduce independence, functional capacity, and quality of life. Alternatives to restraint use should be considered and discussed with the resident. Alternatives to restraint use might include modifying the resident's environment, and/or routine.
- In the case of a person who is incapable of making a decision, the surrogate or representative cannot require the use of a restraint in the absence of a medical symptom. Legally authorized persons have the authority to act on behalf of the resident to refuse treatment that has been offered under 42 CFR 483.10 (b)(4). There is no corresponding right to authorize treatment that is not necessary to treat a medical symptom. The legal representative with durable power of attorney for health care decisions is lawfully authorized to make decisions about restraint use to treat a resident's medical symptoms; however, the representative may not request the restraint for the sake of convenience or discipline.
- Restraints may not be used to countermand an expressed wish of the resident to not receive a particular treatment or to violate an advanced directive.

BED RAILS

- The use of bed rails as restraints is prohibited unless they are necessary to treat a resident's medical symptoms. Residents who attempt to exit a bed through, between, over or around bed rails are at risk of injury or death. Bed rails used as restraints increase the risk of more significant injury from falling from a bed with raised bed rails than without bed rails. They also increase the likelihood that the resident will spend more time in bed and fall when attempting to transfer from bed. Therefore, rigorous assessment should tend to avoid using a bed rail as a restraint. Other interventions that may be incorporated in the care plan include:
 - **Providing frequent staff monitoring at night with periodic assisted toileting for residents attempting to rise to use the bathroom**
 - Providing restorative care to enhance abilities to stand safely and to walk
 - A trapeze to increase bed mobility
 - Placing the bed lower to the floor and surrounding the bed with a soft mat
 - Equipping the resident with a device that monitors attempts to rise
 - Furnishing visual and verbal reminders to use the call bell for residents who are able to comprehend this information
- Assessments should also include a review of the resident's:
 - Bed mobility (Ex. Would the use of the bed rail assist the resident to turn from side to side, or, is the resident totally immobile and cannot shift without assistance?)
 - Ability to transfer between positions, to and from bed or chair, to stand and toilet (Ex. Can the resident transfer safely with no risk of falling? Moderate risk? High risk? Would using a bed rail add to or detract from that risk?)
- It is expected that the restraint reduction process be done in a systematic, individualized and gradual manner. (Ex. Lessening the time the bed rail is used while increasing visual and verbal reminders to use the call bell)
- Bed rails can create a barrier and decrease socialization and interaction with others, **especially when padded**. The plan of care for a resident using bed rails must address these issues.
- The same device may have the affect of restraining one individual but not another, depending on the individual resident's condition and circumstances. For example, partial rails may assist one resident to enter and exit the bed independently while acting as a restraint for another.
- **As a general practice, facilities should consider only adding bed rails when a resident's assessment indicates that a rail or rails would assist with mobility and transfers; bed rails should not automatically be applied to all beds. When bed rails are used, an assessment of the mattress and bed frame for gaps should be completed.**



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MDS 3.0 RAI Manual

This page contains the current MDS 3.0 RAI Manual v1.11, effective October 1, 2013. This version of the MDS 3.0 RAI Manual incorporates clarifications to existing coding and transmission policy, integrates previously published Questions and Answers (Q & As) into the appropriate sections and addresses requested clarifications and scenarios concerning complex areas.

What's New:

June 20, 2014

The June 13 update of Appendix B to the RAI Manual contains changes to the list of state RAI coordinators, MDS automation coordinators, RAI panel members, and regional office contacts. The file is located in the Downloads section below.

November 05, 2013

The following corrections were made to the RAI Manual v1.11:

1. The flowchart "ADL Self-Performance Algorithm," which describes the algorithm for ADL function items in Chapter 3 Section G (page G-7), and the accompanying change table
2. Coding examples in Chapter 3 Section O (page O-33)
3. A change table page incorrectly transcribed from Chapter 3 Section O (page 3)

Three files marked "(R)" are available in the Downloads section below as part of this errata release. Note that two files are revised and one is a new, additional file. All three files include an "(R)" at the end of the file name.

Two previously issued files have been updated in this release:

- "MDS 3 0 RAI Manual v1_11 and Change Tables_October 25 2013 (R).zip" and
- "MDS 3 0 RAI Manual v1_11 Changed Pages and Change Tables_October 25 2013 (R).zip"

Note that "(R)" is printed on page O-33 in Section O, on pages 3, 5, and 6 of the Section O Change Table, on page G-7 in Section G, and on page 7 of the Section G Change Table to indicate that the correction has been made.

An additional file, "MDS 3 0 RAI v1 11 Chapter 3 Sections G and O Replacement Pages_October 25 2013(R).zip" contains only the pages affected in this errata release: RAI manual page O-33, Section O change table pages 5 and 6, Section O change table page 3, manual page G-7, and Section G change table page 7.

- "MDS 3 0 RAI v1 11 Chapter 3 Sections G and O Replacement Pages_October 25 2013(R).zip"

September 24, 2013

The RAI Manual v1.11 Replacement Manual Pages and Change Tables (in a ZIP file) and the RAI Manual v1.11 and Change Tables (also in a ZIP file) are replaced with the revised files in the Downloads section below.

The RAI Manual v1.10 Replacement Manual Pages and Change Tables (in a ZIP file) and the RAI Manual v1.10 and Change Tables (also in a ZIP file) have been moved to the Archived: MDS 3.0 RAI Manuals web page.

September 20, 2013

CMS has issued a Survey and Certification (S&C) memo outlining steps nursing home providers must take to address any MDS 3.0 Discharge assessments that have not been completed and/or submitted since the inception

of MDS 3.0 that have resulted in any residents appearing on the facility's current MDS 3.0 Roster report who are no longer active residents. The memo is located in the Related Links section or can also be accessed at:

<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-56.pdf>.

Providers must complete the steps outlined in the S&C memo no later than September 30, 2013. The memo also outlines CMS's policy for Discharge assessments which is detailed in Chapter 2 of the RAI User's Manual.

April 12, 2013

The MDS 3.0 QM User's Manual containing detailed specification for the MDS 3.0 quality measures has been removed from this page. The table entitled, Quality Measure Identification Number by CMS Reporting Module has been removed from this page. Both the MDS 3.0 QM User's Manual and the table are available in the Downloads section of the NHQI Quality Measures page.

Questions or comments regarding the MDS 3.0 should be directed to your State RAI Coordinator. State RAI Coordinator contact information can be found in *MDS 3.0 RAI Manual Appendix B* in the Downloads section below

Disclaimer: This webpage is the only official site where the MDS 3.0 training materials are posted. Content contained in the files posted on this site should not be changed in any manner.

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Downloads

[MDS 3 0 RAI Manual v1_11 Changed Pages and Change Tables_October 25 2013 \(R\).zip \[ZIP, 4MB\]](#) 

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[MDS 3 0 RAI v1_11 Chapter 3 Sections G and O Replacement Pages_October 25 2013\(R\).zip \[ZIP, 606KB\]](#) 

[MDS RAI Manual Appendix B 6.13.2014 \[PDF, 118KB\]](#) 

Related Links

[Survey and Cert Letter 13-56 \[PDF, 91KB\]](#) 

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RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form CMS-672)

GENERAL INSTRUCTIONS:

THIS FORM IS TO BE COMPLETED BY THE FACILITY AND REPRESENTS THE CURRENT CONDITION OF RESIDENTS AT THE TIME OF COMPLETION

There is not a federal requirement for automation of the 672 form. The facility may continue to complete the 672 with manual methods. The facility may use the MDS data to start the 672 form, but must verify all information, and in some cases, re-code the item responses to meet the intent of the 672 to represent current resident status according to the definitions of the 672. Since the census is designed to be a representation of the facility during the survey, it does not directly correspond to the MDS in every item.

For the purpose of this form “the facility” equals certified beds (i.e., Medicare and/or Medicaid certified beds).

For the purpose of this form “residents” means residents in certified beds regardless of payor source.

Following the definition of each field, the related MDS codes and instructions will be noted within square brackets ([]).

Where coding refers to the admission assessment, use the first assessment done after the most recent admission or readmission event.

Complete each item by specifying the number of residents characterized by each category. If no residents fall into a category enter a “0”.

INSTRUCTIONS AND DEFINITIONS:

Provider No.: Enter the facility’s assigned provider number. Leave blank for initial certifications.

Block F75: Enter the number of facility residents, whose primary payer is Medicare.
[Code manually]

Block F76: Enter the number of facility residents, whose primary payer is Medicaid.
[Code manually]

Block F77: Enter the number of facility residents, whose primary payer is neither Medicare nor Medicaid.
[Code manually]

Block F78: Enter the number of total residents for whom a bed is maintained, on the day the survey begins, including those temporarily away in a hospital or on leave.
[Total residents in nursing facility or on bedhold]

ADLS (F79 – F93)

To determine resident status, unless otherwise noted, consider the resident’s condition for the 7 days prior to the survey.
[Horizontal totals must equal the number in F78; Manually re-code all “8” responses.]

Bathing (F79 – F81)

The process of bathing the body (excluding back and shampooing hair). This includes a full-body bath/shower, sponge bath, and transfer into and out of tub or shower.
[F79: G0120A = 0; F80: G0120A = 1, 2, 3; F81: G0120A = 4]

Many facilities routinely provide “setup” assistance to all residents such as drawing water for a tub bath or laying out bathing materials. If this is the case and the resident requires no other assistance, count the resident as independent.

Dressing (F82 – F84)

How the resident puts on, fastens, and takes off all items of clothing, including donning or removing prostheses (e.g., braces and artificial limbs).
[F82: G0110G1 = 0; F83: G0110G1 = 1, 2, 3; F84: G0110G1 = 4]

Many facilities routinely set out clothes for all residents. If this is the case and this is the only assistance the resident receives, count the resident as independent. However, if a resident receives assistance with donning a brace, elastic stocking, a prosthesis and so on, securing fasteners, or putting a garment on, count the resident as needing the assistance of 1 or 2 staff.

Transferring (F85 – F87)

How the resident moves between surfaces, such as to and from the bed, chair, wheelchair or to and from a standing position. (EXCLUDE transfers to and from the bath or toilet).
[F85: G0110B1 = 0; F86: G0110B1 = 1, 2, 3; F87: G0110B1 = 4]

Many facilities routinely provide “setup” assistance to all residents, such as handing the equipment (e.g., sliding board) to the resident. If this is the case and is the only assistance required, count the resident as independent.

Toilet Use (F88 – F90)

How the resident uses the toilet room (or bedpan, bedside commode, or urinal). How resident transfers on and off toilet, cleans self after elimination, changes sanitary napkins, ostomy, external catheters, and adjusts clothing prior to and after using toilet. If all that is done for the resident is to open a package (e.g., a clean sanitary pad), count the resident as independent.
[F88: G0110I1 = 0; F89: G0110I1 = 1, 2, 3; F90: G0110I1 = 4]

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form CMS-672)

Eating (F91 – F93)

How resident eats and drinks regardless of skill. Many facilities routinely provide “setup” activities, such as opening containers, buttering bread, and organizing the tray; if this is the case and is the extent of assistance, count this resident as independent.

[F91: G0110H1 = 0; F92: G0110H1 = 1, 2, 3; F93: G0110H1 = 4]

A. BOWEL/BLADDER STATUS (F94 – F99)

F94: With an indwelling or an external catheter

The number of residents whose urinary bladder is constantly drained by a catheter (e.g., a Foley catheter, a suprapubic catheter) or who wears an appliance that is applied over the penis and connected to a drainage bag to collect urine from the bladder (e.g., a Texas catheter).

[H0100A or B = check]

F95: Of the total number of residents with catheters

The number of residents who had a catheter present on admission. For a resident readmitted from a hospital with a catheter, count this resident as admitted with a catheter.

[(H0100A or B = checked) and (A0310A = 01 or A0310B = 01 or 06)]

F96: Occasionally or frequently incontinent of bladder

The number of residents who have an incontinent episode two or more times per week. Do not include residents with an indwelling or external catheter.

[(H0300 = 1, 2, or 3) and (H0100A and B = not checked)]

F97: Occasionally or frequently incontinent of bowel

The number of residents who have a loss of bowel control two or more times per week.

[H0400 = 1, 2, or 3]

F98: On individually written bladder training program

The number of residents with a detailed plan of care to assist the resident to gain and maintain bladder control (e.g., pelvic floor exercises). Count all residents on training programs including those who are incontinent.

[H0200A = 1 or code manually]

F99: On individually written bowel training program

The number of residents with a detailed plan of care to assist the resident to gain and maintain bowel control (e.g., use of diet, fluids, and regular schedule for bowel movements). Count all residents on training programs including those who are incontinent.

[H0500 = 1 or code manually]

B. MOBILITY (F100 – F107)

[Total for F100 – F103 should = F78; Algorithm to force mutual exclusivity: Test for each resident. If F100 = 1 then add 1 to F100, and go to the next resident; If F101 = 1 then add 1 to F101 and go to the next resident; If F103 = 1 then add 1 to F103 and go to the next resident; If F102 = 1 then add 1 and go to the next resident.]

F100: Bedfast all or most of time

The number of residents who were in bed or recliner 22 hours or more per day in the past 7 days. Includes bedfast with bathroom privileges.

[Code manually]

F101: In chair all or most of time

The number of residents who depend on a chair for mobility. Includes those residents who can stand with assistance to pivot from bed to wheelchair or to otherwise transfer. The resident cannot take steps without extensive or constant weight-bearing support from others and is not bedfast all or most of the time.

[Code manually]

F102: Independently ambulatory

The number of residents who require no help or oversight; or help or oversight was provided only 1 or 2 times during the past 7 days. Do not include residents who use a cane, walker or crutch.

[(G0110C1 or G0110D1 = 0 or 7) and (G0600A1 and G0600B1 = not checked)]

F103: Ambulation with assistance or assistive devices

The number of residents who required oversight, cueing, physical assistance or who used a cane, walker, crutch. Count the use of lower leg splints, orthotics, and braces as assistive devices.

[(G0110C1 or G0110D1 = 1, 2, or 3) or (G0600A1 or G0600B = checked)]

F104: Physically restrained

The number of residents whose freedom of movement and/or normal access to his/her body is restricted by any manual method or physical or mechanical device, material or equipment that is attached or adjacent to his/her body and cannot be easily removed by the resident.

[Any P0100B, C, D, E, F, G, or H = 1 or 2]

F105: Of total number of restrained residents,

number admitted or readmitted with an order for restraint.

[Code manually when criteria for F104 is met and P0100B, C, D, E, F, G, or H = 1 or 2 and A0310A = 01 or A0310B = 01 or 06]

F106: With contractures

The number of residents that have a restriction of full passive range of motion of any joint due to deformity, disuse, pain, etc. Includes loss of range of motion in fingers, wrists, elbows, shoulders, hips, knees and ankles.

[Code manually for neck; G0400A or B = 1 or 2]

F107: Of total of residents with contractures, the number who had a contracture(s) on admission.

[Code when criteria for F106 is met on admission or readmission assessment and A0310A = 01 or A0310B = 01 or 06]

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form CMS-672)

C. MENTAL STATUS (F108 – F114)

F108: With mental retardation

Identify the total number of residents in all of the categories of developmental disability regardless of severity, as determined by the State Mental Health or State Mental Retardation Authorities. [Any A1550A, B, C, D, or E = check]

F109: With documented signs and symptoms of depression

The total number of residents with documented signs and symptoms of depression as defined by MDS. [D0300 > 0 or D0600 > 0]

F110: With documented psychiatric diagnosis (exclude dementias and depression)

The number of residents with primary or secondary psychiatric diagnosis including:

- Schizophrenia
- Schizo-affective disorder
- Schizophreniform disorder
- Delusional disorder
- Anxiety disorder
- Psychotic mood disorders (including mania and depression with psychotic features, acute psychotic episodes, brief reactive psychosis, and atypical psychosis).

[I5700, I5900, I5950, or I6000 = checked. Code manually for other psychiatric diagnoses listed here.]

F111: Dementia: Multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type

The number of residents with a primary or secondary diagnosis of dementia or organic mental syndrome including multi-infarct, senile type, Alzheimer's type, or other than Alzheimer's type. [I4200 or I4800 = checked. Code manually for other dementia diagnoses listed here.]

F112: With behavioral symptoms

The number of residents with one or more of the following symptoms: wandering, verbally abusive, physically abusive, socially inappropriate/disruptive, resistive to care. (See MDS Section (Behavior)).

[E0300 = 1 or E0800 = 1, 2, or 3 or E0900 = 1, 2, or 3]

F113: Of the total number with behavioral symptoms, the number receiving a behavior management program. The number of residents with behavior symptoms who are receiving an individualized care plan/program designed to address behavioral symptoms (as listed above). [Code manually when criteria for F112 is met.]

F114: Receiving health rehabilitative services for MI/MR

The number of residents for whom the facility is providing health rehabilitative services for MI/MR as defined at 483.45(a). [Use item for Residents who meet F108 or F110, then code manually.]

D. SKIN INTEGRITY (F115 – F118)

F115: With pressure sores

The number of residents with ischemic ulcerations and/or necrosis of tissues overlying a bony prominence (exclude Stage I).

[Any M0300B1, M0300C1, or M0300D1 > 0; Code for first assessment after latest admission or re-entry]

F116: Of the total number of residents with pressure sores excluding Stage I, the number who had pressure sores on admission or who were readmitted with a new pressure sore (exclude Stage I).

[Any M0300B2, M0300C2, or M0300D2 > 0]

F117: Receiving preventive skin care

The number of residents receiving non-routine skin care provided according to a physician's order, and/or included in the resident's comprehensive plan of care (e.g., hydrocortisone ointment to areas of dermatitis three times a day, granulex sprays, etc.)

[Any M1200A, B, C, D, E, F, G, H, or I = checked]

F118: With rashes

Enter the number of residents who have rashes which may or may not be treated with any medication or special baths, etc. (e.g., but not limited to antifungals, corticosteroids, emollients, diphenhydramines or scabidulids, etc.)

[Code manually]

E. SPECIAL CARE (F119 – F132)

F119: Receiving hospice care

Number of residents who have elected or are currently receiving the hospice benefit.

[O0100K1 or O0100K2 = checked]

F120: Receiving radiation therapy

The number of residents who are under a treatment plan involving radiation therapy.

[O0100B1 or O0100B2 = checked]

F121: Receiving chemotherapy

The number of residents under a specific treatment plan involving chemotherapy.

[O0100A1 or O0100A2 = checked]

F122: Receiving dialysis

The number of residents receiving hemodialysis or peritoneal dialysis either within the facility or offsite.

[O0100J1 or O0100J2 = checked]

F123: Receiving intravenous therapy, IV nutritional feedings and/or blood transfusion

The number of residents receiving fluids, medications, all or most of their nutritional requirements and/or blood and blood products administered intravenously.

[K0500A = checked, or O0100H1 or O0100H2 = checked, or O0100I1 or O0100I2 = checked]

F124: Receiving respiratory treatment

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form CMS-672)

The number of residents receiving treatment by the use of respirators/ventilators, oxygen, IPPB or other inhalation therapy, pulmonary toilet, humidifiers, and other methods to treat conditions of the respiratory tract. This does not include residents receiving tracheotomy care or respiratory suctioning. [O0100C1, O0100C2, O0100F1, O0100F2, O0100G1, or O0100G2 = checked or O0400D1 > 0]

F125: Receiving tracheotomy care

The number of residents receiving care involved in maintenance of the airway, the stoma and surrounding skin, and dressings/coverings for the stoma. [O0100E1 or O0100E2 = checked]

F126: Receiving ostomy care

The number of residents receiving care for a colostomy, ileostomy, uretostomy, or other ostomy of the intestinal and/or urinary tract. DO NOT include tracheotomy. [Code manually]

F127: Receiving suctioning

The number of residents that require use of a mechanical device which provides suction to remove secretions from the respiratory tract via the mouth, nasal passage, or tracheotomy stoma. [O0100D1 or O0100D2 = checked]

F128: Receiving injections

The number of residents that have received one or more injections within the past 7 days. (Exclude injections of Vitamin B 12.) [Review residents for whom N0300 > 0. Omit from count any resident whose only injection currently is B12.]

F129: Receiving tube feeding

The number of residents who receive all or most of their nutritional requirements via a feeding tube that delivers food/nutritional substances directly into the GI system (e.g., nasogastric tube, gastrostomy tube). [K0500B = checked]

F130: Receiving mechanically altered diets

The number of residents receiving a mechanically altered diet including pureed and/or chopped foods (not only meat). [K0500C = checked]

F131: Receiving rehabilitative services

The number of residents receiving care designed to improve functional ability provided by, or under the direction of a rehabilitation professional (physical therapist, occupational therapist, speech-language pathologist. (Exclude health rehab. for MI/MR.) [O0400A1, 2, or 3 or O0400B1, 2, or 3 or O0400C1, 2, or 3 > 0]

F132: Assistive devices with eating

The number of residents who are using devices to maintain independence and to provide comfort when eating (i.e., plates with guards, large handled flatware, large handle mugs, extend hand flatware, etc.). [Code manually]

F. MEDICATIONS (F133 – F139)

F133: Receiving psychoactive drugs

The number of residents that receive drugs classified as antidepressants, antianxiety, sedative and hypnotics, and antipsychotics. [Any N0400A, B, C or D = checked].

Use the following lists to assist you in determining the number of residents receiving psychoactive drugs. These lists are not meant to be all inclusive; therefore, a resident receiving a psychoactive drug not on this list, should be counted under F133 and any other drug category that applies: F134, F135, F136, and/or F137.

F134: Receiving antipsychotic medications

[N0400A = checked]

- Clorazil (Clozapine)
- Haldol (Haloperidol)
- Haldol Deconate (Haloperidol Deconate)
- Inapsine (Droperidol)
- Loxitane (Loxapine)
- Mellaril (Thioridazine)
- Moban (Molindone)
- Navane (Theothixene)
- Olazapine (Zyprexa)
- Orap (Pimozide)
- Prolixin, Deconoate (Fluphenazine Deconate)
- Prolixin, Permitil (Fluphenazine)
- Quetiapine (Seroquel)
- Risperdal (Risperidone)
- Serentil (Mesoridazine)
- Sparine (Promazine)
- Stelazine (Trifluoperazine)
- Taractan (Chlorprothixene)
- Thorazine (Chlorpromazine)
- Tindel (Acetophenazine)
- Trilafon (Perphenazine)

F135: Receiving antianxiety medications

[N0400B = checked]

- Ativan (Lorazepam) Serax (Oxazepam)
- Centrax (Prazepam) Valium (Diazepam)
- Klonopin (Clonazepam) Vistaril, Atarax (Hydrox-
- Librium (Chlordiazepoxide) yzine)
- Paxipam (Halazepam) Xanax (Alprazolam)

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

(use with Form CMS-672)

F136: Receiving antidepressant medications

[N0400C = checked]

- Asendin (Amoxapine)
- Aventyl, Pamelor (Nortriptyline)
- Bupropion (Wellbutrin)
- Desyrel (Trazodone)
- Effexor (Venlafaxine)
- Elavil (Amtriptyline)
- Lithonate, Lithane (Lithium)
- Ludiomil (Maprotiline)
- Marplan (Isocarboxazid)
- Nardil (Phenelzine)
- Nefazodone (Serzone)
- Norpramin (Desipramine)
- Parnate (Tranlycypromine)
- Paroxetine (Paxil)
- Prozac (Fluoxetine)
- Sertraline (Zoloft)
- Sinequan (Doxepin)
- Tofranil (Imipramine)
- Vivactil (Protriptyline)

F137: Receiving hypnotic medications

[N0400D = checked]

- Dalmane (Flurazepam) Quazepam (Doral)
- Estazolam (ProSom) Restoril (Temazepam)
- Halcion (Triazolam) Zolpidem (Ambien)

F138: Receiving antibiotics

The number of residents receiving sulfonamides, antibiotics, etc., either for prophylaxis or treatment.

[N0400F = checked]

F139: On a pain management program

The number of residents with a specific plan for control of difficult to manage or intractable pain, which may include self medication pumps or regularly scheduled administration of medication alone or in combination with alternative approaches (e.g., massages, heat, etc.).

[J0100A, B, or C = 1]

G. OTHER RESIDENT CHARACTERISTICS**(F140 – F146)****F140: With unplanned or significant weight loss/gain**

The number of residents who have experienced gain or loss of 5% in one month or 10% over six months.

[K0300 = 2]

F141: Who do not communicate in the dominant language at the facility

The number of residents who only express themselves in a language not dominant at the facility (e.g., this would include residents who speak only Spanish, but the majority of staff that care for the residents speak only English).

[Code manually]

F142: Who use non-oral communication devices

(e.g., picture board, computers, sign-language).

[Code manually]

F143: Who have advanced directives (living will/durable power of attorney)

The number of residents who have advanced directives, such as a living will or durable power of attorney for health care, recognized under state law and relating to the provisions of care when the individual is incapacitated.

[Code manually]

F144: Received influenza immunization

The number of residents known to have received the influenza immunization within the last 12 months.

[Code manually]

F145: Received pneumococcal vaccine

The number of residents known to have received the pneumococcal vaccine.

[Code manually]

F146: Ombudsman notice: LEAVE BLANK

This will be completed by survey team. Indicate yes or no whether Ombudsman office was notified prior to survey.

F147: LEAVE BLANK

This will be completed by the survey team. Indicate whether Ombudsman was present at any time during the survey, 1 (yes) or 2 (no).

F148: Medication error rate: LEAVE BLANK

This will be completed by the survey team.