



User Manual

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[redacted] develops and delivers advanced healthcare information technology (HIT) solutions that provide the fast path to breakthroughs for healthcare systems in order to improve access to care, patient satisfaction and performance outcomes. [redacted]

World Wide Web [redacted]

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Revision History

Note: The revision history cycle begins once changes or enhancements are requested after the document has been base-lined.

	Revision Number	Description of Change	Author
05/10/2021	3.0	Updated for the new Covid-19 flag, new reports features, and new reports view formatting, all new screenshots	[REDACTED]
04/20/2020	3.0	Updated screenshots & added Observations charting section	[REDACTED]
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Introduction

Our Company

██████████ is a software development and solutions integration company focused on providing the fast path to healthcare breakthroughs to improve patient access to care, satisfaction, and performance outcomes. ██████████ products and integration software development toolkits are used for bi-directional Health Information Exchange, Integrating Commercial Off-The-Shelf (COTS) products into Electronic Health Records and sharing information across disparate Health Information Technology (IT) systems. Since our first involvement with VistA, we have modernized and transformed the legacy system into a robust platform with hundreds of Best-of-Suite, Best-of-Breed, custom applications, and integrated components.

What is ██████████?

██████████ a web-based solution located in the ██████████, is designed to identify the functional and health care needs of Veterans in long-term care facilities. The VA offers a dynamic array of short-stay and long-stay, non-acute services for Veterans who are medically and psychiatrically stable. ██████████ consists of Minimum Data Set (MDS), Care Plans, Care Manager, and National (Central) Reports. The software helps the user to develop a plan of care where services are individualized to meet the needs of each Veteran. ██████████ assists the staff in gathering definitive information on a resident's strengths and needs, which must be addressed in an individualized care plan.

██████████ increases user productivity across the resident care team as multiple ██████████ data points are integrated. Resident admissions, discharges, and transfers (ADT) are tracked through ██████████ integration, OBRA and PPS scheduling, MDS batching, and reports. Care Manager results are linked to multiple MDS sections and enables the user to quickly enter data into the assessments without exhaustive searches through ██████████/CPRS for the relevant data.

What is ██████████ MDS?

██████████ MDS is a standardized assessment and treatment planning process designed to identify the functional and health care needs of the Veteran and to help develop a plan of care where services are individualized to meet the needs of each resident. Caribou adheres to the Resident Assessment Instrument/ Minimum Data Set (RAI/MDS) 3.0 standards set forth by Centers for Medicare & Medicaid Services (CMS). ██████████ Admission Discharge Transfer (ADT) events, combined with business rules, automate Omnibus Budget Reconciliation Act (OBRA) and Prospective Payment System (PPS) MDS Scheduling. The schedule automatically calculates the next OBRA MDS assessment due, based on an administrative setting for quarterly/annual calculation, and it calculates the next PPS assessment due, giving the Resident Assessment Coordinator the ability to adjust the team workload and set the ARD and the Care Plan Review dates, while remaining compliant with CMS and VA requirements.

Section I of the MDS assessment is ICD-10 ready using the ██████████ Lexicon. Section V is directly linked to 20 CMS-recommended Care Area Assessment (CAA) forms with areas for multiple users to complete and sign. CAAs are saved as TIU Notes and are viewable in CPRS.

The Care Area Assessment (CAA) connects to the MDS assessments and integrates with the web Care Plans. The CAAs, refers to the basic tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring. When people are unable to perform these activities, they need help to cope, either from other human beings, or mechanical devices, or both. The CAA is the most important aspect of the care planning process. It precedes the official interdisciplinary treatment planning or care-planning team meeting. Working the CAAs requires designated interdisciplinary involvement to develop a person-centered care plan.

National (Central) Report provides reports on the all or selected Community Living Center data and allows reporting on any or all activities in the MDS assessments. This feature is only available for the VA Central Staff and allows specific user(s) or group(s) to generate reports that span multiple facilities. The report identifies functionality of the MDS Ad-Hoc report, where specific assessment items can be selected in addition to other criteria: date range, resident type, and neighborhood.

Additional reports such as Residents Admitted w/in Past 30 days, Alzheimer's/Dementia, Medications, Fall(s): w/ Injury, Fall(s), w/ Major Injury are available through the SQL Service Reporting Service (SSRS) feature. Each report has the following selections to be able to run the report:

- Regions (All, or 1 or 2 or 3 or 4)
- [REDACTED]
- Facility (All or each facility)
- Assessment Status (Work-in-progress or Complete)
- ARD Range Start Date and ARD Range End Date
- Resident Type (Active or Inactive)

What is [REDACTED] Care Manager?

[REDACTED] Care Manager includes Activities for Daily Living (ADL) and Events.

ADL refers to the basic tasks of everyday life and covers eating, bathing, dressing, toileting, and transferring, which can be done several times per day. Daily notes will be completed by the nursing staff during shift visits. The software is designed to only allow one user to chart the resident's ADL per shift. The user should complete ALL sections of ADL per each resident's ADL documentation per SHIFT, such as (Bed Mobility, Eating, Toileting, Transfer, Hygiene, Bathing, Dressing, Walk in Room, Walk in Corridor, Locomotion on Unit, Locomotion off unit). Users should complete Resident 1 documentation then proceed to Resident 2 etc.)

Users may chart toward the end of their shift for accurate ADL assessment charting (to ensure accurate assessment for the entire shift). Also, to ensure that coding is done to the highest value, users can make changes to their ADL entries.

Events allow for point of care documentation and cover activities for Rounding, Nutrition, Bladder, Bowel, Mobility, Bathing & Oral Care, Mood, Behavior and Cognitive. Event data can be documented per 1 hour or any pre-determined interval set by the Facility Administrator. Multiple users can update Events section.

Nursing staff can complete ADL and Event shift charting on residents with a simple flow and easy to access data points. We recommend creation of only one combined ADL and Events Progress Note per shift.

Shift charting reports are also included. Facility Administrator can generate an ADL report or individual Event reports for each resident. In addition, we have included reports for all residents in the facility by neighborhood. These reports are useful for resident monitoring and ensuring that resident shift charting is being performed correctly.

Care Manager Best Practices

Software Usability

1. Exit the [REDACTED] application using the proper SSOi/IAM logout sequence. This will greatly assist you and reduce the excessive need for clearing of cache and cookies.
2. Shared Workstations or Computers on Wheels (COWS) are not recommended as the system retains a 24-hour token. However, if your facility uses shared computers or COWS, ensure data integrity with the following steps:
 - DO NOT use the “X” in the top right-hand corner to close the application.
 - Always sign out [REDACTED]. DO NOT remove your [REDACTED] from machine and leave the [REDACTED] open.
 - Always Log out of Windows. DO NOT leave your Windows session open.

Daily Operations

1. Outside of FALL Protocol, is there a need to document every 15min on residents?

Caribou Events was designed to chart 1-hour or 2-hour intervals etc.

Suggestion: Use the **Comments** field and enter “Staff has eyes on resident every 15mins per policy” or “Staff visited resident Q15, Q30, Q45 & Q60”. Please note that there will be information overload. Data goes into our SQL database and may cause issues when your [REDACTED] Provider is reviewing documentation.
2. PO Fluid on intake can be added in the comments section.

Use the **comments** section to add your fluids – you can also use the comment section to document nourishment (ensure, magic cup, etc.) The comment section shows up on the report, so you would be able to see how much a resident consumed. Outputs are documented under Bowel and Bladder on the Events section.
3. 12-hour shift documentation process:

12-hour shifts are allowed based on the [REDACTED] workflow, although Care Manager defaults to 8-hour shifts. ADLs will be documented 2-times per 24-hour day and Events are documented throughout the shifts.

 - 12 AM – 8 AM
 - 8 AM – 4 PM
 - 4 PM – 12 AM

Example: It is recommended to chart ADL at the end of the shift

12-hour shift **8:00am-8:00pm** shift – you chart at 6:00pm in the **4:00pm-12:00am** shift.

12-hour shift **8:00pm-8:00am** would chart at 6:00am in the **12:00am – 8:00am** shift.

What is [REDACTED] Care Plans?

[REDACTED] Care Plans is designed to facilitate the development of resident focused interdisciplinary care plan. [REDACTED] provides a library which includes modifiable care plans for all 20 MDS Care Area Triggers, as well as all body systems.

The [REDACTED] Care Plan architecture directly interfaces with MDS and follows the ADT process.

Each resident requires a plan of the care to be provided based on their needs. The needs of each resident is determined based on review of hospital records, admission assessments, physician orders, diagnoses, conditions, etc. [REDACTED] captures each resident's Care Plan which allows the Clinical team to move from the assessments and develop the resident's individualized care plan.

Care plans are sortable by ward and users can easily see their assigned resident group and select a resident's care plan to create, update, or resolve. Our solution contains a comprehensive modifiable care plan database that includes CMS and [REDACTED] requirements for including the resident's voice with "I" goals and approaches, which supports a dynamic, collaborative process between residents, families, and staff. Each care plan problem in the library contains an educational component. The care plan library also includes categories and care plans for the 20 CAAs and body systems.

The Care Plan solution allows for global or individual goal set dates. Care Plan Meeting screens within the application allow for comprehensive documentation and review of CAAs and Care Plans. [REDACTED] Care Plans contain the point of access to document attendees, resident and family participation, as well as acceptance of the plan of care. The Care Plans allows the creation of Progress Notes to be signed and sent to CPRS. The application allows the care plans to be updated, reviewed, and signed by multiple users and reviewers.

Some advanced features are available to administrators for customization and control of the overall content of the care plan library database.

How This Manual is Organized

This manual follows user workflow through the [REDACTED] software. It explains [REDACTED] functions and options, then explores the clinical evaluations, daily ADL charting, MDS scheduling and assessments, Care Area assessments updating [REDACTED] Care Plans, and reports. The content is delivered in a step-by-step narrative format, with screen shots to aid in reading and understanding.

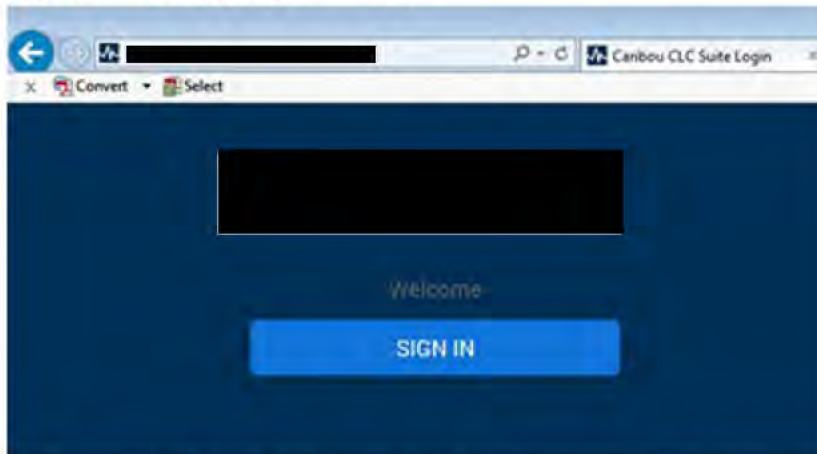
Getting Started

components are accessed through a web URL address.

Register as a New User

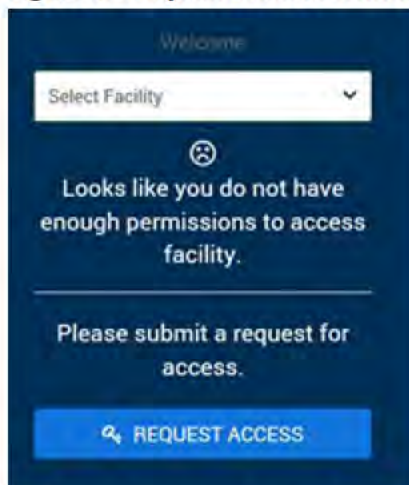
1. Launch the web application. The Sign In page opens.

Figure 1: Web App Sign In Window



2. Click the **Sign In** button. The Request Access window opens.

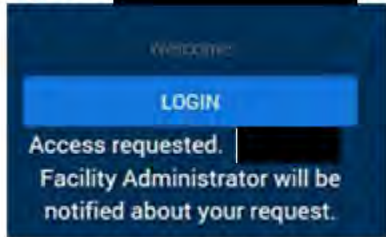
Figure 2: Request Access Window



3. Select your facility from the **Select Facility** drop-down list.
4. Click the **Request Access** button.

Access is requested. As soon as your facility administrator approves your access request, you will be able to log into the web application by clicking the **Login** button.

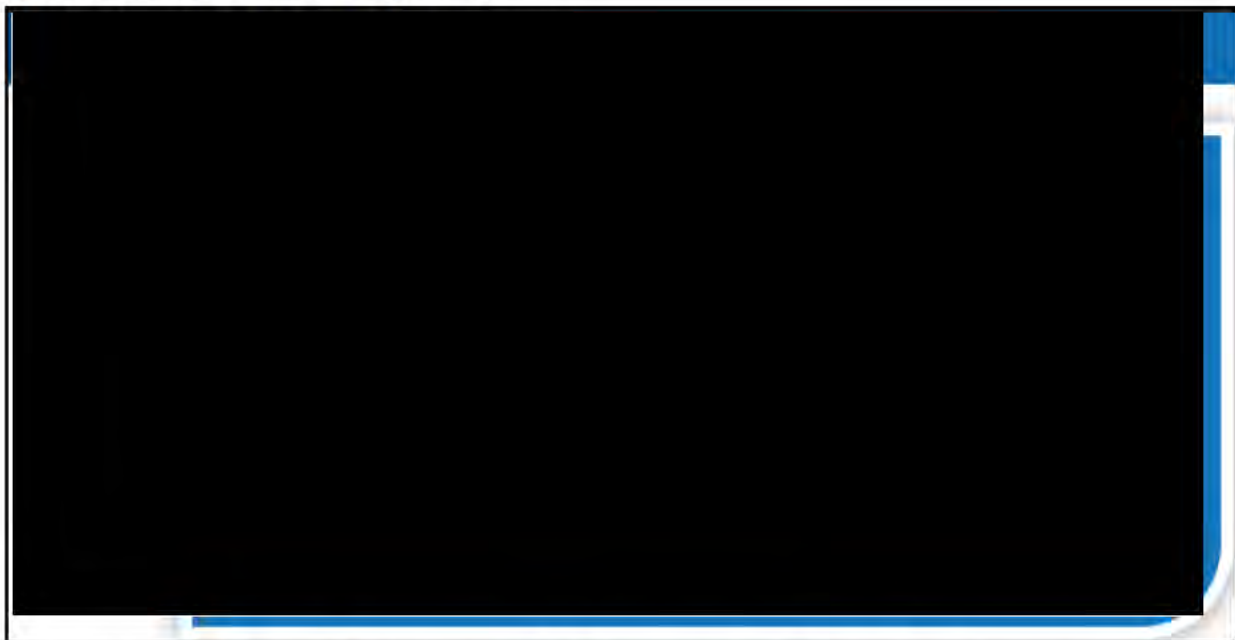
Figure 3: [REDACTED] Web App Login Window



Log In as a Registered User

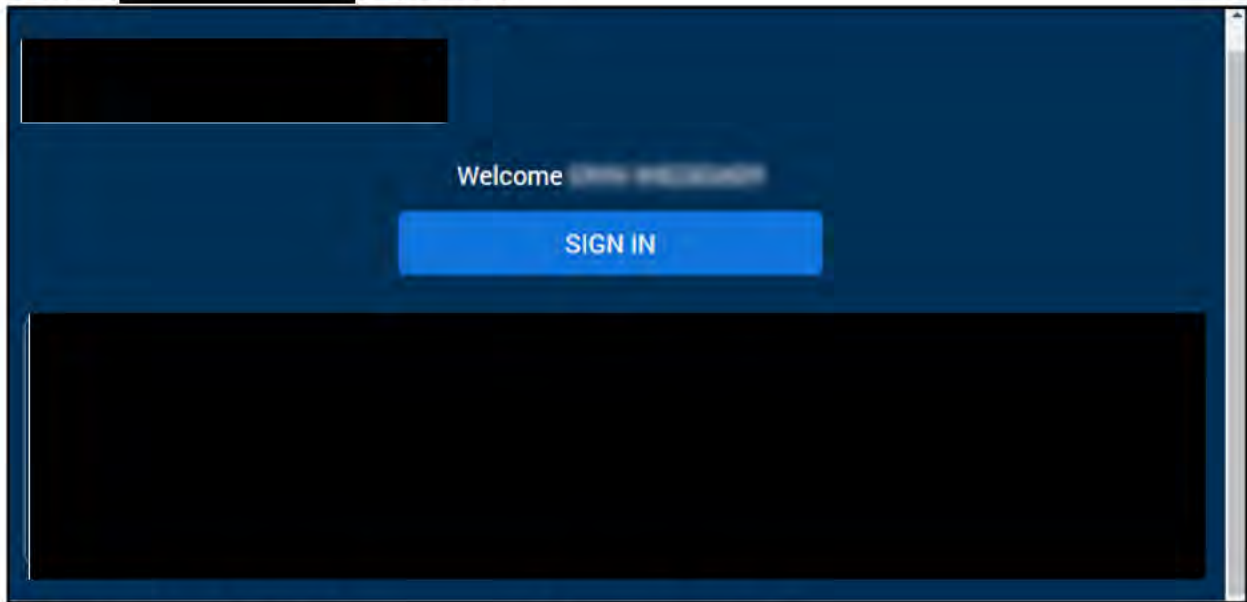
1. Launch the [REDACTED] web application. The [REDACTED] page opens
2. Sign in with your [REDACTED] card.

Figure 4: Caribou CLC Suite Sign In Screen



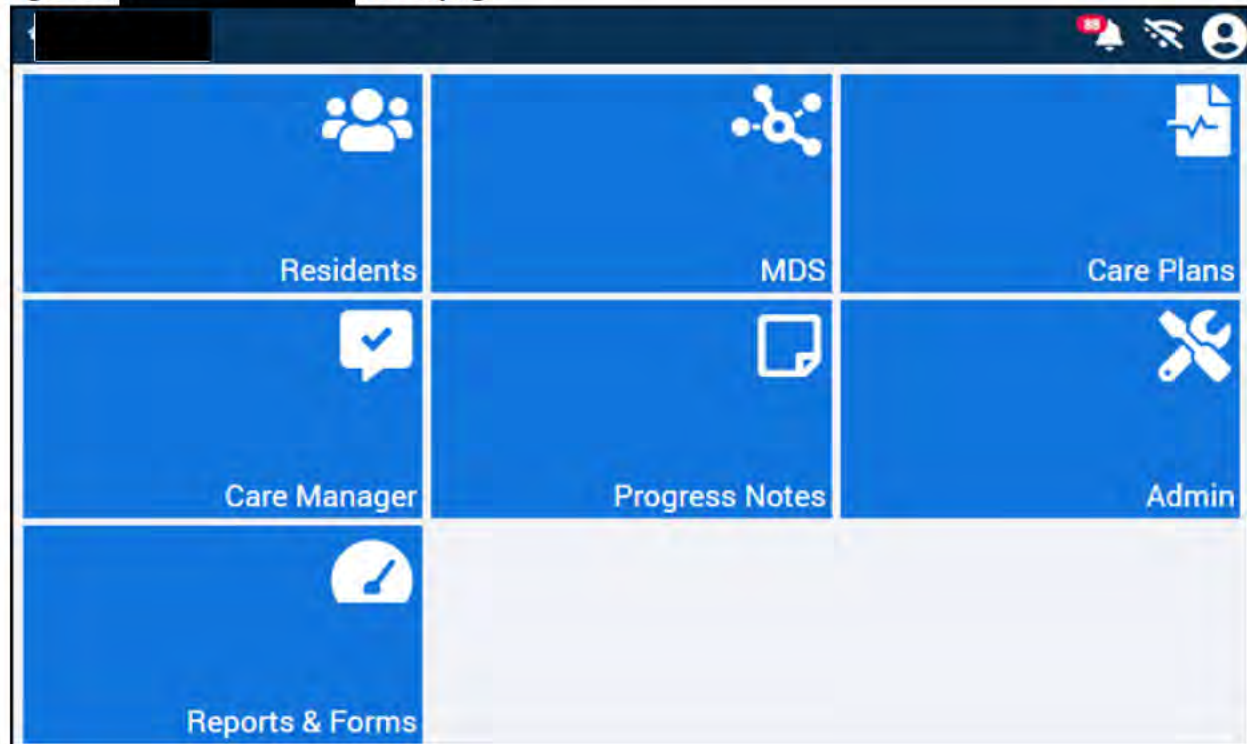
3. Select your [REDACTED] and enter your [REDACTED], as requested. The [REDACTED] Sign In page opens.

Figure 5: [REDACTED] Sign In Page



4. Click **Sign In**. The [REDACTED] homepage opens.

Figure 6: [REDACTED] Homepage



Header Bar

The header bar shows the breadcrumbs, alerts, synchronization status, and User icon.

Breadcrumbs

The breadcrumbs show where you are in the system and provides links to the previous areas of the system you have been in, concluding with the homepage.

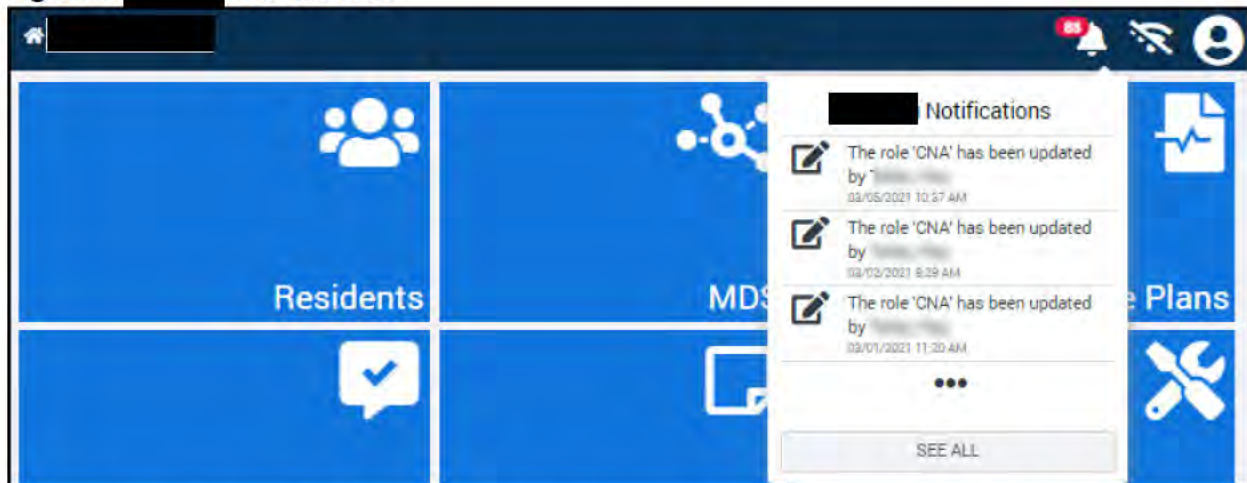
Figure 7: Breadcrumbs



Notifications

On the right side of the header bar is the notification bell icon. The icon shows the number of notifications you have in a red bubble over the bell icon. Click the bell icon to open a list of your notifications. You can select a notification to open the Notifications list, where they can be read and cleared if you are an admin.

Figure 8: Notifications



The notifications shown in this panel include: permissions changes, role assignment, and access approval.

Synchronization

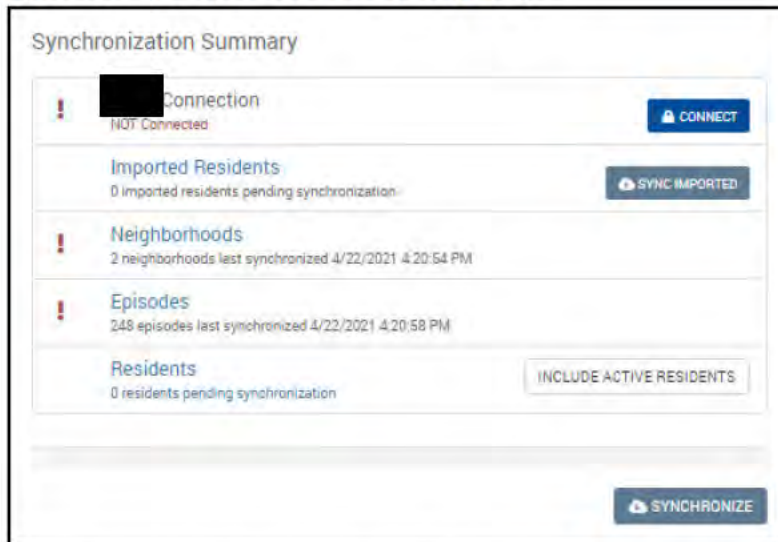
The next icon on the header bar is the Synchronization icon. The Synchronization icon looks like a wi-fi symbol. If you are not synced to CPRS, the wi-fi symbol has a line slashed through it.

Figure 9: Synchronization Icon



Click the **Synchronization** icon to access the Synchronization Summary page.

Figure 10: Synchronization Summary Page



The Synchronization Summary page shows your [REDACTED] Connection status, Imported Residents pending synchronization, number of synchronized Neighborhoods and last synced status and number of Episodes, and the number of Residents pending synchronization.

To perform a synchronization:

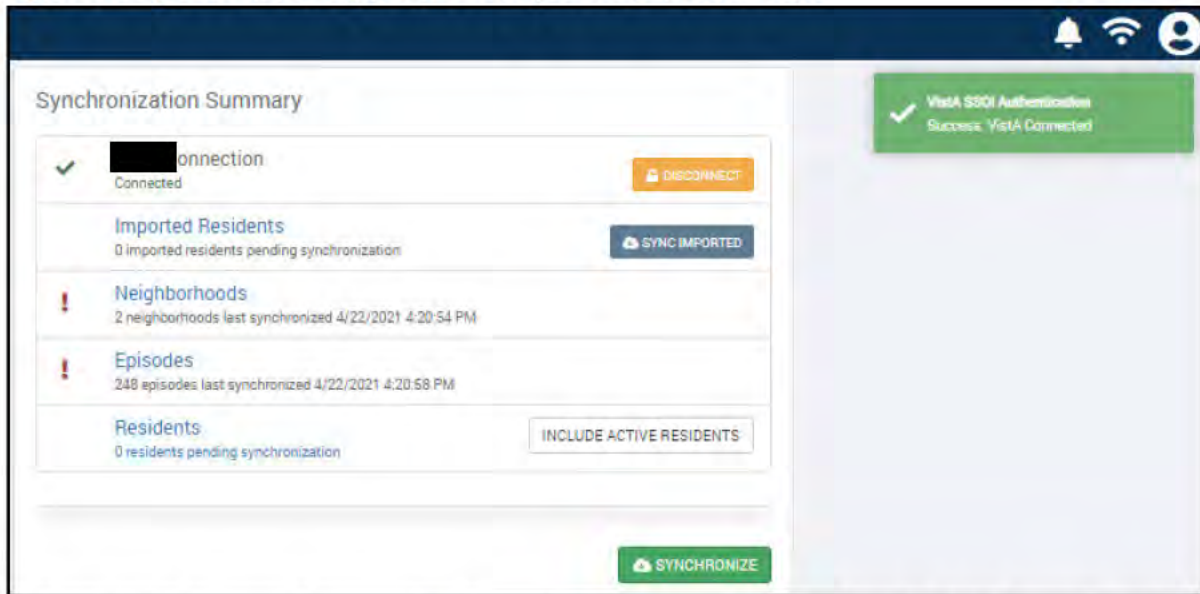
1. In the [REDACTED] Connection section, click **Connect**.

Figure 11: Connect to [REDACTED]



2. The page refreshes and produces a confirmation message that “[REDACTED] SSOI Authentication” was a success. Your connection to [REDACTED] is established.

Figure 12: Synchronize Neighborhoods, Episodes, and Residents

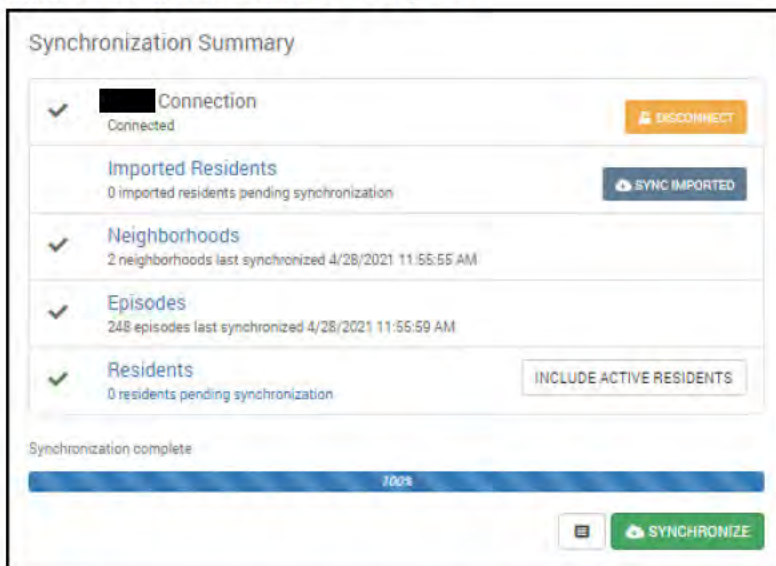



3. At the bottom of the page, click **Synchronize** to sync Neighborhoods, Episodes, and Residents.

The page refreshes when synchronization is complete. This could take a few minutes.

After synchronization, the page will show green check marks next to **Connection**, **Neighborhoods**, **Episodes**, and **Residents** to denote that the synchronization completed successfully.

Figure 13: Synchronization Complete



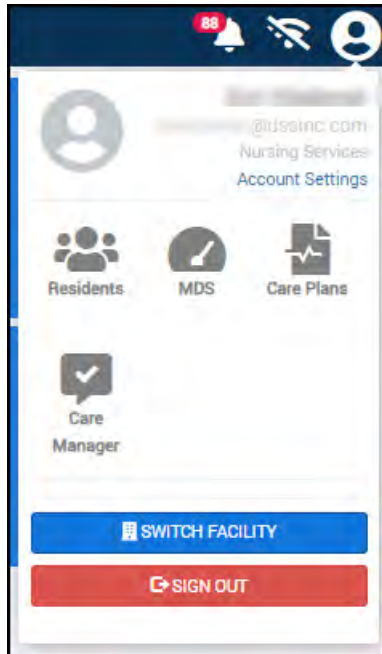
Click the **Synchronization Log** button  to open a log with details on what you just synced.

For a more complete synchronization, click the **Include Active Residents** button before you click the **Synchronize** button. This button includes active residents in the sync. This results in a longer sync time.

User Menu

The last icon to the right on the [REDACTED] header bar is the User Menu. This menu is your User icon or photo. Click the icon to open the **User Menu** drop-down list. In the User Menu list, you can access your **Account Settings**, go straight to **Residents**, **MDS**, **Care Plans**, or **Care Manager** without returning to the homepage, **Switch** to a different facility, or **Sign Out** of Caribou.

Figure 14: User Menu

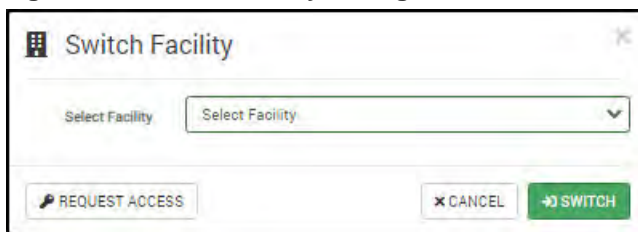


Switch Facility

If you have permissions to more than one facility, or if you want to request access to another facility:

1. Click the User Menu icon to open the panel.
2. Click the **Switch Facility** button. The Switch Facility dialog opens.

Figure 15: Switch Facility Dialog



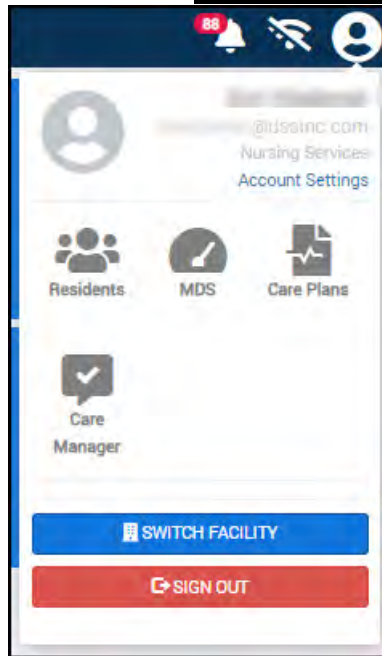
3. Use the **Select Facility** list to select the facility you want to switch to. Or click **Request Access** to request access to a new facility.
4. Click **Switch** to change to the selected facility.

Exiting [REDACTED]

Click the **User Menu** icon at the top right corner of the window and click **Sign Out**.

CAUTION: If you close [REDACTED] without signing out, the next person to open the software will enter it under your credentials. You must sign out of the software to keep your data safe.

Figure 16: Exit [REDACTED]



Care Manager

The [REDACTED] Care Manager facilitates shift charting, specifically patient ADL and Event documentation. To access a resident's shift charting:

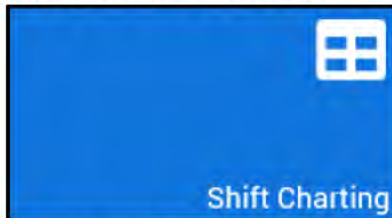
1. From the [REDACTED] homepage, click the **Care Manager** tile.

Figure 17: Care Manager Tile



2. Click the **Shift Charting** tile.

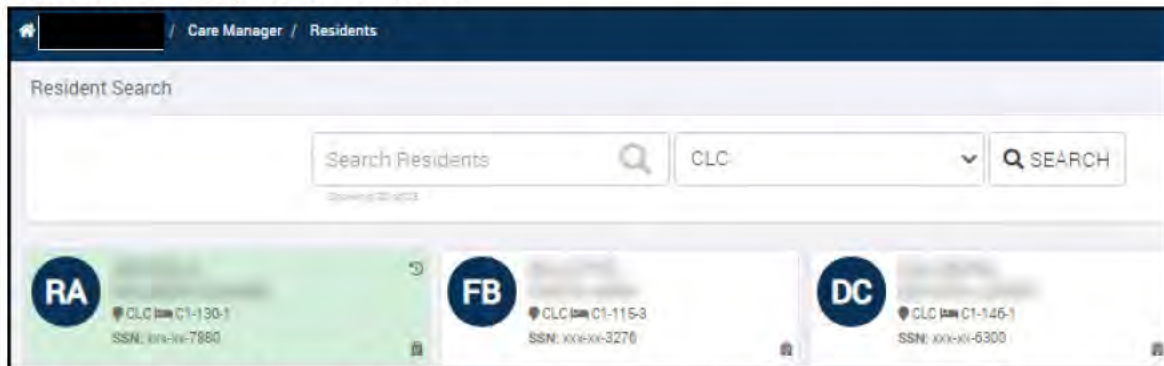
Figure 18: Shift Charting Tile



The Resident Search page opens.

Note: A green background on a resident tile indicates that this resident was most recently viewed.

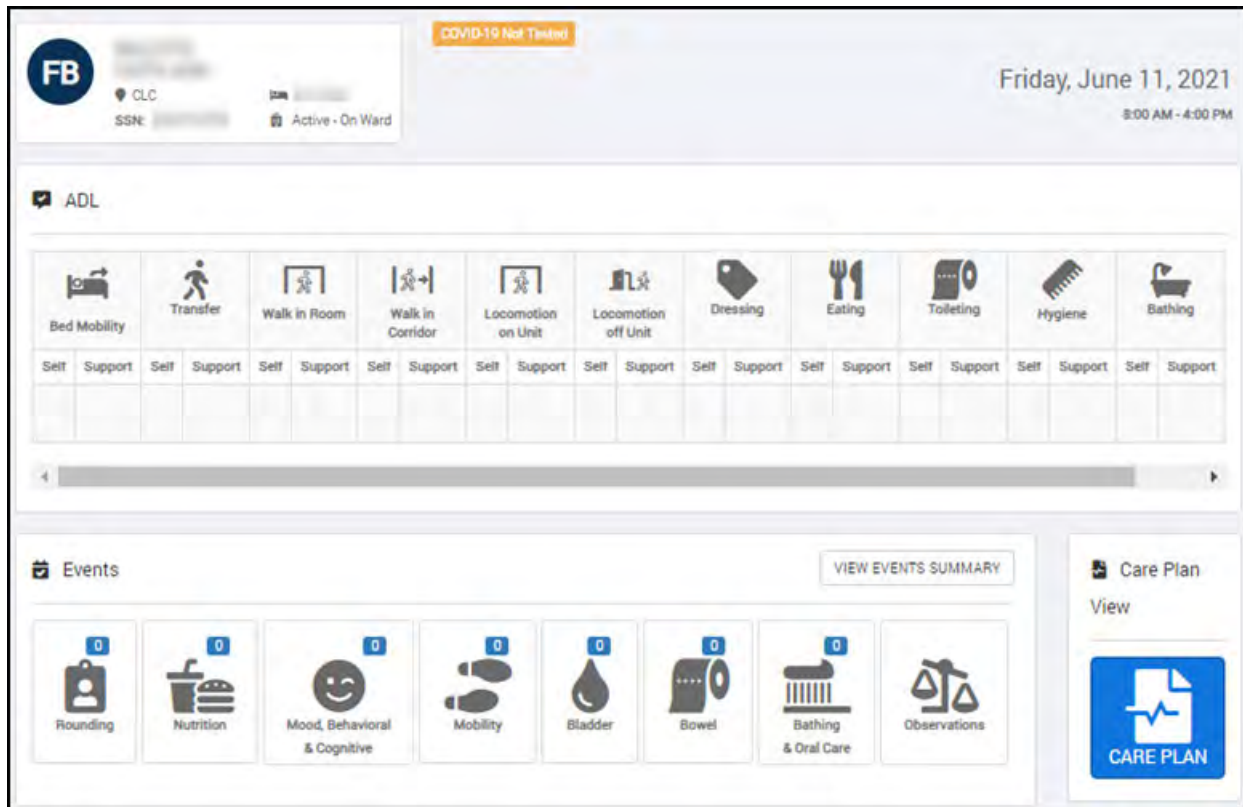
Figure 19: Recently Viewed Resident



3. Use either of these methods to choose the resident for whom you want to perform shift charting:
 - Enter the residents name in the **Search Residents** box.
 - Use the **Select Neighborhood** drop-down list to select the neighborhood for the resident you want to chart.
4. Click **Search**. The residents of that neighborhood populate the page.
5. Click the resident for whom you want to chart.

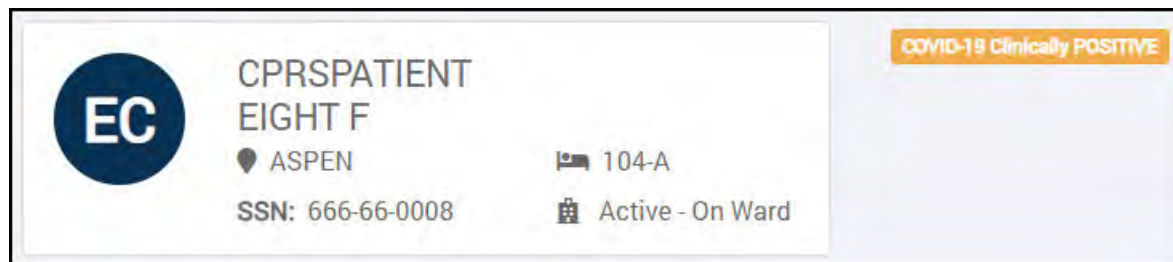
The Shift Charting page opens with ADL and Events charting panes.

Figure 20: Shift Charting Page



now includes a Covid-19 notice that identifies residents' Covid-19 status. The notice is placed next to the resident demographics on many of the web pages.

Figure 21: Resident Covid-19 Banner Example



Possible Covid-19 notice statuses are:

- COVID-19 POSITIVE Test
- COVID-19 Clinically POSITIVE
- COVID-19 Pending Test
- COVID-19 Recovered Test
- COVID-19 Recovered
- COVID-19 Negative Test
- COVID-19 Not Tested
- COVID-19 Status unknown- see labs/notes

ADL Charting

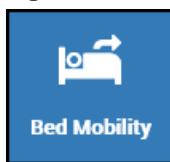
CNAs perform daily Activities of Daily Living (ADL) charting by documenting the charting flow for the selected resident. ADL Charting cannot be started by one user and finished by another. If you know you cannot complete the ADL charting, do not start it. Though users can update the ADL entries to ensure that coding is done to the highest value, it is recommended to perform ADL charting at the end of your shift so that the ADL assessment of the entire shift is accurate.

ADL charting offers the following charting functionality. Responses that are entered into pages of the daily ADL charting are also shown on the MDS assessment Section G for review and analysis.

Chart Bed Mobility

1. From the Shift Charting page, in the ADL pane, click **Bed Mobility**.

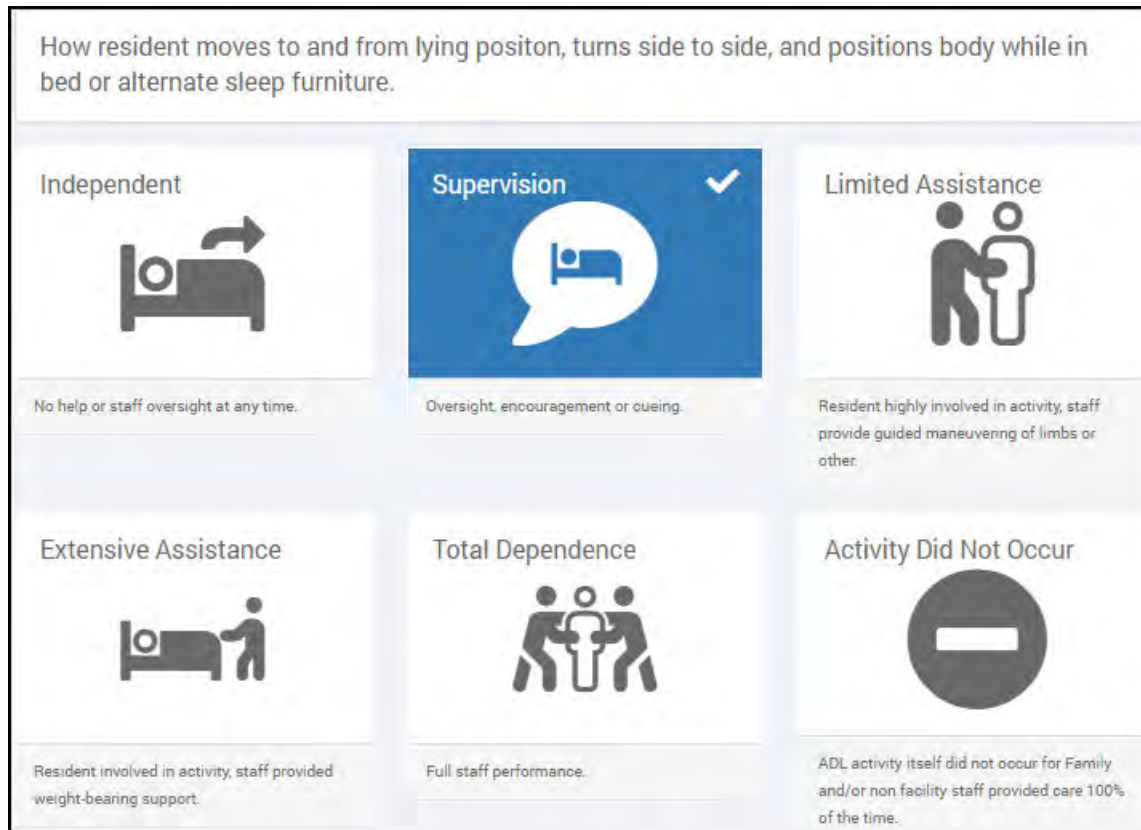
Figure 22: Bed Mobility Icon



The Bed Mobility page opens.

2. Choose the option that best describes how the resident moves to and from a lying position, turns side to side, and positions body while in bed or alternate sleep furniture. Bed Mobility options are:
 - **Independent**
 - **Supervision**
 - **Limited Assistance**
 - **Extensive Assistance**
 - **Total Dependence**
 - **Activity Did Not Occur**

Figure 23: Bed Mobility Choices

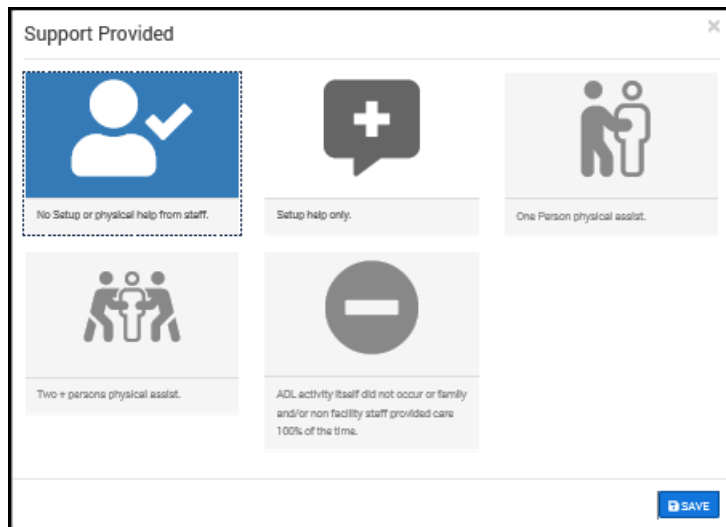


The Support Provided pop-up appears.

3. Choose the type of support that was provided to the resident. Support options are:

- **No setup or physical help from staff**
- **Setup help only**
- **One person physical assist**
- **Two + persons physical assist**
- **ADL activity itself did not occur or family and/or facility staff provided care 100% of the time**

Figure 24: Choose Support Provided



4. Click **Save**. A green confirmation message appears in the top right corner of the page and the entry is reflected on the Shift Charting page under the Bed Mobility icon.
5. To continue ADL charting, either:
 - Click the next activity in the left column of the page.
 - Click **Shift Charting** in the breadcrumbs at the top of the page.

Chart Transfer

1. From the Shift Charting page, in the ADL pane, click **Transfer**.

Figure 25: Transfer Icon









2. Choose the most accurate description of how the resident moves between surfaces, including to or from bed, chair, wheelchair, and standing position. The options are:

- **Independent**
- **Supervision**
- **Limited Assistance**
- **Extensive Assistance**
- **Total Dependence**
- **Activity Did Not Occur**

Figure 26: Charting Transfer Page

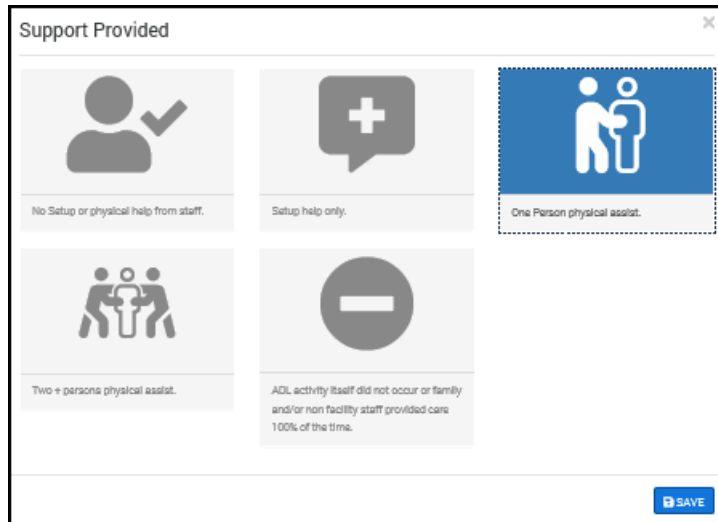
How resident moves between surfaces including to or from; bed, chair, wheelchair, standing position (excludes to/from bath/toilet).

<p>Independent</p>  <p>No help or staff oversight at any time.</p>	<p>Supervision</p>  <p>Oversight, encouragement or cueing.</p>	<p>Limited Assistance ✓</p>  <p>Resident highly involved in activity, staff provide guided maneuvering of limbs or other.</p>
<p>Extensive Assistance</p>  <p>Resident involved in activity, staff provided weight-bearing support.</p>	<p>Total Dependence</p>  <p>Full staff performance.</p>	<p>Activity Did Not Occur</p>  <p>ADL activity itself did not occur for Family and/or non facility staff provided care 100% of the time.</p>

The Support Provided pop-up opens.

3. Choose the type of support provided. The options are:
 - **No Setup or physical help from staff.**
 - **Setup help only.**
 - **One person physical assist.**
 - **Two + persons physical assist.**
 - **ADL activity itself did not occur or family and/or non facility staff provided care 100% of the time.**

Figure 27: Transfer Support Provided

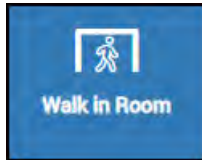


4. Click **Save**. A green confirmation message appears in the top right corner of the page and the entry is reflected on the Shift Charting page under the Transfer icon.
5. To continue ADL charting, either:
 - Click the next activity in the left column of the page.
 - Click **Shift Charting** in the breadcrumbs at the top of the page.

Chart Walk In Room

1. From the Shift Charting page, in the ADL pane, click **Walk in Room**.

Figure 28: Walk in Room Icon









2. Choose the most accurate description of how the resident walks between locations in his/her room. The options are:

- **Independent**
- **Supervision**
- **Limited Assistance**
- **Extensive Assistance**
- **Total Dependence**
- **Activity Did Not Occur**

Figure 29: Charting Walk In Room Page

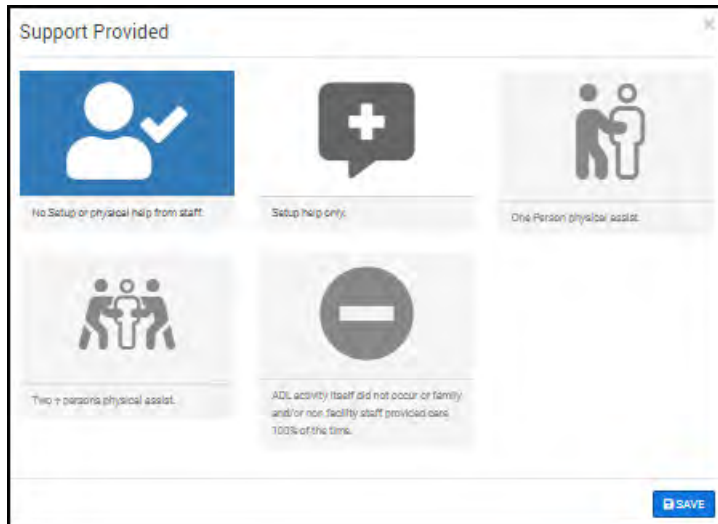
How resident walks between locations in his/her room.

<p>Independent</p>  <p>No help or staff oversight at any time.</p>	<p>Supervision <input checked="" type="checkbox"/></p>  <p>Oversight, encouragement or cueing.</p>	<p>Limited Assistance</p>  <p>Resident highly involved in activity, staff provide guided maneuvering of limbs or other.</p>
<p>Extensive Assistance</p>  <p>Resident involved in activity, staff provided weight-bearing support.</p>	<p>Total Dependence</p>  <p>Full staff performance.</p>	<p>Activity Did Not Occur</p>  <p>ADL activity itself did not occur for Family and/or non facility staff provided care 100% of the time.</p>

The Support Provided pop-up opens.

3. Choose the type of support provided. The options are:
 - **No Setup or physical help from staff.**
 - **Setup help only.**
 - **One person physical assist.**
 - **Two + persons physical assist.**
 - **ADL activity itself did not occur or family and/or non facility staff provided care 100% of the time.**

Figure 30: Walk In Room Support Provided

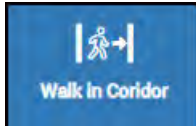


4. Click **Save**. A green confirmation message appears in the top right corner of the page and the entry is reflected on the Shift Charting page under the Walk In Room icon.
5. To continue ADL charting, either:
 - Click the next activity in the left column of the page.
 - Click **Shift Charting** in the breadcrumbs at the top of the page.

Chart Walk In Corridor

1. From the Shift Charting page, in the ADL pane, click **Walk in Corridor**.







Figure 31: Walk in Corridor Icon



2. Choose the most accurate description of how the resident walks in the corridor on unit. The options are:
 - **Independent**
 - **Supervision**
 - **Limited Assistance**
 - **Extensive Assistance**
 - **Total Dependence**
 - **Activity Did Not Occur**

Figure 32: Charting Walk In Corridor Page

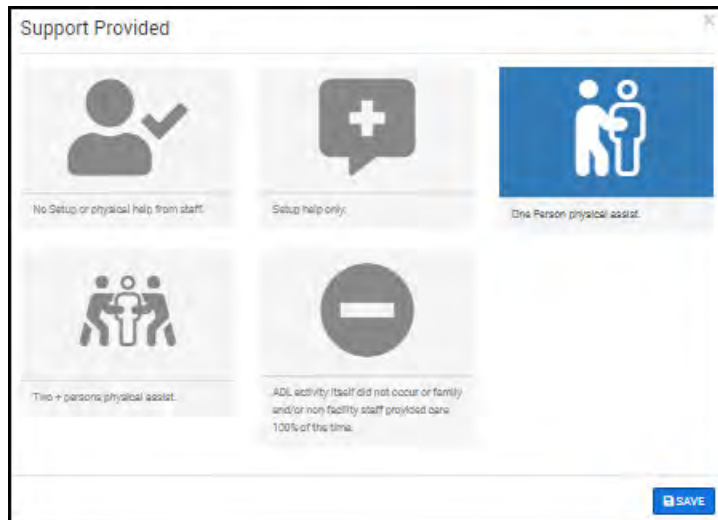
How resident walks in corridor on unit.

<p>Independent</p>  <p>No help or staff oversight at any time.</p>	<p>Supervision</p>  <p>Oversight, encouragement or cueing.</p>	<p>Limited Assistance ✓</p>  <p>Resident highly involved in activity, staff provide guided maneuvering of limbs or other.</p>
<p>Extensive Assistance</p>  <p>Resident involved in activity, staff provided weight-bearing support.</p>	<p>Total Dependence</p>  <p>Full staff performance.</p>	<p>Activity Did Not Occur</p>  <p>ADL activity itself did not occur for Family and/or non facility staff provided care 100% of the time.</p>

The Support Provided pop-up opens.

3. Choose the type of support provided. The options are:
 - **No Setup or physical help from staff.**
 - **Setup help only.**
 - **One person physical assist.**
 - **Two + persons physical assist.**
 - **ADL activity itself did not occur or family and/or non facility staff provided care 100% of the time.**

Figure 33: Walk In Corridor Support Provided

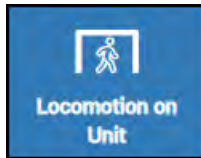


4. Click **Save**. A green confirmation message appears in the top right corner of the page and the entry is reflected on the Shift Charting page under the Walk In Corridor icon.
5. To continue ADL charting, either:
 - Click the next activity in the left column of the page.
 - Click **Shift Charting** in the breadcrumbs at the top of the page.

Chart Locomotion on Unit

1. From the Shift Charting page, in the ADL pane, click **Locomotion on Unit**.

Figure 34: Locomotion on Unit Icon









2. Choose the most accurate description of how the resident moves between locations in his/her room and adjacent corridor on the same floor. The options are:

- **Independent**
- **Supervision**
- **Limited Assistance**
- **Extensive Assistance**
- **Total Dependence**
- **Activity Did Not Occur**

Figure 35: Charting Locomotion on Unit Page

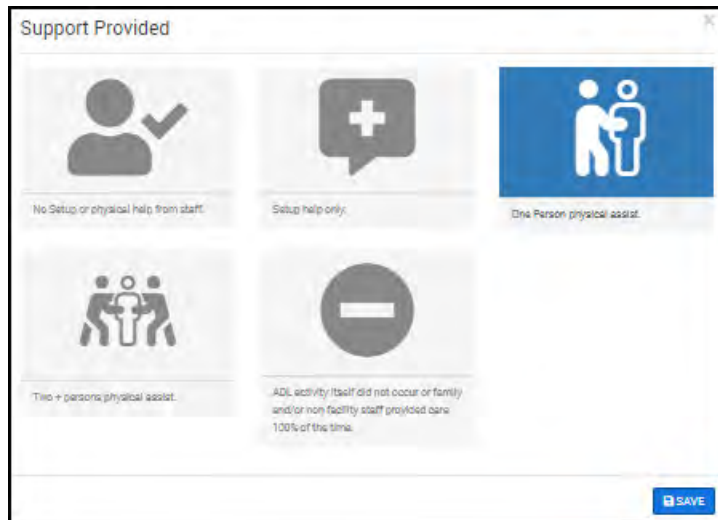
How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair.

<p>Independent</p>  <p>No help or staff oversight at any time.</p>	<p>Supervision</p>  <p>Oversight, encouragement or cueing.</p>	<p>Limited Assistance ✓</p>  <p>Resident highly involved in activity, staff provide guided maneuvering of limbs or other.</p>
<p>Extensive Assistance</p>  <p>Resident involved in activity, staff provided weight-bearing support.</p>	<p>Total Dependence</p>  <p>Full staff performance.</p>	<p>Activity Did Not Occur</p>  <p>ADL activity itself did not occur for Family and/or non facility staff provided care 100% of the time.</p>

The Support Provided pop-up opens.

3. Choose the type of support provided. The options are:
 - **No Setup or physical help from staff.**
 - **Setup help only.**
 - **One person physical assist.**
 - **Two + persons physical assist.**
 - **ADL activity itself did not occur or family and/or non facility staff provided care 100% of the time.**

Figure 36: Locomotion on Unit Support Provided

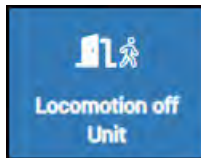


4. Click **Save**. A green confirmation message appears in the top right corner of the page, and the entry is reflected on the Shift Charting page under the Locomotion on Unit icon.
5. To continue ADL charting, either:
 - Click the next activity in the left column of the page.
 - Click **Shift Charting** in the breadcrumbs at the top of the page.

Chart Locomotion Off Unit

1. From the Shift Charting page, in the ADL pane, click **Locomotion off Unit**.

Figure 37: Locomotion off Unit Icon









2. Choose the most accurate description of how the resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities, or treatments). The options are:

- **Independent**
- **Supervision**
- **Limited Assistance**
- **Extensive Assistance**
- **Total Dependence**
- **Activity Did Not Occur**

Figure 38: Charting Locomotion Off Unit Page

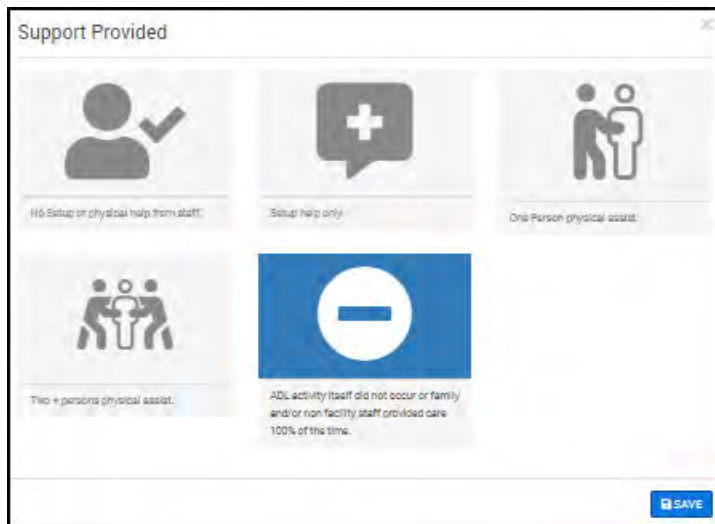
How resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair.

<p>Independent</p> 	<p>Supervision</p> 	<p>Limited Assistance</p> 
<p>No help or staff oversight at any time.</p>	<p>Oversight, encouragement or cueing.</p>	<p>Resident highly involved in activity, staff provide guided maneuvering of limbs or other.</p>
<p>Extensive Assistance</p> 	<p>Total Dependence</p> 	<p>Activity Did Not Occur ✓</p> 
<p>Resident involved in activity, staff provided weight-bearing support.</p>	<p>Full staff performance.</p>	<p>ADL activity itself did not occur for Family and/or non facility staff provided care 100% of the time.</p>

The Support Provided pop-up opens.

3. Choose the type of support provided. The options are:
 - **No Setup or physical help from staff.**
 - **Setup help only.**
 - **One person physical assist.**
 - **Two + persons physical assist.**
 - **ADL activity itself did not occur or family and/or non facility staff provided care 100% of the time.**

Figure 39: Locomotion Off Unit Support Provided

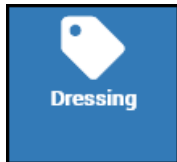


4. Click **Save**. A green confirmation message appears in the top right corner of the page, and the entry is reflected on the Shift Charting page under the Locomotion Off Unit icon.
5. To continue ADL charting, either:
 - Click the next activity in the left column of the page.
 - Click **Shift Charting** in the breadcrumbs at the top of the page.

Chart Dressing

1. From the Shift Charting page, in the ADL pane, click **Dressing**.

Figure 40: Dressing Icon









2. Choose the most accurate description of how the resident puts on, fastens, and takes off all items of clothing, including donning/removing a prosthesis or TED hose. The options are:

- **Independent**
- **Supervision**
- **Limited Assistance**
- **Extensive Assistance**
- **Total Dependence**
- **Activity Did Not Occur**

Figure 41: Charting Dressing Page

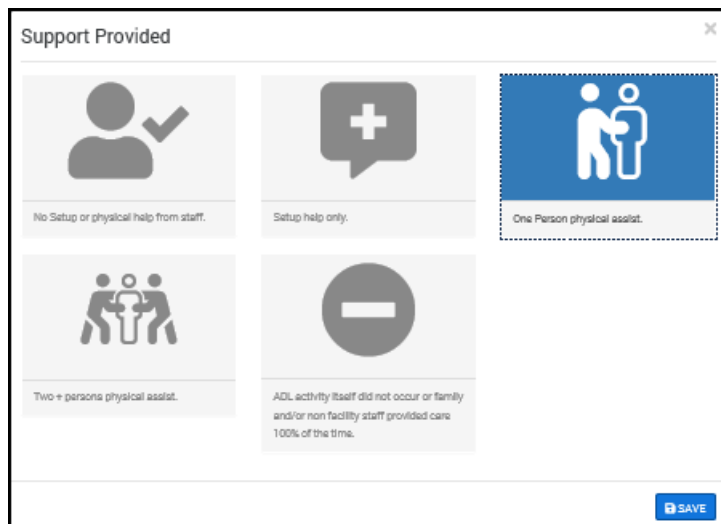
How resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses.

<p>Independent</p>  <p>No help or staff oversight at any time.</p>	<p>Supervision</p>  <p>Oversight, encouragement or cueing.</p>	<p>Limited Assistance ✓</p>  <p>Resident highly involved in activity, staff provide guided maneuvering of limbs or other.</p>
<p>Extensive Assistance</p>  <p>Resident involved in activity, staff provided weight-bearing support.</p>	<p>Total Dependence</p>  <p>Full staff performance.</p>	<p>Activity Did Not Occur</p>  <p>ADL activity itself did not occur for Family and/or non facility staff provided care 100% of the time.</p>

The Support Provided pop-up opens.

3. Choose the type of support provided. The options are:
 - **No Setup or physical help from staff.**
 - **Setup help only.**
 - **One person physical assist.**
 - **Two + persons physical assist.**
 - **ADL activity itself did not occur or family and/or non facility staff provided care 100% of the time.**

Figure 42: Dressing Support Provided



4. Click **Save**. A green confirmation message appears in the top right corner of the page and the entry is reflected on the Shift Charting page under the Dressing icon.
5. To continue ADL charting, either:
 - Click the next activity in the left column of the page.
 - Click **Shift Charting** in the breadcrumbs at the top of the page.

Chart Eating

1. From the Shift Charting page, in the ADL pane, click **Eating**.

Figure 43: Eating Icon









2. Choose the most accurate description of how the resident eats and drinks. The options are:

- **Independent**
- **Supervision**
- **Limited Assistance**
- **Extensive Assistance**
- **Total Dependence**
- **Activity Did Not Occur**

Figure 44: Chart Eating Page

How resident eats and drinks. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parental nutrition, IV fluids administered for nutrition or hydration).

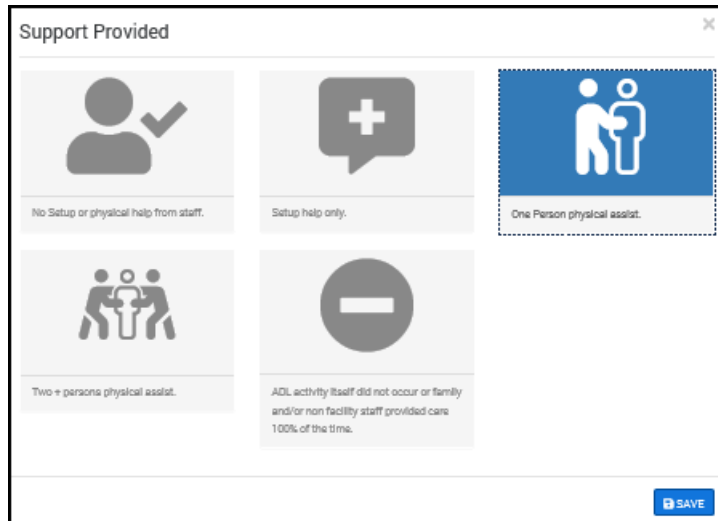
<p>Independent</p>  <p>No help or staff oversight at any time.</p>	<p>Supervision</p>  <p>Oversight, encouragement or cueing.</p>	<p>Limited Assistance <input checked="" type="checkbox"/></p>  <p>Resident highly involved in activity, staff provide guided maneuvering of limbs or other.</p>
<p>Extensive Assistance</p>  <p>Resident involved in activity, staff provided weight-bearing support.</p>	<p>Total Dependence</p>  <p>Full staff performance.</p>	<p>Activity Did Not Occur</p>  <p>ADL activity itself did not occur for Family and/or non facility staff provided care 100% of the time.</p>

The Support Provided pop-up opens

3. Choose the type of support provided. The options are:

- **No Setup or physical help from staff.**
- **Setup help only.**
- **One person physical assist.**
- **Two + persons physical assist.**
- **ADL activity itself did not occur or family and/or non facility staff provided care 100% of the time.**

Figure 45: Eating Support Provided



4. Click **Save**. A green confirmation message appears in the top right corner of the page and the entry is reflected on the Shift Charting page under the Eating icon.

5. To continue ADL charting, either:

- Click the next activity in the left column of the page.
- Click **Shift Charting** in the breadcrumbs at the top of the page.

Chart Toileting

1. From the Shift Charting page, in the ADL pane, click **Toileting**.

Figure 46: Toileting Icon









2. Choose the most accurate description of how the resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. The options are:

- **Independent**
- **Supervision**
- **Limited Assistance**
- **Extensive Assistance**
- **Total Dependence**
- **Activity Did Not Occur**

Figure 47: Charting Toileting Page

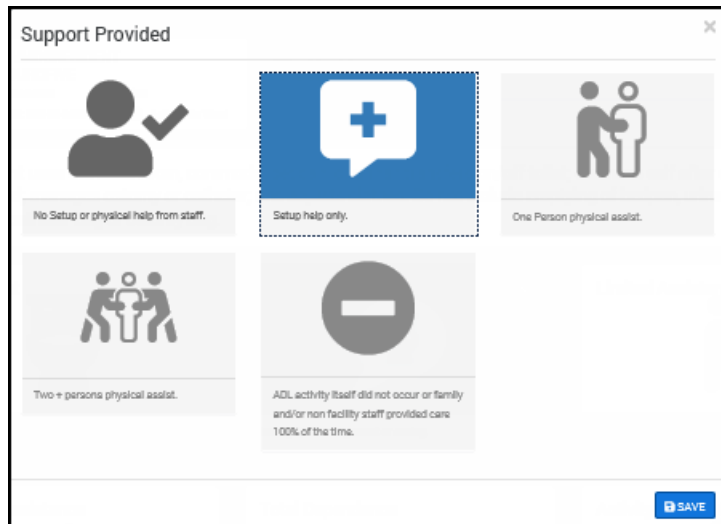
How resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag.

<p>Independent</p>  <p>No help or staff oversight at any time.</p>	<p>Supervision</p>  <p>Oversight, encouragement or cueing.</p>	<p>Limited Assistance</p>  <p>Resident highly involved in activity, staff provide guided maneuvering of limbs or other.</p>
<p>Extensive Assistance</p>  <p>Resident involved in activity, staff provided weight-bearing support.</p>	<p>Total Dependence</p>  <p>Full staff performance.</p>	<p>Activity Did Not Occur</p>  <p>ADL activity itself did not occur for Family and/or non facility staff provided care 100% of the time.</p>

The Support Provided pop-up opens.

3. Choose the type of support provided. The options are:
 - **No Setup or physical help from staff.**
 - **Setup help only.**
 - **One person physical assist.**
 - **Two + persons physical assist.**
 - **ADL activity itself did not occur or family and/or non facility staff provided care 100% of the time.**

Figure 48: Toileting Support Provided



4. Click **Save**. A green confirmation message appears in the top right corner of the page and the entry is reflected on the Shift Charting page under the Toileting icon.
5. To continue ADL charting, either:
 - Click the next activity in the left column of the page.
 - Click **Shift Charting** in the breadcrumbs at the top of the page.

Chart Hygiene

1. From the Shift Charting page, in the ADL pane, click **Hygiene**.







Figure 49: Hygiene Icon



2. Choose the most accurate description of how the resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing and drying the hands and face. This chart excludes baths and showers. Those are charted in [“Chart Bathing” on page 36](#). The options are:
 - **Independent**
 - **Supervision**
 - **Limited Assistance**
 - **Extensive Assistance**
 - **Total Dependence**
 - **Activity Did Not Occur**

Figure 50: Charting Hygiene Page

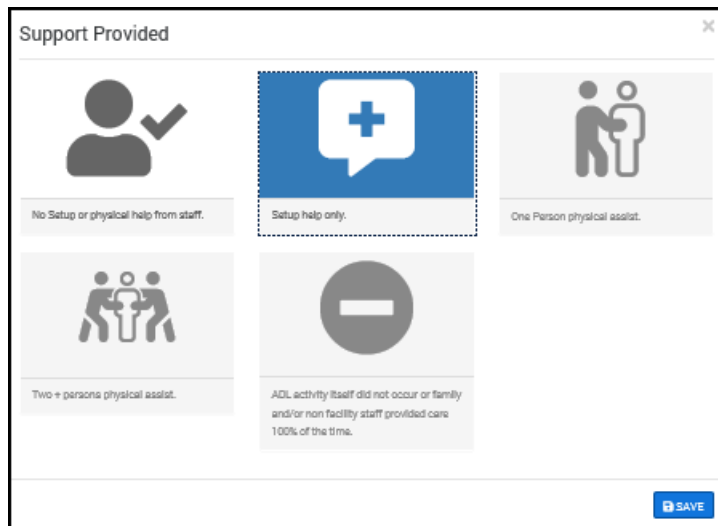
How resident maintains personal hygiene, including, combing hair, brushing teeth, shaving, applying makup, washing/drying face and hands. Excludes baths and showers.

<p>Independent</p> 	<p>Supervision</p> 	<p>Limited Assistance</p> 
<p>No help or staff oversight at any time.</p>	<p>Oversight, encouragement or cueing.</p>	<p>Resident highly involved in activity, staff provide guided maneuvering of limbs or other.</p>
<p>Extensive Assistance</p> 	<p>Total Dependence</p> 	<p>Activity Did Not Occur</p> 
<p>Resident involved in activity, staff provided weight-bearing support.</p>	<p>Full staff performance.</p>	<p>ADL activity itself did not occur for Family and/or non facility staff provided care 100% of the time.</p>

The Support Provided pop-up opens.

3. Choose the type of support provided. The options are:
 - **No Setup or physical help from staff.**
 - **Setup help only.**
 - **One person physical assist.**
 - **Two + persons physical assist.**
 - **ADL activity itself did not occur or family and/or non facility staff provided care 100% of the time.**

Figure 51: Hygiene Support Provided

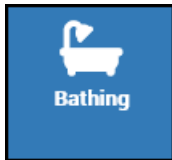


4. Click **Save**. A green confirmation message appears in the top right corner of the page and the entry is reflected on the Shift Charting page under the Hygiene icon.
5. To continue ADL charting, either:
 - Click the next activity in the left column of the page.
 - Click **Shift Charting** in the breadcrumbs at the top of the page,

Chart Bathing

1. From the Shift Charting page, in the ADL pane, click **Bathing**.

Figure 52: Bathing Icon









2. Choose the most accurate description of how the resident takes a full-body bath, shower, or sponge bath, and transfers in/out of the tub or shower. The options are:

- **Independent**
- **Supervision**
- **Physical help limited to transfer only**
- **Physical help in part of bathing activity**
- **Total Dependence**
- **Activity Did Not Occur**

Figure 53: Charting Bathing Page

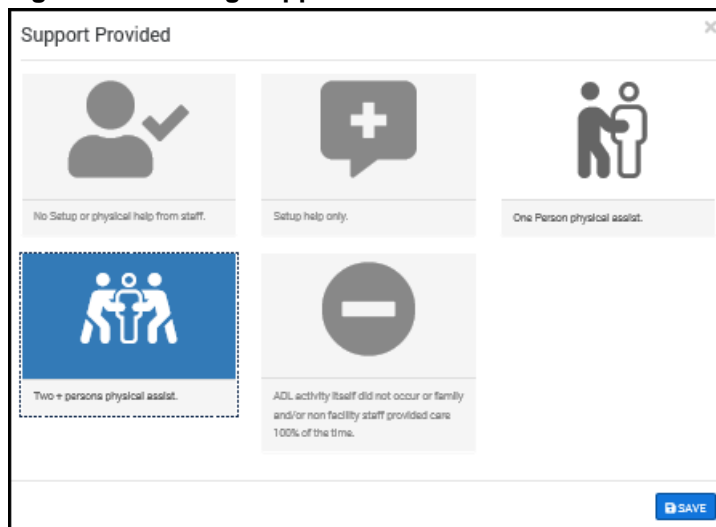
How resident takes full-body bath/shower, or sponge bath, and transfers in/out of tub/shower. Excludes washing of back and hair. Code for MOST DEPENDENT in self performance and support.

<p>Independent</p>  <p>No help or staff oversight at any time.</p>	<p>Supervision</p>  <p>Oversight, encouragement or cueing.</p>	<p>Physical help limited to transfer only</p>  <p>The resident is able to perform the bathing activity, but required help with the transfer only.</p>
<p>Physical help in part of bathing activity</p>  <p>The resident required assistance with some aspect of bathing.</p>	<p>Total Dependence</p>  <p>Full staff performance.</p>	<p>Activity Did Not Occur</p>  <p>ADL activity itself did not occur for Family and/or non facility staff provided care 100% of the time.</p>

The Support Provided pop-up opens.

3. Choose the type of support provided. The options are:
 - **No Setup or physical help from staff.**
 - **Setup help only.**
 - **One person physical assist.**
 - **Two + persons physical assist.**
 - **ADL activity itself did not occur or family and/or non facility staff provided care 100% of the time.**

Figure 54: Bathing Support Provided



4. Click **Save**. A green confirmation message appears in the top right corner of the page and the entry is reflected on the Shift Charting page under the Bathing icon.
5. To continue ADL charting, either:
 - Click the next activity in the left column of the page.
 - Click **Shift Charting** in the breadcrumbs at the top of the page.

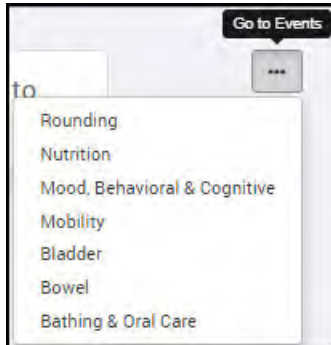
Go to Nursing Event Charting

While conducting ADL charting, you can use the **Go to Events** button to open any of the following Event charting pages:

- **Rounding**
- **Nutrition**
- **Mood, Behavioral & Cognitive**
- **Mobility**
- **Bladder**
- **Bowel**
- **Bathing & Oral Care**

The **Go to Events** button is an ellipsis button on the right side of all ADL charting pages.

Figure 55: Go to Events Button Options



See [“Events Charting” on page 40](#) for more information on charting these nursing events.

Complete ADL Charting

As the resident’s ADL charting is underway, the charting is scored on the Shift Charting page. When all activities have been documented, the chart is marked as 100% complete.

Figure 56: ADL Charting Complete

ADL																		VIEW SUMMARY				
Bed Mobility		Eating		Toileting		Transfer		Hygiene		Bathing		Dressing		Walk in Room		Walk in Corridor		Locomotion on Unit		Locomotion off Unit		
Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	
2	2	0	0	0	0	1	1	0	0	1	1	2	2	1	1	1	1	1	1	2	2	100% Complete

Click the **View Summary** button to open the ADL Shift Summary to review the resident’s ADL charting. If redirected to the VistA Login page, use your PIV card to log in.

Figure 57: ADL Shift Summary

ADL Shift Summary

EC CPRSPATIENT
EIGHT F
ASPEN 104-A
SSN: 666-66-0008 Active - On Ward

Include ADL Items Include Events

ADL Single-Shift Note

Resident Name: EIGHT F CPRSPATIENT
Facility: Caribou V37
Neighborhood: ASPEN

Shift Date: 03/02/2021
Shift Time: 4:00 PM - 12:00 AM
ADL Items:

BED MOBILITY:
Self: Supervision
Support: No setup or physical help from staff.

EATING:
Self: Limited Assistance
Support: One person physical assistance.

TOILETING:
Self: Supervision
Support: Setup help only.

TRANSFER:
Self: Limited Assistance
Support: One person physical assistance.

HYGIENE:
Self: Supervision
Support: Setup help only.

PRINT Enter E-signature CREATE TIU NOTE CANCEL

The ADL Shift Summary can show ADL items and Events from the shift chart. Select or deselect the **Include ADL Items** and **Include Events** boxes to customize which information you see in the summary. From the ADL Shift Summary, you can view or print the resident's ADL charting and can create a TIU Note.

To create a TIU Note:

1. At the bottom of the ADL Shift Summary page, in the **Enter E-signature** field, enter your e-signature.
2. Click the **Create TIU Note** button.

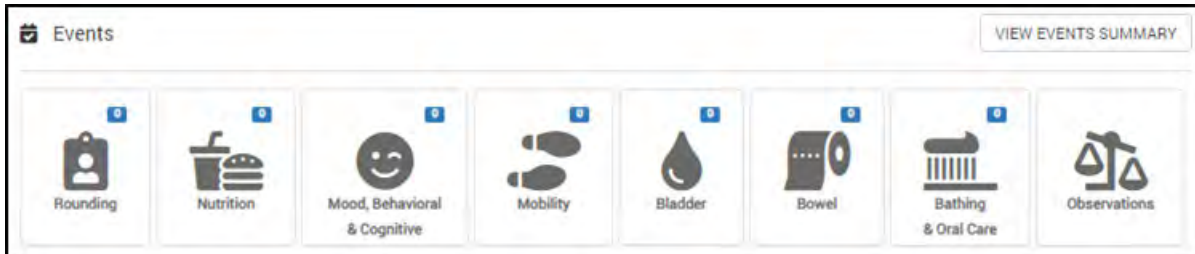
If redirected to the [REDACTED] Login page, use your [REDACTED] to log in.

To print the ADL Shift Summary, click the **Print** button at the bottom left corner of the page.

Events Charting

Nursing staff also perform resident events charting by documenting the charting flow for the selected resident. Any user may document any POC events on a resident's Events chart section. None of the events charting is mandatory, so staff should document events as they occur. As events are charted, the number in the blue square changes to reflect the charting.

Figure 58: Events Charting Pane

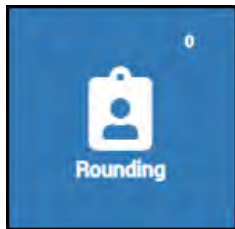


Events charting offers the following charting functionality.

Chart Rounding

1. From the Shift Charting page, in the Events pane, click **Rounding**.

Figure 59: Rounding Icon



The Rounding charting page opens.

Figure 60: Rounding Page

2. Use the drop-down lists to select the start time for the round.

Figure 61: Round Start Time

3. Use the **Resident Location Confirmed** boxes to choose the location of the resident. Location options are:
 - **Chair in Room**
 - **Bed in Room**
 - **Dining Room**
 - **Activity Room**
 - **Therapy Room**
 - **Other**

4. Select the **Room Environment** boxes that apply to the resident location. Room environment options are:
 - **Cords Secure**
 - **Lights**
 - **No Obstructions**
 - **Call Light Within Reach**
 - **Personal Items Within Reach**
 - **Bed Height Check**
 - **Floor Mats in Place**

Figure 62: Room Environment Check Boxes

Room Environment	
<input checked="" type="checkbox"/> Cords Secure	<input checked="" type="checkbox"/> Call Light Within Reach
<input checked="" type="checkbox"/> Lights	<input checked="" type="checkbox"/> Personal Items Within Reach
<input checked="" type="checkbox"/> No Obstructions	<input checked="" type="checkbox"/> Bed Height Check
	<input checked="" type="checkbox"/> Floor Mats In Place

5. Select the **Safety Equipment** boxes that apply to the resident location. Safety equipment options are:
 - **WC - Independent**
 - **WC - Wheels Locked**
 - **WC - Anti-tip**
 - **WC - Motorized**
 - **Low Position Bed**
 - **Call Staff Advisory**
 - **Hipster**
 - **Non-Skid Footwear**
 - **Floor Mats**
 - **Cane - Single Prong**
 - **Cane - Four Prong**
 - **Limb Prosthesis**
 - **Secure Pads**
 - **Protective Headgear**
 - **Chair Tray**
 - **Alarm**
 - **Positioning Wedges**
 - **Bed Cradle**
 - **Side Rails - Left**
 - **Side Rails - Right**

Figure 63: Safety Equipment Options

The screenshot shows a form titled "Safety Equipment" with a grid of 16 checkboxes. The options are: W/C - Independent, W/C - Wheels Locked, W/C - Anti-Tip, W/C - Motorized, Low Position Bed, Call Staff Advisory, Hipster, Non-Skid Footwear (checked), Floor Mats (checked), Cane - Single Prong (checked), Cane - Four Prong, Limb Prosthesis, Secure Pads, Protective Headgear, Chair With Tray, Alarm, Positioning Wedges, Bed Cradle, Side Rails - Left, and Side Rails - Right.

6. Select the appropriate **Comfort Status Check** option (**Sleeping, Hydration, or Potty**).
7. Enter the number of hours the resident was repositioned and select the appropriate **Position** option:
 - **Turned and repositioned # of hours** (free text field)
 - **Resident Refused to reposition**
 - **Right Side**
 - **Left Side**
 - **Back Side**

Figure 64: Position Data Entry and Options

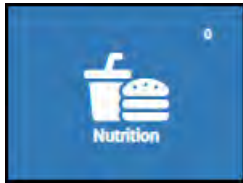
The screenshot shows a form titled "Position" with a text input field for "Turned and repositioned # of Hours" containing the number "4". Below the input field are four checkboxes: Resident Refused to reposition, Right Side (checked), Left Side, and Back Side.

8. Select the appropriate **Possessions** option:
 - **Glasses**
 - **Hearing Aid**
 - **Partial Dentures**
 - **Full Dentures**
9. In the **Comments** box, enter any free text comments on this round for the resident.
10. Click the **Save** button. A green “Success” confirmation message appears in the top right corner of the page, and the entry is reflected on the Shift Charting page on the Rounding icon.
11. To continue Event charting, either:
 - Click the next event in the left column of the page.
 - Click **Shift Charting** in the breadcrumbs at the top of the page.

Chart Nutrition

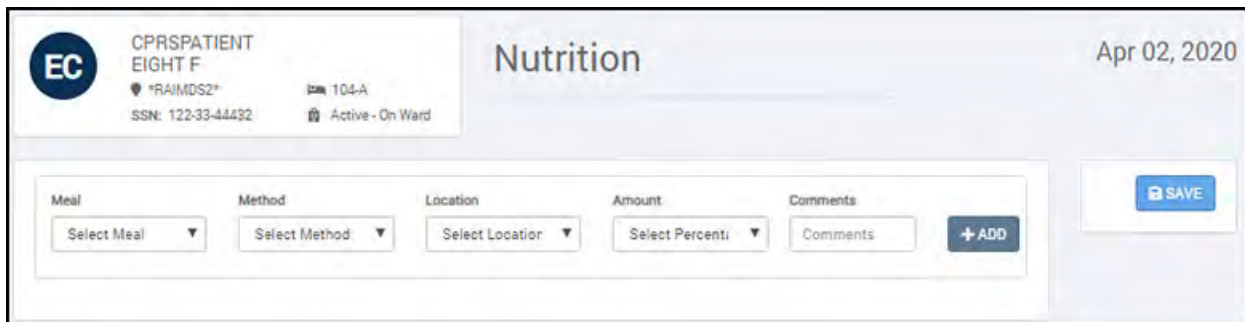
1. From the Shift Charting page, in the Events pane, click **Nutrition**.

Figure 65: Nutrition Icon



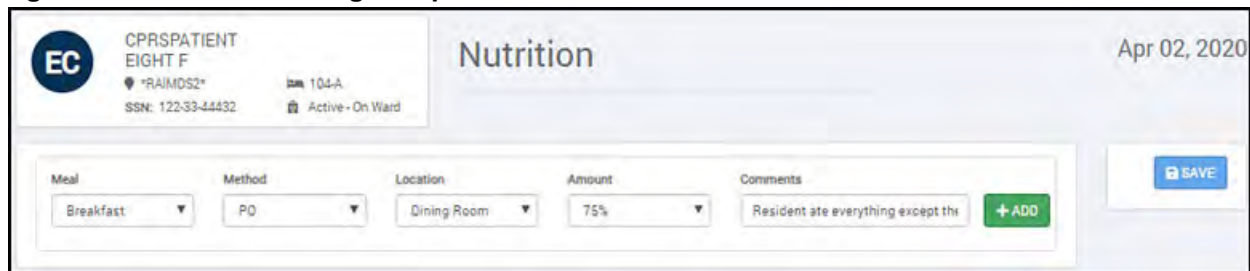
The Nutrition charting page opens.

Figure 66: Nutrition Page



2. Use the drop-down list to select the type of **Meal** for this event. Options are: **Breakfast**, **Lunch**, **Dinner**, and **Snack**.
3. Use the drop-down list to select the meal **Method** for this event. Options are: **PO**, **Tube**, **TPN**, and **NPO**.
4. Use the drop-down list to select the **Location** for this nutrition event. Options are: **Dining Room**, **Bedside**, and **Other**.
5. Use the drop-down list to select the **Amount** of nutrition for this event. Options are: **0%**, **25%**, **50%**, **75%**, and **100%**.
6. In the **Comments** box, add any free-text comments about the nutrition event.

Figure 67: Nutrition Charting Completed

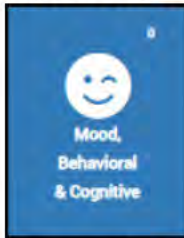


7. Click **Add**.
8. Click **Save**. A green “Success” confirmation message appears in the top right corner of the page, and the entry is reflected on the Shift Charting page on the Nutrition icon.
9. To continue Event charting, either:
 - Click the next event in the left column of the page.
 - Click **Shift Charting** in the breadcrumbs at the top of the page.

Chart Mood, Behavioral & Cognitive

1. From the Shift Charting page, in the Events pane, click **Mood, Behavioral & Cognitive**.

Figure 68: Mood, Behavioral & Cognitive Icon



The Mood, Behavioral & Cognitive charting page opens.

Figure 69: Mood, Behavioral & Cognitive Page

The screenshot shows the "Mood, Behavioral & Cognitive" charting page. At the top left, there is a circular logo with "FB" and a patient information box containing a redacted name, "CLC", "C1-115-3", "SSN: 223-57-3276", and "Active - On Ward". The main title "Mood, Behavioral & Cognitive" is on the right. The form is divided into three sections: "Mood Observation" with checkboxes for "Happy/Content", "Sad/Feeling Down", and "Angry/Hostile"; "Behavioral" with checkboxes for "Pleasant/Cooperative", "Physical To Others", "Verbal To Others", "Care Rejected", "Wanders", "Auditory Hallucination", "Other", "Delusions", "No Behavior", and "Visual Hallucination"; and "Cognitive" with checkboxes for "Alert & Disoriented", "Alert & Oriented", "Confused", "Unresponsive", and "Dozed Off". Below these sections are two buttons for "Was Change Significant?" labeled "YES" and "NO", a "Comments:" text area, and a blue "SAVE" button at the bottom right.

2. Record the resident's observed mood by checking the **Happy/Content**, **Sad/Feeling Down**, or **Angry/Hostile** box.
3. Under **Behavioral**, select the attributes that best describe the resident. Behavioral options are:
 - **Pleasant/Cooperative**
 - **Physical to Others**
 - **Verbal to Others**
 - **Care Rejected**
 - **Wanders**
 - **Auditory Hallucination**
 - **Other**
 - **Delusions**
 - **No Behavior**
 - **Visual Hallucination**

If a free-text box opens under a behavioral selection, enter details of the resident's behavior.

4. Use the **Cognitive** boxes to check the resident's cognitive attributes. Cognitive options are:
 - **Alert & Disoriented**
 - **Alert & Oriented**
 - **Confused**
 - **Unresponsive**
 - **Dozed Off**
5. For the **Was Change Significant** select either **Yes** or **No**.
6. In the **Comments** box, enter any additional comments on the resident's mood, behavior, or cognition.

Figure 70: Mood, Behavioral & Cognitive Event Charting Completed

Mood Observation

Happy/Content

Sad/Feeling Down

Angry/Hostile

Behavioral

Pleasant/Cooperative

Physical To Others

Verbal To Others

Care Rejected

Wanders

Auditory Hallucination

Other

Delusions

No Behavior

Visual Hallucination

Cognitive

Alert & Disoriented

Alert & Oriented

Confused

Unresponsive

Dozed Off

Was Change Significant?

Comments:

7. Click **Save**. A green “Success” confirmation message appears in the top right corner of the page, and the entry is reflected on the Shift Charting page on the Mood, Behavior & Cognitive icon.
8. To continue Event charting, either:
 - Click the next event in the left column of the page.
 - Click **Shift Charting** in the breadcrumbs at the top of the page.

Chart Mobility

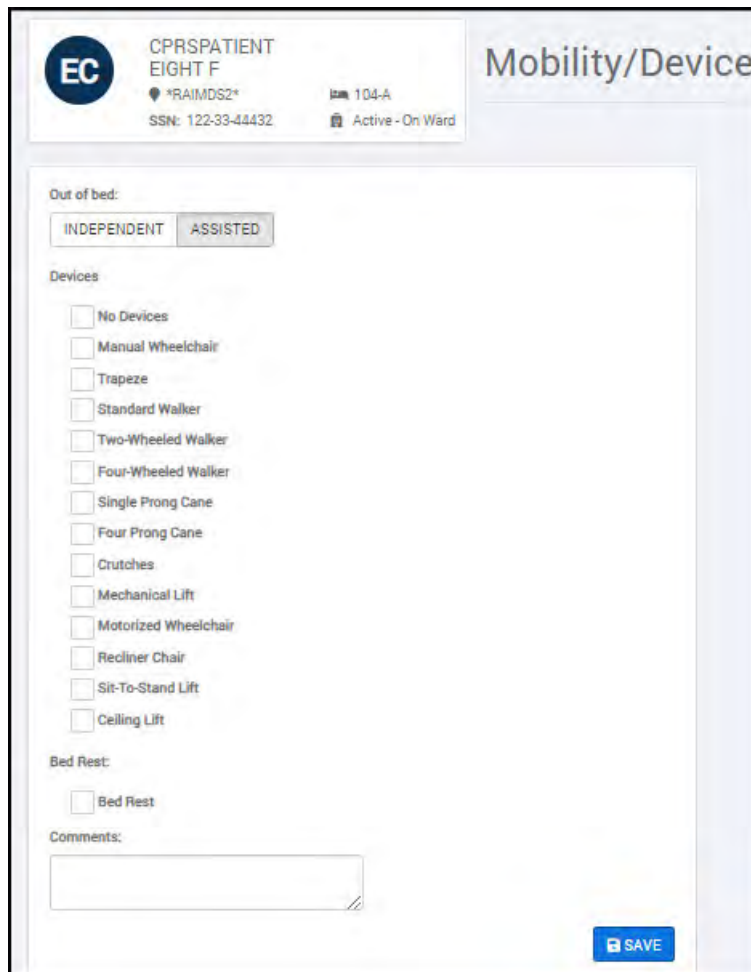
1. From the Shift Charting page, in the Events pane, click **Mobility**.

Figure 71: Mobility Icon



The Mobility/Device charting page opens.

Figure 72: Mobility Charting Page



2. Under **Out of bed**, choose either **Independent** or **Assisted**.
3. Use the **Devices** drop-down list to select the devices the resident users. Device options are:
 - **No Devices**
 - **Manual Wheelchair**
 - **Trapeze**
 - **Standard Walker**
 - **Two-Wheeled Walker**

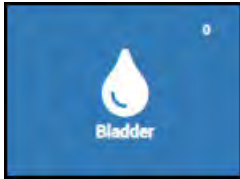
- **Four-Wheeled Walker**
- **Single Prong Cane**
- **Four Prong Cane**
- **Crutches**
- **Mechanical Lift**
- **Motorized Wheelchair**
- **Recliner Chair**
- **Sit-To-Stand Lift**
- **Ceiling Lift**

4. Under **Bed Rest**, check the box if the resident is prescribed bed rest.
5. In the **Comments** box, enter any further details about the resident's mobility.
6. Click **Save**. A green "Success" confirmation message appears in the top right corner of the page, and the entry is reflected on the Shift Charting page on the Mobility icon.
7. To continue Event charting, either:
 - Click the next event in the left column of the page.
 - Click **Shift Charting** in the breadcrumbs at the top of the page.

Chart Bladder

1. From the Shift Charting page, in the Events pane, click **Bladder**.

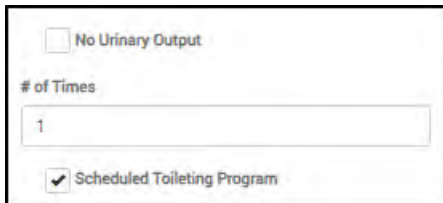
Figure 73: Bladder Icon



The Bladder charting page opens.

2. Check the No Urinary Output box if the resident has not passed urine.
3. In the **# of Times** field, enter the number of times the resident passed urine during your shift.
4. If the resident has a **Scheduled Toileting Program** check the box.

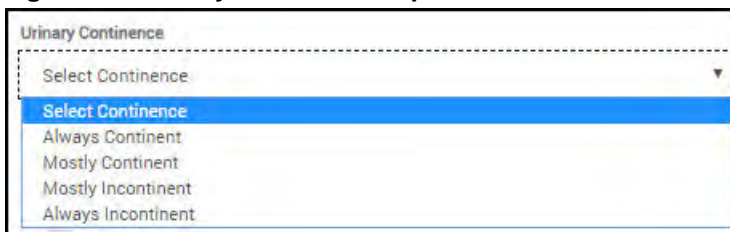
Figure 74: Bladder Movement



5. Under **Urinary Contenance**, select the appropriate option. Urinary Contenance options are:

- **Always Continent**
- **Mostly Continent**
- **Mostly Incontinent**
- **Always Incontinent**

Figure 75: Urinary Contenance Options



6. Under **Appliances**, select the bladder appliances the resident uses. The appliance options are:

- **Toilet**
- **Bedpan**
- **Incontinent/Adult Briefs**
- **Bedside Commode**
- **Urinal**
- **Foley Catheter**
- **Intermittent Catheter**
- **Nephrostomy Catheter**
- **Suprapubic Catheter**

- **External Catheter**
7. Under **Urinary Output**, enter the quantity of urine passed in cc/ml.
 8. Under **Urine Description**, select the most accurate description of the resident’s urine. Options are:
 - **Clear**
 - **Cloudy**
 - **Light Yellow**
 - **Pink**
 - **Dark Yellow**
 - **Foul Odor**

Figure 76: Bladder Charting Urine Volume and Description

The screenshot shows a web form for bladder charting. It is divided into four main sections:

- Appliances:** A list of checkboxes for different types of urinary collection devices. 'Toilet' and 'Bedpan' are checked, while 'Incontinent / Adult Briefs', 'Bedside Commode', 'Urinal', 'Foley Catheter', 'Intermittent Catheter', 'Nephrostomy Catheter', 'Suprapubic Catheter', and 'External Catheter' are unchecked.
- Urinary Output:** A text input field containing the number '4'.
- Urine Description:** A list of checkboxes for urine characteristics. 'Light Yellow' is checked, while 'Clear', 'Cloudy', 'Pink', 'Dark Yellow', and 'Foul Odor' are unchecked.
- Comments:** A large, empty text area for providing additional details.

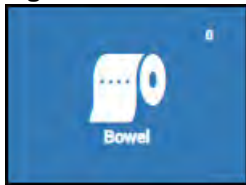
A blue 'SAVE' button is located at the bottom right of the form.

9. In the **Comments** box, enter details on the resident’s urine.
10. Click **Save**. A green “Success” confirmation message appears in the top right corner of the page, and the entry is reflected on the Shift Charting page on the Bladder icon.
11. To continue Event charting, either:
 - Click the next event in the left column of the page.
 - Click **Shift Charting** in the breadcrumbs at the top of the page.

Chart Bowel

1. From the Shift Charting page, in the Events pane, click **Bowel**.

Figure 77: Bowel Icon



The Bowel charting page opens.

2. If the resident has not had a bowel movement, check the **No Bowel Movement** box. If the resident has had a bowel movement, in the **# of Times** field, enter the number of times the resident had a bowel movement.
3. If the resident has a **Scheduled Toileting Program**, check the box.
4. Under **Bowel Continence**, select the resident's bowel continence. Bowel continence options are:
 - **Always Continent**
 - **Mostly Continent**
 - **Mostly Incontinent**
 - **Always Incontinent**
5. Under Appliances, select the appliance(s) the resident uses. Appliance options are:
 - **Toilet**
 - **Bedpan**
 - **Incontinent/Adult Briefs**
 - **Ostomy**
6. Under **Size**, select the size of the resident's bowel movement. Options are **BM Output – Small**, **BM Output –Medium**, and **BM Output –Large**.
7. Under **Texture Description**, select the texture of the resident's bowel movement. Options are **Soft**, **Hard**, **Formed**, and **Liquid**.
8. In the **Comments** box, enter any further details on the resident's bowel movement.

Figure 78: Bowel Charting Page

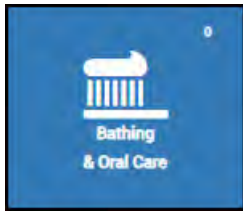
The screenshot shows a form for recording bowel movements. It includes a checkbox for "No Bowel Movement", a text input for "# of Times" (set to 1), a checked checkbox for "Scheduled Toileting Program", a dropdown for "Bowel Continence" (set to "Always Continent"), a section for "Appliances" with checkboxes for "Toilet", "Bedpan", "Incontinent / Adult Briefs", and "Ostomy", a dropdown for "Size" (set to "BM Output - Medium"), a dropdown for "Texture Description" (set to "Soft"), and a text area for "Comments". A blue "SAVE" button is located in the bottom right corner.

9. Click **Save**. A green “Success” confirmation message appears in the top right corner of the page, and the entry is reflected on the Shift Charting page on the Bowel icon.
10. To continue Event charting, either:
 - Click the next event in the left column of the page.
 - Click **Shift Charting** in the breadcrumbs at the top of the page.

Chart Bathing & Oral Care

1. From the Shift Charting page, in the Events pane, click **Bathing & Oral Care**.

Figure 79: Bathing & Oral Care Icon



The Bathing & Oral Care charting page opens.

2. Under **Attire**, select either **Pajamas/Gown** or **Personal Attire**.
3. Under **Bath Type**, select the resident's type of bathing. Bathing options are: **Bedbath**, **Shower**, **Tub/Whirlpool**, and **Partial Bath**.
4. Under **Oral Care**, select the resident's type of mouth care. Mouth care options are:
 - **Independent**
 - **Partial Assist**
 - **Total Assist**
 - **Refused**
 - **No Oral Care Provided**
 - **Oral Care Provided**
5. Under **Type of care provided**, select the options that apply to the resident. Options are:
 - **Brush All Oral Surfaces**
 - **Clean Dentures/Partial**
 - **Swab All Oral Surfaces**
 - **Other**
6. Under **Dental Condition**, select the options that apply to the resident. Options are:
 - **Upper Denture**
 - **Lower Denture**
 - **Full Dentures**
 - **Partial Teeth**
 - **Natural Teeth**
 - **Edentulous**
7. In the **Comments** box, enter further details on the resident's bathing and oral care.

Figure 80: Bathing and Oral Care Charting Completed

The screenshot shows a web form for charting bathing and oral care. The form is titled "Attire:" and has two tabs: "PAJAMAS/GOWN" (selected) and "PERSONAL ATTIRE". Below this are sections for "Bath Type", "Oral Care", "Type of care provided", and "Dental Condition". Each section contains several checkboxes, with some checked. At the bottom, there is a "Comments:" field with a text area containing the text "Resident is capable and willing to perform self oral care." and a blue "SAVE" button.

Attire:

PAJAMAS/GOWN PERSONAL ATTIRE

Bath Type

Bedbath

Shower

Tub/Whirlpool

Partial Bath

Oral Care

Independent

Partial Assist

Total Assist

Refused

No Oral Care Provided

Oral Care Provided

Type of care provided

Brush All Oral Surfaces

Clean Dentures/Partial

Swab All Oral Surfaces

Other

Dental Condition

Upper Denture

Lower Denture

Full Dentures

Partial Teeth

Natural Teeth

Edentulous

Comments:

Resident is capable and willing to perform self oral care.

SAVE

8. Click **Save**. A green “Success” confirmation message appears in the top right corner of the page, and the entry is reflected on the Shift Charting page on the Bathing and Oral Care icon.
9. To continue Event charting, either:
 - Click the next event in the left column of the page.
 - Click **Shift Charting** in the breadcrumbs at the top of the page.

Charting Observations


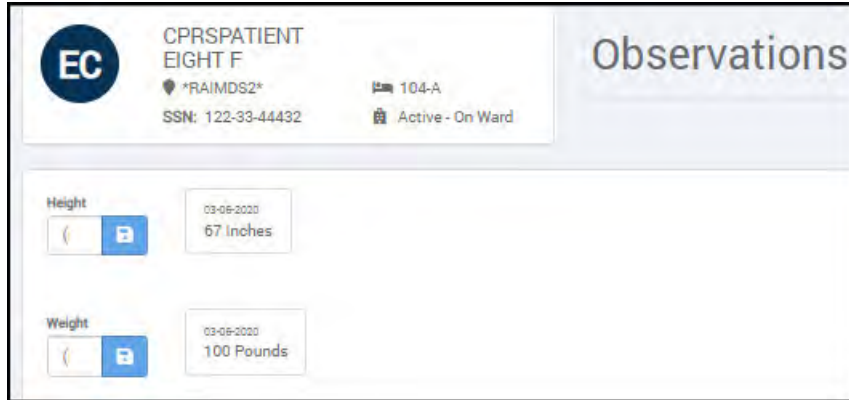
If this is the first shift charting for this resident, or if these metrics have not been previously recorded for the resident, use the **Height** and **Weight** selectors to choose the resident's height in inches and weight in pounds. When the correct number is entered, click the blue **Save** icon .

Figure 81: Chart Resident's Height and Weight



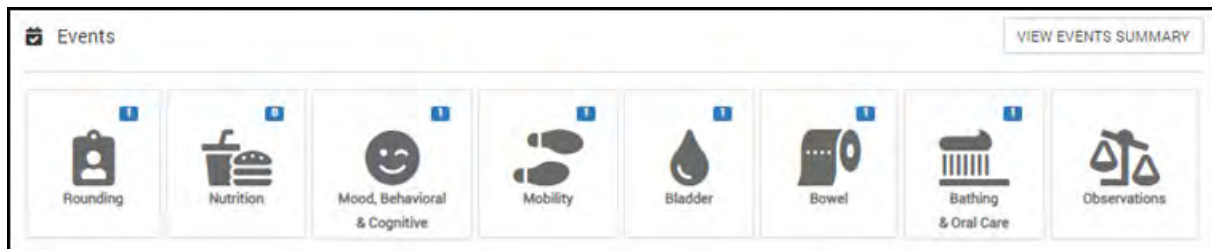
The screenshot shows the 'Observations' section of a resident's chart. At the top left, there is a circular icon with 'EC' and the resident's name 'CPRSPATIENT EIGHT F'. Below the name are the resident's ID '*RAIMDS2*', SSN '122-33-44432', room number '104-A', and status 'Active - On Ward'. The main area contains two input fields: 'Height' and 'Weight'. Each field has a date selector (03-06-2020) and a value (67 Inches and 100 Pounds). To the right of each value is a blue 'Save' icon.

Use the breadcrumbs at the top of the page to return to the Shift Charting page to view the resident's charted Events and ADL.

Event Charting Complete

When all resident events have been charted, all of the individual events show the charting in the blue boxes in the top right of each event icon.

Figure 82: Event Charting Complete



View Events Summary

After all of the events have been charted, you can click the **View Events Summary** button in the top right of the Events section to review the event shift summary.

To open the Event Shift Summary:

1. At the top right corner of the Events pane, click **View Events Summary**.

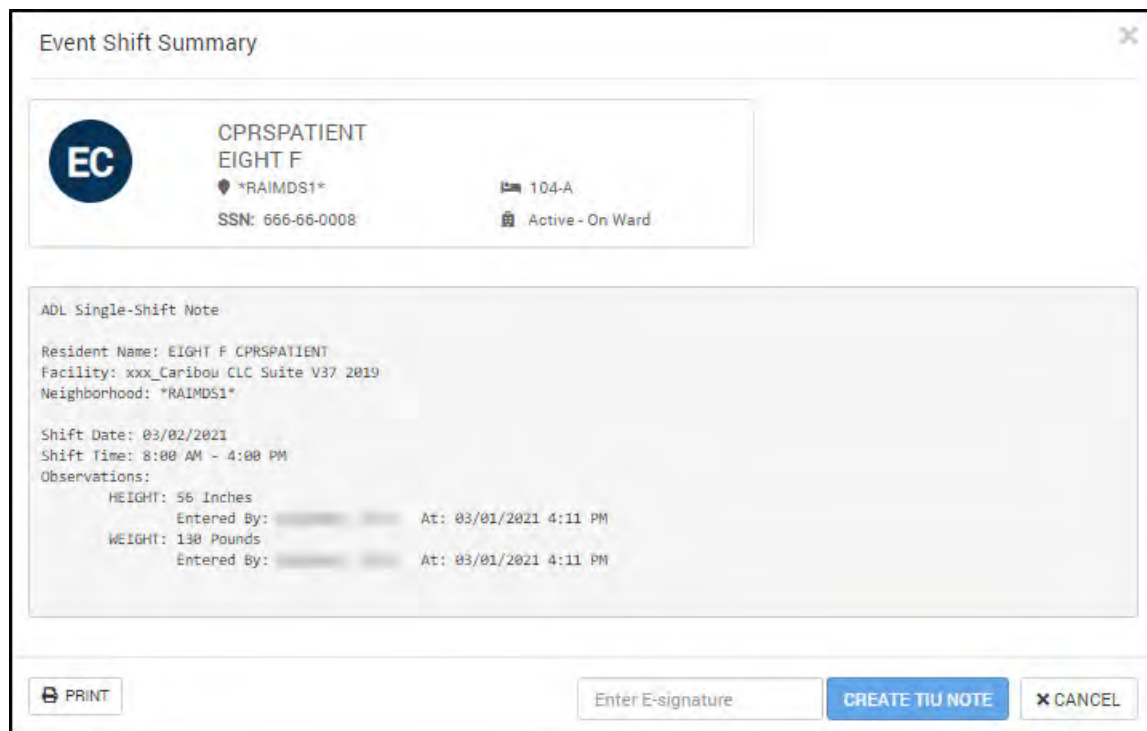
Figure 83: View Events Summary Button



2. If you aren't already connected to [REDACTED], a [REDACTED] screen appears. Use your [REDACTED] to log into [REDACTED].

The Event Shift Summary pops up.

Figure 84: Event Shift Summary



The Event Shift Summary shows a short summary of an ADL shift. The summary includes:

- Resident name
- Facility
- Neighborhood
- Shift date
- Shift time

- Logged shift observations

The Event Shift Summary can be printed or turned into a TIU Note.

To print the Event Shift Summary, at the bottom left corner of the page, click the **Print** button. The Print dialog opens with your print options. Select the correct print settings and click the **Print** button.

To turn the summary into a TIU Note:

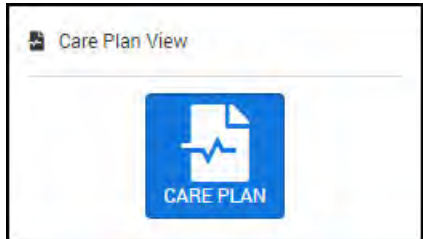
1. At the bottom of the Event Shift Summary, enter your E-signature in the **Enter E-signature** field.
2. Click the **Create TIU Note** button.

To close the Event Shift Summary, click the **Cancel** button.

Care Plan View

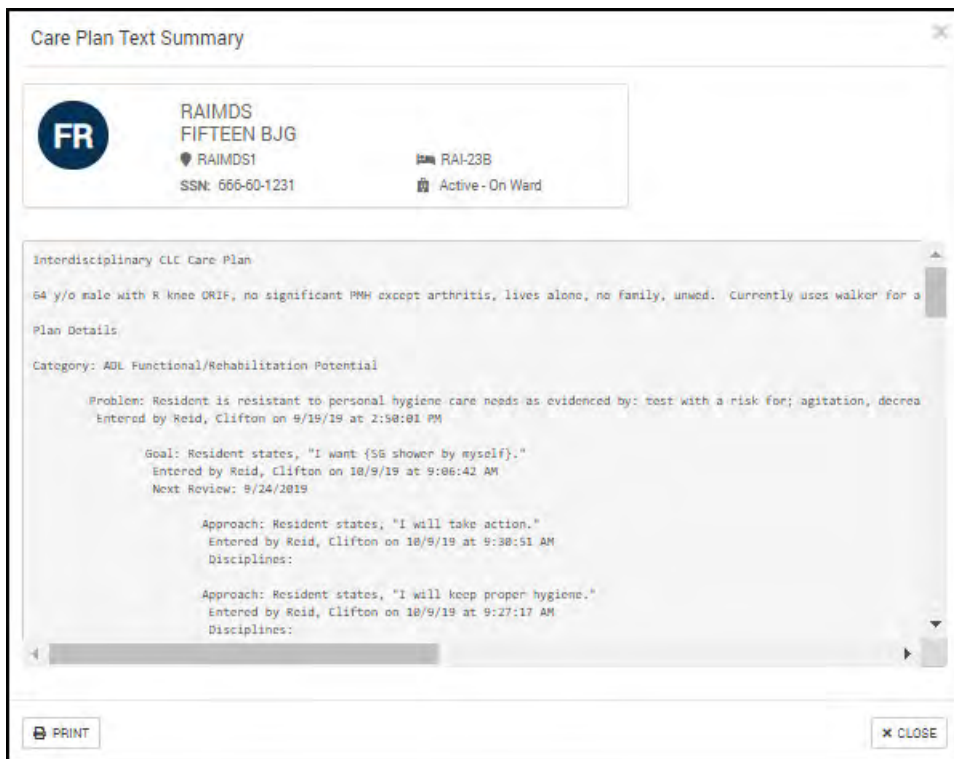
At any time you can view the resident's Care Plan from the Shift Charting page. Click the **Care Plan** button on the Shift Charting page to open the Care Plan Text Summary pop-up window that shows the resident's Care Plan summary.

Figure 85: Care Plan Button



To print the resident's Care Plan Text Summary, click the **Print** button at the bottom of the pop-up window.

Figure 86: Care Plan Text Summary



To close the Care Plan Text Summary pop-up window, click the **Close** button at bottom right corner of the window.

Care Manager Reports

There are Care Manager reports available in the Reports & Forms section and from the Care Manager Reports page. The available reports are:

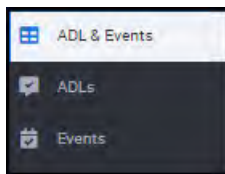
- ADL & Events report
- ADLs report
- Events report

Choose a Care Manager reports from the left column.

Note: To create ADL reports for an entire neighborhood, go to [“ADL Charts Report” on page 156](#).

Note: To create Events reports for an entire neighborhood, go to [“Events Report” on page 157](#).

Figure 87: ADL and Events Reports from the Care Manager Reports Page



ADL & Events Report

1. From the Care Manager tile, click **Reports**
2. On the Resident Search page, enter the first, last, or full name of the resident in the **Search Residents** field, and you can filter the results with the **Neighborhoods** filter to find the resident for whom you want to run a report.
3. Choose the correct resident from the search results.
4. Click the **ADL & Events** report option on the left column.
5. On the ADL & Events Reports page, enter or select a **Start Date** and **End Date** for the report.
6. Click **Run Report**. The ADL report and the Events report are generated for the stated date range and resident.

Figure 88: ADL & Events Report

CLC

SSN: [REDACTED]

Active - On Ward

ADL & Events Reports

COVID-19 Exit Status

Start Date: 01-01-2021

End Date: 06-11-2021

Showing 3 days

RUN REPORT
NOTE SUMMARY
PRINT

ADLs

Date	Bed Mobility		Transfer		Walk in Room		Walk in Corridor		Locomotion on Unit		Locomotion off Unit		Dressing		Eating		Toileting		Hygiene		Bathing			
	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support		
	8 AM - 4 PM																							
06-08-2021			0	1			2	2	2	2	4	3	8	8	1	1	0	0						
04-28-2021			1	1	1	0	0	0	1	0	1	0	2	2	2	2	0	0	0	1	2	2	2	2
03-25-2021			0	1	1	1	4	2	4	3	8	8	0	0	3	3	0	1	1	0	2	2	3	2
ADL Score			7	1	1	1	7	2	7	3	7	3	7	2	7	3	0	1	7	1	2	2	3	2

Events

Rounding Events

Start Hour	Locations	Room Environment	Safety Equipment	Comfort Status	Position	Possessions	Comments	Created By	Created
15	Chair in Room	Cords Secure, Call Light Within Reach, Personal Items Within Reach	Chair With Tray	Hydration		Glasses, Hearing Aide		[REDACTED]	03/25/2021 3:19PM

Nutrition Events

Meal	Method	Location	Amount	Comments	Created By	Created
Lunch	TPN	Dining Room	100 %		[REDACTED]	03/25/2021 3:26PM

Mobility Events

OutOfBed	Devices	BedRest	Comments	Created	Created By
Assisted	Single Prong Cane, Crutches	No	TEST COMMENT: Mobility	03/25/2021 3:42PM	[REDACTED]

Mood, Behavioral and Cognitive Events

Mood Observation	Behavioral	Cognitive	Significant Change	Comments	Created	Created By
Angry/Hostile	Verbal To Others (Profane and aggressive), Wanders (Pacing and secretive)	Alert & Oriented	Yes	Resident has become uncooperative and unruly. May pose a danger to staff and other residents.	06/11/2021 12:57PM	[REDACTED]
Happy/Content	Pleasant/Cooperative	Alert & Oriented	No	TEST COMMENT: Mood and Behavior	03/25/2021 3:42PM	[REDACTED]

Bladder Events

No Urinary Output	# of Times	Scheduled	Continenence	Appliances	Volume	Urine Descriptions	Comments	Created	Created By
No	1	Yes	Always Continent	urinal	200 cc/ml	Cloudy, Dark Yellow	TEST COMMENT: Bladder	03/25/2021 3:43PM	[REDACTED]

Bowel Events

No Bowel Movement	# of Times	Scheduled	Continenence	Appliances	Size	Texture	Comments	Created	Created By
Yes	0	No						03/25/2021 3:59PM	[REDACTED]

Bathing and Oral Care

Attire	Bath Type	Oral Care	Oral Education Provided	Dental Condition	Types of Oral Care Provided	Comments	Created	Created By
Pajamas/Gown	Shower	Partial Assist	No	Full Dentures	Clean Dentures/Partial		03/25/2021 3:59PM	[REDACTED]

Note: If this report spans more than a single day, you will not be able to send notes using the generated report.

Click **Note Summary** to view the ADL Report Note. If the report spans ore than a single day, reduce the date range to one day and run the report again to create a TIU note from the ADL Report Note.

Click **Print** to print the report.

ADLs Report

1. From the Care Manager tile, click **Reports**
2. On the Resident Search page, enter the first, last, or full name of the resident in the **Search Residents** field, and you can filter the results with the **Neighborhoods** filter to find the resident for whom you want to run a report.
3. Choose the correct resident from the search results.
4. Click the **ADLs** report option from the left column.
5. On the ADL Reports page, enter or choose a **Start Date** and an **End Date**.
6. Click **Run Report**. The ADL report is generated for the stated date range and resident.

Figure 89: ADL Reports

The screenshot shows the ADL Reports interface. At the top, there are input fields for 'Start Date' (02-01-2021) and 'End Date' (06-11-2021), along with buttons for 'RUN REPORT', 'NOTE SUMMARY', and 'PRINT'. Below this is a table with columns for various ADL categories and their sub-categories (Self and Support). The table shows data for three days: 06-08-2021, 04-28-2021, and 03-25-2021. An 'ADL Score' row is also present at the bottom of the table.

Date	Bed Mobility		Transfer		Walk in Room		Walk in Corridor		Locomotion on Unit		Locomotion off Unit		Dressing		Eating		Toileting		Hygier	
	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	
06-08-2021	8 AM - 4 PM	0	1			2	2	2	2	4	3	8	8	1	1	0	0			
04-28-2021	8 AM - 4 PM	1	1	1	0	0	0	1	0	1	0	2	2	2	2	0	0	0	1	2
03-25-2021	8 AM - 4 PM	0	1	1	1	4	2	4	3	8	8	0	0	3	3	0	1	1	0	2
ADL Score		7	1	1	1	7	2	7	3	7	3	7	2	7	3	0	1	7	1	2

Note: If this report spans more than a single day, you will not be able to send notes using the generated report.

Click **Note Summary** to view the ADL Report Note. If the report spans ore than a single day, reduce the date range to one day and run the report again to create a TIU note from the ADL Report Note.

Click **Print** to print the report.

Events Report

1. From the Care Manager tile, click **Reports**
2. On the Resident Search page, enter the first, last, or full name of the resident in the **Search Residents** field, and you can filter the results with the **Neighborhoods** filter to find the resident for whom you want to run a report.
3. Choose the correct resident from the search results.
4. Click the **Events** report option from the left column.
5. On the Events Reports page, enter or choose a **Start Date** and an **End Date**.
6. From the **Select Event** list, select an event upon which to run the report.
7. Click **Run Report**. The Events report is generated for the stated date range, event, and resident.

Figure 90: Events Report

The screenshot displays the Events Report interface. At the top, there are three input fields: 'Start Date' with the value '01-01-2021', 'End Date' with the value '06-11-2021', and 'Select Event' with a dropdown menu showing 'Nutrition'. To the right of these fields are three buttons: 'RUN REPORT' (blue), 'NOTE SUMMARY', and 'PRINT'. Below the filters, it says 'Showing 1 items'. A table titled 'Nutrition Events' is shown below, with columns: Meal, Method, Location, Amount, Comments, Created By, and Created. The table contains one row: Lunch, TPN, Dining Room, 100 %, [redacted], 03/25/2021 3:26PM.

Meal	Method	Location	Amount	Comments	Created By	Created
Lunch	TPN	Dining Room	100 %		[redacted]	03/25/2021 3:26PM

Note: If this report spans more than a single day, you will not be able to send notes using the generated report.

Click **Note Summary** to view the Events Report Note. If the report spans ore than a single day, reduce the date range to one day and run the report again to create a TIU note from the Events Report Note.

Click **Print** to print the report.

Care Plans

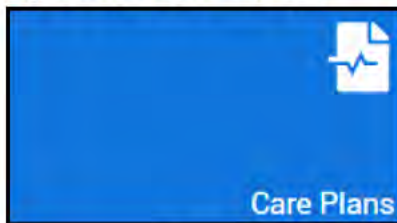
Note: After users have been given access to [REDACTED] and allocated the [REDACTED], they will be able to log into the [REDACTED] Care Plans.

Access [REDACTED] Care Plans

To enter the [REDACTED] Care Plans:

1. Go to the [REDACTED] URL.
2. From the [REDACTED] homepage, click the **Care Plans** tile.

Figure 91: Care Plans Tile



[REDACTED] Care Plans Navigation Window

There are three sub-tiles within the Care Plans page:

- Active Care Plans
- History
- Reports

Figure 92: Care Plans Sub-tile



Active Care Plans

To show all active Care Plans, click the **Active Care Plans** sub-tile. All active care plans for the facility are shown in a table.

Figure 93: All Active Care Plans Table

Resident Initials	Resident Name, Neighborhood, and SSN	Care Plan Title, Start Date, and End Date	Care Plan Status and Care Coordinator name	Care Plan Review Date (Overdue reviews are shown with a red background.)	Care Plan Created and Last Modified Dates	Details button
TA	ACMRAT_THIRTEEN #151A #151A 151A-12345	Interdisciplinary CLD Care Plan Start Date: 09/24/19 End Date: 09/27/19	Active Care Coordinator: [Name]	Next Review: 14/2019	Created: 06/06/2019 Last Modified: 12/04/2019	DETAILS
EA	ACMRATIENT_EIGHT #151 151A-12345	Interdisciplinary CLD Care Plan Start Date: 09/22/19 End Date: [Blank]	Active Care Coordinator: [Name]	Next Review: 25/2019	Created: 06/27/2019 Last Modified: 12/04/2019	DETAILS
QA	ACMRATIENT_ONE #151 151A-12345	Interdisciplinary CLD Care Plan Start Date: 10/11/19 End Date: [Blank]	Active Care Coordinator: [Name]	Next Review: 18/2019	Created: 10/11/2019 Last Modified: 12/04/2019	DETAILS
TA	ACMRATIENT_TWO #151 151A-12345	Interdisciplinary CLD Care Plan Start Date: 10/13/19 End Date: [Blank]	Active Care Coordinator: [Name]	Next Review: 20/2019	Created: 10/13/2019 Last Modified: 12/29/2019	DETAILS
BC	CARIBOUTWO_BETA B #151 151A-12345	Interdisciplinary CLD Care Plan Start Date: 11/22/19 End Date: 11/22/19	Active Care Coordinator: [Name]	Next Review: 19/2019	Created: 11/22/2019 Last Modified: [Blank]	DETAILS

The Active Care Plans table shows the following data for each care plan (from left to right):

- Resident Initials
- Resident Name, Neighborhood, and SSN
- Care Plan Title, Start Date, and End Date
- Care Plan Status and Care Coordinator name
- Care Plan Review Date (Overdue reviews are shown with a red background.)
- Care Plan Created and Last Modified Dates
- Details button.

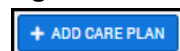
Add a Care Plan

Note: If the resident already has an active Care Plan, a new care plan or continuation plan cannot be added.

To add a Care Plan:

1. At the top of the Active Care Plans page, search for and select a resident. See [“Filter the Active Care Plans” on page 67](#) for details on how to find a resident.
2. At the top of the Active Care Plan page, click the + **Add Care Plan** button.

Figure 94: Add Care Plan Button



The Resident Search page opens.

3. Search for and select a resident. See [“Filter the Active Care Plans” on page 67](#) for details on how to find a resident.

The Add Care Plan page opens.

4. In the **Title** field, enter a descriptive title.
5. In the **Description** field, enter a free-text, brief synopsis of the resident’s care plan.

6. The **Start Date** field automatically default's to today's date. If necessary, select a different start date for the plan using the calendar button.
7. In the **End Date** field, enter or select the end date using the calendar button. The date format is mm-dd-yyyy.
8. The **Review Date** field automatically defaults to 90 days from the plan start date. Use the calendar button to change this date if necessary.
9. In the **Care Plan Coordinator** field, enter the Coordinator's last name. The full name appears as a drop-down option. Select the name.
10. Click **Add**.

Figure 95: Add care Plan Page

The screenshot displays the 'Add Care Plan' interface. At the top, a patient header shows the name RAIMDSRESONE ONE, RA-1B, and status Active - On Ward. The main form area is titled 'Add Care Plan' and contains several input fields:

- Title:** Interdisciplinary Care Plan
- Description:** This is a sample care plan description.
- Start Date:** 04-16-2020
- End Date:** 04-30-2020
- Review Date:** 07-20-2020
- Care Plan Coordinator:** Nurse (with a dropdown menu open showing 'Nurse, Test')

 At the bottom right of the form, there are two buttons: 'CANCEL' and '+ ADD'.

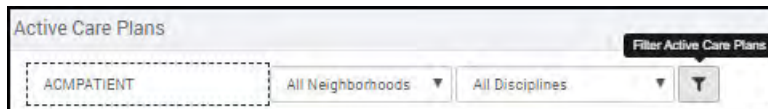
11. The Care Plan Details page opens and the new Care Plan is shown with no Care Plan Items. See [“Add Plan Items” on page 77](#) for steps to add care plan items.

Filter the Active Care Plans

The Active Care Plans table can be filtered by Resident Name, Neighborhood, Disciplines, or a combination of these metrics. To filter the Active Care Plans table:

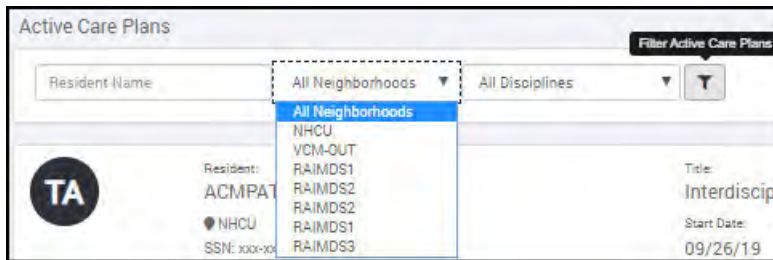
1. At the top of the Active Care Plans table, perform one or more of the following steps:
 - a. In the **Resident Name** field, enter the last name of resident you want to view. You can also enter only the first few letters of a name to help narrow down a resident search.

Figure 96: Filter Active Care Plans by Resident Name



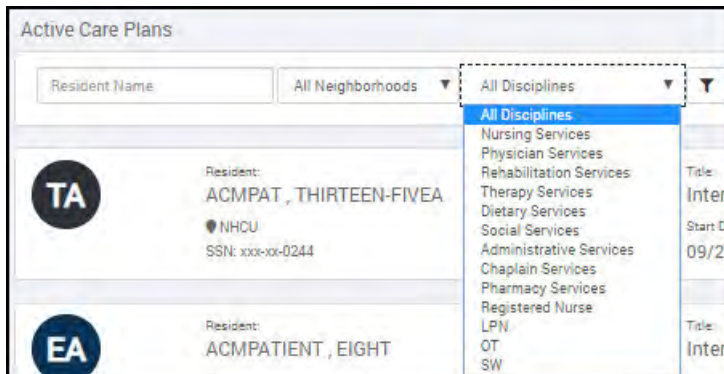
- b. In the **All Neighborhoods** drop-down list, select the neighborhood for which you'd like to view the residents.

Figure 97: Filter Active Care Plans by Neighborhood



- c. In the **All Disciplines** drop-down list, select the discipline for which you'd like to view the residents.

Figure 98: Filter Active Care Plans by Discipline



2. Click the **Filter**  icon. The Active Care Plans table refreshes with the filtered care plan results.

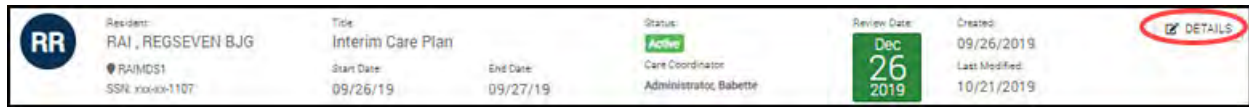
To return to the full table of Active Care Plans:

1. Clear the **Resident Name** field.
2. Select **All Neighborhoods** from the Neighborhoods drop-down list.
3. Select **All Disciplines** from the Disciplines drop-down list.
4. Click the **Filter** icon.

View an Active Care Plan Details

To open an Active Care Plan, click the **Details** button to the right of the care plan.

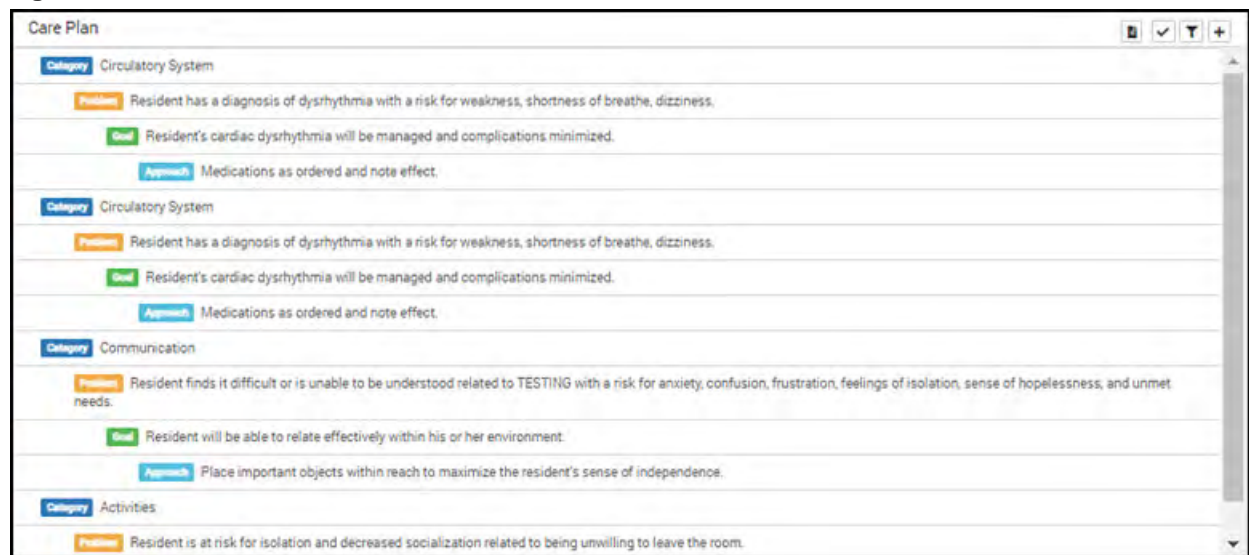
Figure 99: Active Care Plans Details Button



The Care Plan Details page opens. At the top of the page is a banner with the same information as is shown in the Active Care Plans table. In the far right side of the banner is an **Edit** button. Below this banner is the care plan.

The Care Plan Details shows the Categories, Problems, Goals, and Approaches (CPGA) included in the resident's Care Plan.

Figure 100: Care Plan Details

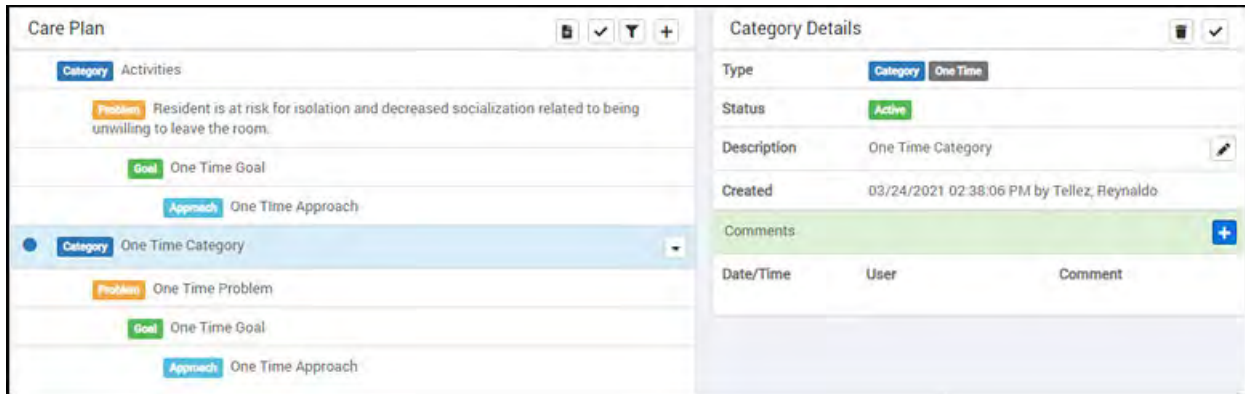


If a Category, Problem, Goal, or Approach is entered as a “one time” event, a *One Time* label is added to the Category Details.

Note: When using the “one time” care plan item entry method, the Care Manager default database entries are not available for use. You must manually enter the items in free-text fields.

Click the One Time **Category, Problem, Goal, or Approach** in the Care Plan pane on the Care Plan Details page. The details pane for the selection opens to the right. The One Time label is in the Type field at the top of the details pane.

Figure 101: One Time Care Plan Entry



At the top of the Care Plan Details are four action icons (from left to right):

- **Show CAA Narrative**
- **Reviews**
- **Filter Plan Items**
- **Add Plan Items**

Figure 102: Care Plan Details Action Icons



Show CAA Narrative


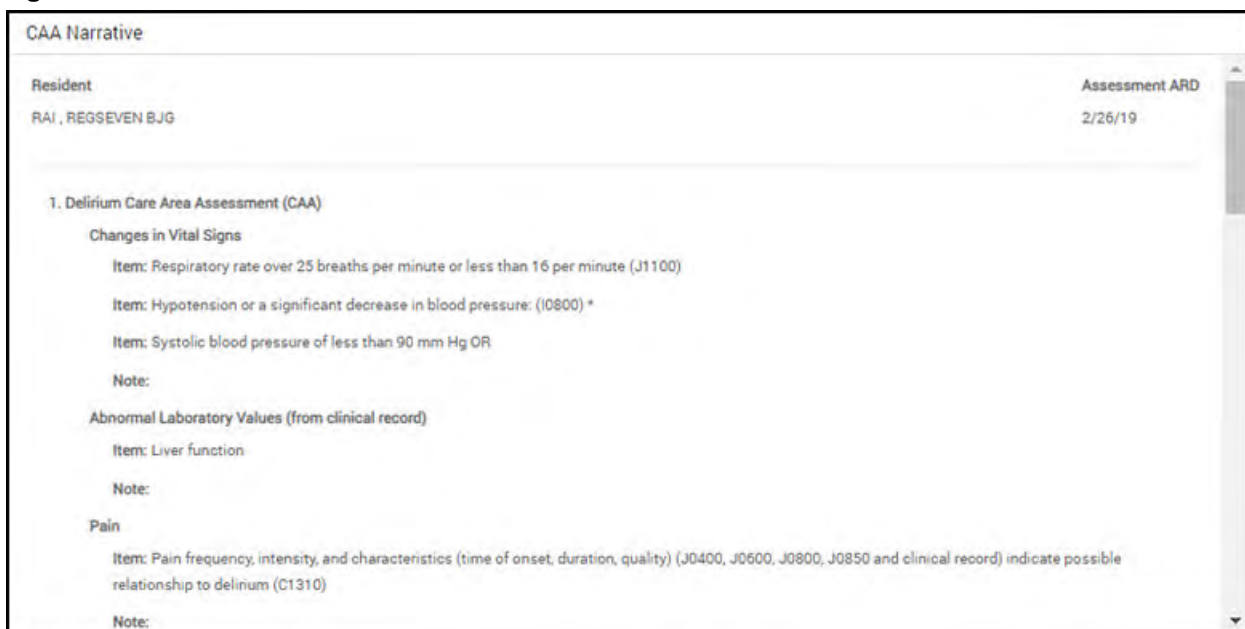
Click the **Show CAA Narrative** icon  to open the CAA Narrative in a pane to the right of the Care Plan Details. The CAA Narrative is a text pane that describes the Care Area Assessment (CAA) for the resident. The CAA Narrative shows the most recent Care Area Assessment.

Figure 103: CAA Narrative



The CAA represents items that are checked in the MDS assessment. Certain items in the MDS trigger problem areas. This alerts the interdisciplinary treatment team to address areas that need attention and care planning. Working with the CAAs facilitates residents achieving their highest level of function and well-being. The CAAs identify current and potential problems so that the care team may determine the nature and extent of the problem and create interventions to address the problem. The final treatment plan, generated in collaboration with the resident, is based on:

- Assessment
- Aggregation of data (CAA)
- Interventions that relate to the reason for admission
- Goals of care, including discharge to less restrictive levels of care

The CAAs are explored in advance of the treatment-planning meeting. The full treatment plan supports or develops further the recommendations based on all of the CAAs. Multiple disciplines work on areas of the CAA. Although one discipline is assigned responsibly for completion of a CAA, other disciplines may be involved as needed.

Each facility must complete the CAA Worksheet template that is included in the software

Show Care Plan Reviews


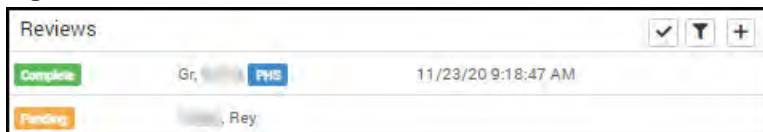
Click the **Reviews** icon  to open the Reviews pane to the right of the Care Plan Details. The Reviews pane shows all Complete and Pending reviews of the care plan. It also allows for the addition of a review and new reviews.

Figure 104: Care Plan Reviews




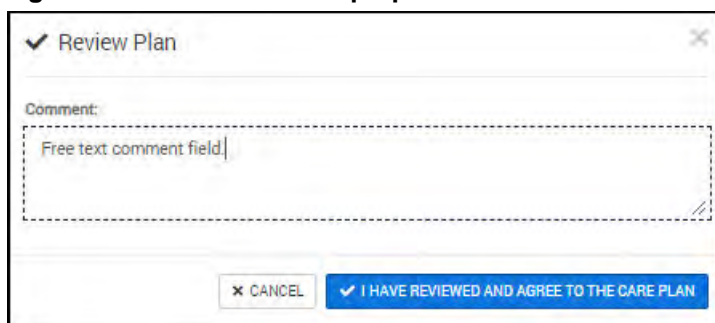
To add your review to an active care plan, click the **Review Plan** icon  on the Reviews pane. The Review Plan pop-up appears. Enter the text of your review in the Comment field and click the **I have Reviewed and Agree to the Care Plan** button.

Figure 105: Review Plan Pop-up




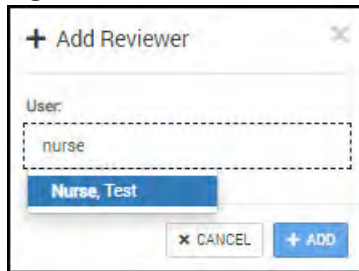
To assign someone to review this care plan, click the **Add Reviewer** icon . The Add Review pop-up appears. Enter the user's last name in the field and click **Add** to send a notification to that users that their review of the care plan and signature is required.

Figure 106: Add Reviewer Pop-up



If there are a lot of reviews in the resident's care plan, you can filter the reviews by clicking the **Filter** icon



Staff Receiving Alerts and Notifications

The following are the possible invested/designated staff to receive alerts and notifications.

Table 1: Staff Names for Alert Receipt

Short Name	Full Name
CCC	Clinical Care Coordinator
NRS	Nursing Services
■ ARNP	
■ RN	
■ LPN	
■ CNA	
■ NA	
PHY	Physician Services
■ DO	■ Osteopathic
■ MD	■ Medical
■ DMD	■ Dentist
REHB	Rehabilitation Services
TX	Therapy Services
■ OT	■ Occupational
■ CRT	■ Respiratory
■ PT	■ Physical
■ ST	■ Speech
■ CTRS	■ Recreational
DIET	Dietary Services
LAB	Laboratory Services
RAD	Radiology Services
SS	Social Services
	■ Social Worker

Notifications are shown in the user's Notifications Bell next to their User icon at the top of the page.

Figure 107: Notifications Bell

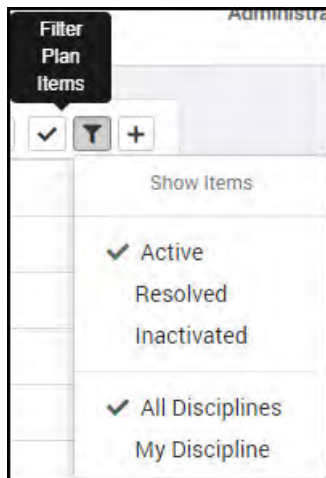


Filter Plan Items

To filter the care plan items, click the Filter icon  and select what care plan items to show from the following options:

- Active
- Resolved
- Inactivated
- All Disciplines
- My Discipline

Figure 108: Filter Plan Items Drop-down List



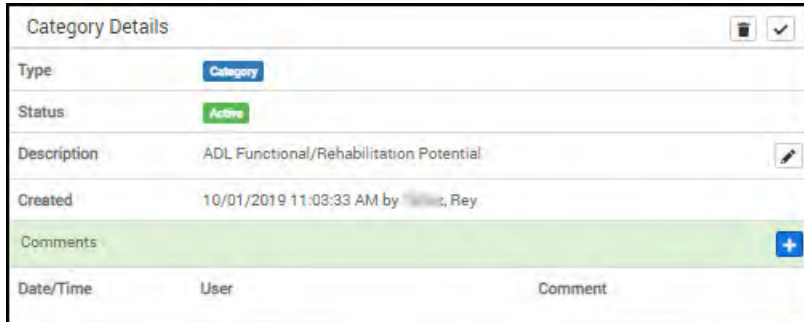
The items checked on the drop-down list are what is shown in the care plan. If there are no items for the selected filter(s), the care plan will be blank.

Add Comment to the Care Plan Items

To add comments to the care plan items:

1. In the Care Plan, click the Category, Problem, Goal, or Approach you want to comment on. The item Details pane opens next to the Care Plan pane.
2. Click the **Add** (blue plus sign) icon in the Comments section.

Figure 109: Add Comment



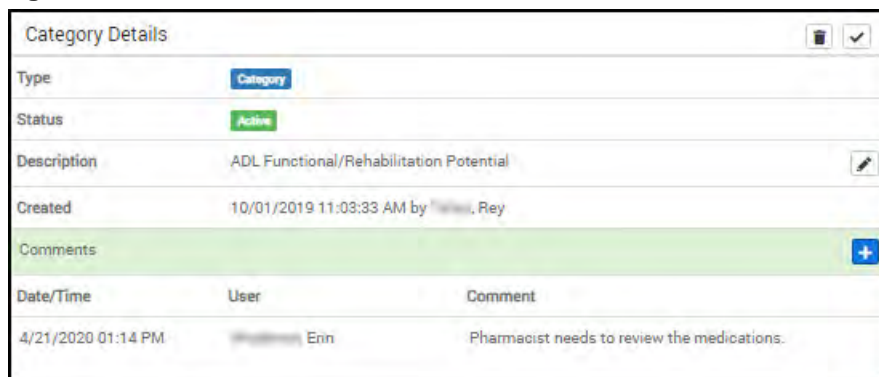
3. In the resulting pop-up, enter your comment in the free text **Comments** field.

Figure 110: Enter Comment



4. Click the **Save** button. The comment appears on the Details pane.

Figure 111: Comment Added

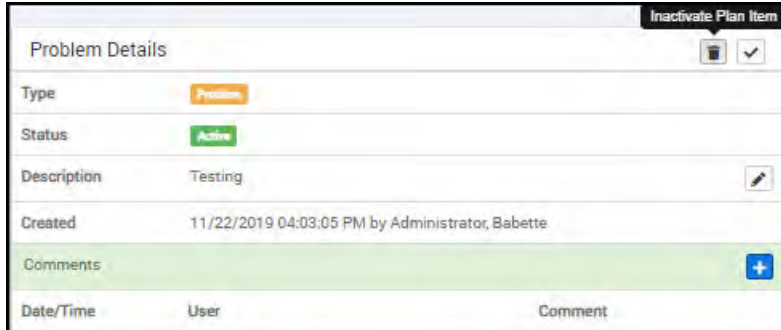


Resolve or Inactivate a Plan Item

To inactivate a selected care plan item:

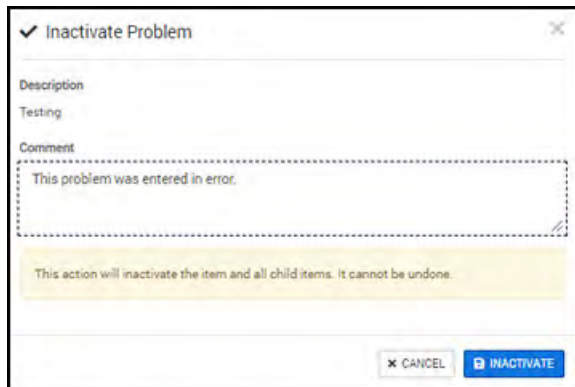
1. Click the **Inactivate** trash can icon. The Inactivate dialog box opens.

Figure 112: Resolve or Inactivate CPGA



2. Enter a comment in the free-text **Comment** field.

Figure 113: Inactivate Dialog Box

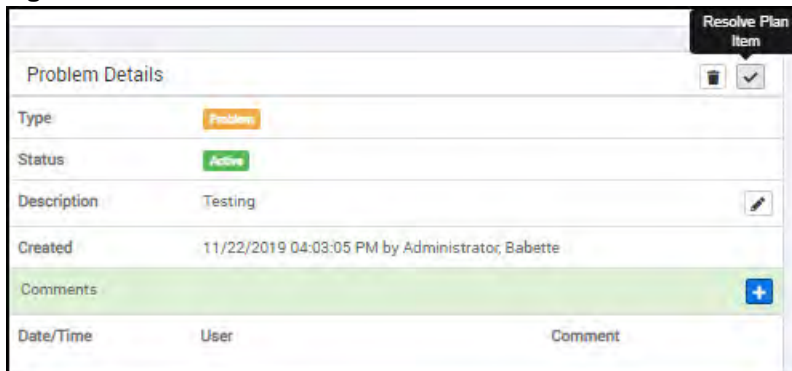


3. Click the **Inactivate** button.

To resolve a selected care plan item:

1. Click the **Resolve Plan Item** check mark icon. The Resolve item dialog box opens.

Figure 114: Resolve Plan Item



2. In the dialog box, in the **Comment** field, enter the details of the item resolution.

Figure 115: Resolve Goal

✓ Resolve Problem

Description

Testing

Resolved On

04-21-2020

Comment

This problem has been solved.

This action will resolve the item and all child items. It cannot be undone.

Resolve Items

CANCEL RESOLVE

3. Click the **Resolve** button.

A comment is required when performing updates to the care plan.

Resolved and Inactivated items do not show on the active care plan.

Add Plan Items

To add a care plan item from the Care Plan Details page:


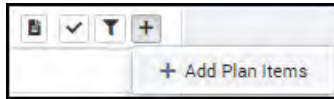
1. Use one of these methods to open the Add Care Plan Items page.
 - Click the **Add Plan Items** icon  and choose **Add Plan Items** from the drop-down list.

Figure 116: Add Plan Items Option



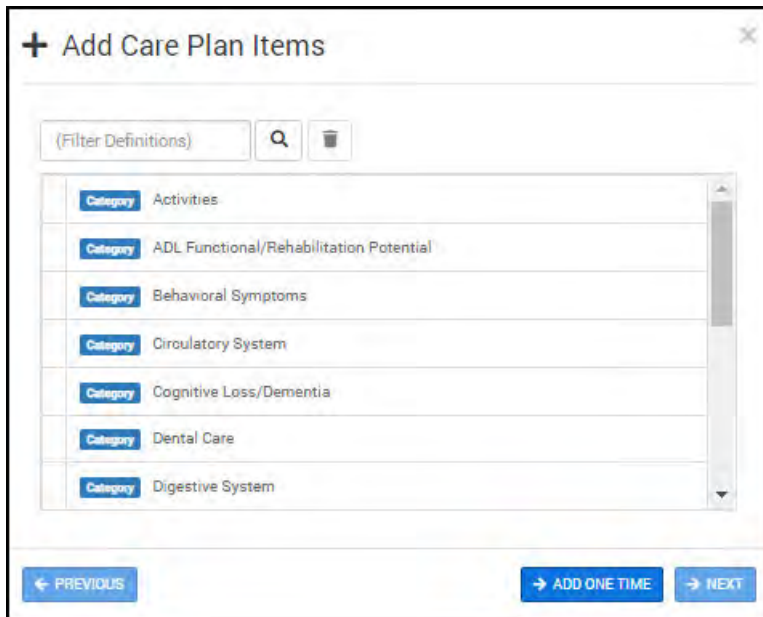
- Hover over the category, problem, or goal in the resident's care plan, and click the down arrow icon. An action item menu opens.
- Click **Add Plan Items**.

Figure 117: Add Plan Items From Care Plan



The Add Care Plan Items window opens.

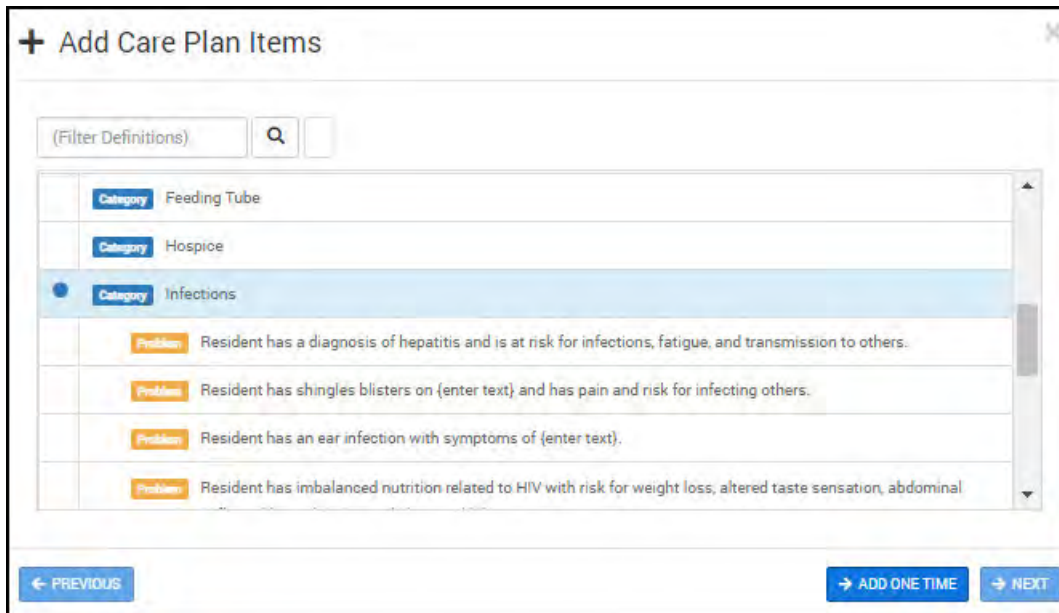
Figure 118: Add Care Plan Items Window



2. Select the category of item to add to the plan. If necessary, use the **Filter Definitions** field to search for the category you want.

The window refreshes and shows the problem options that go with the selected category.

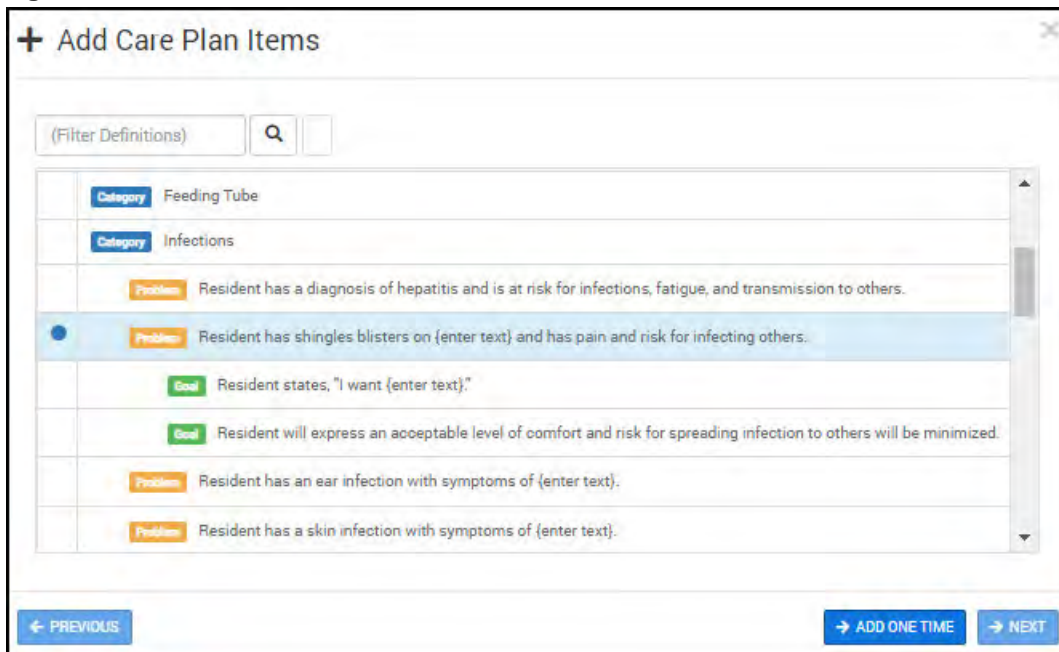
Figure 119: Add Care Plan Items – Problems



3. Click the problem you want to add to this care plan item.

The window refreshes and shows the goal options that go with the selected problem.

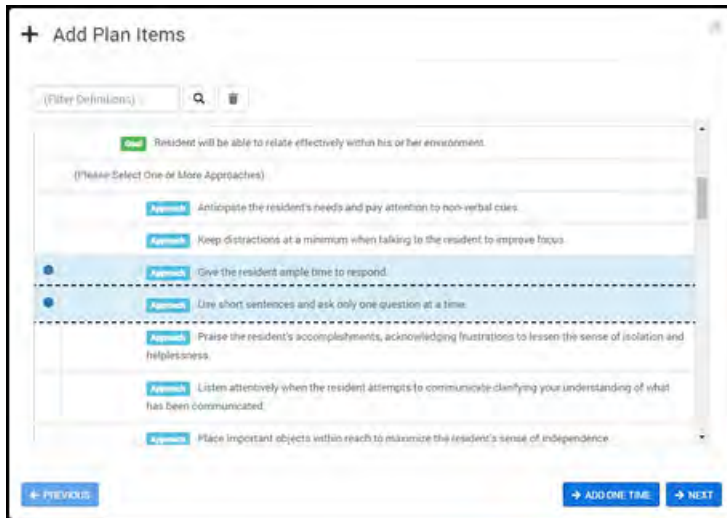
Figure 120: Add Care Plan Items – Goals



4. Click the goal of the selected problem. The window refreshes and shows the approach options that go with the selected goal. You can choose one or more approaches for a goal.

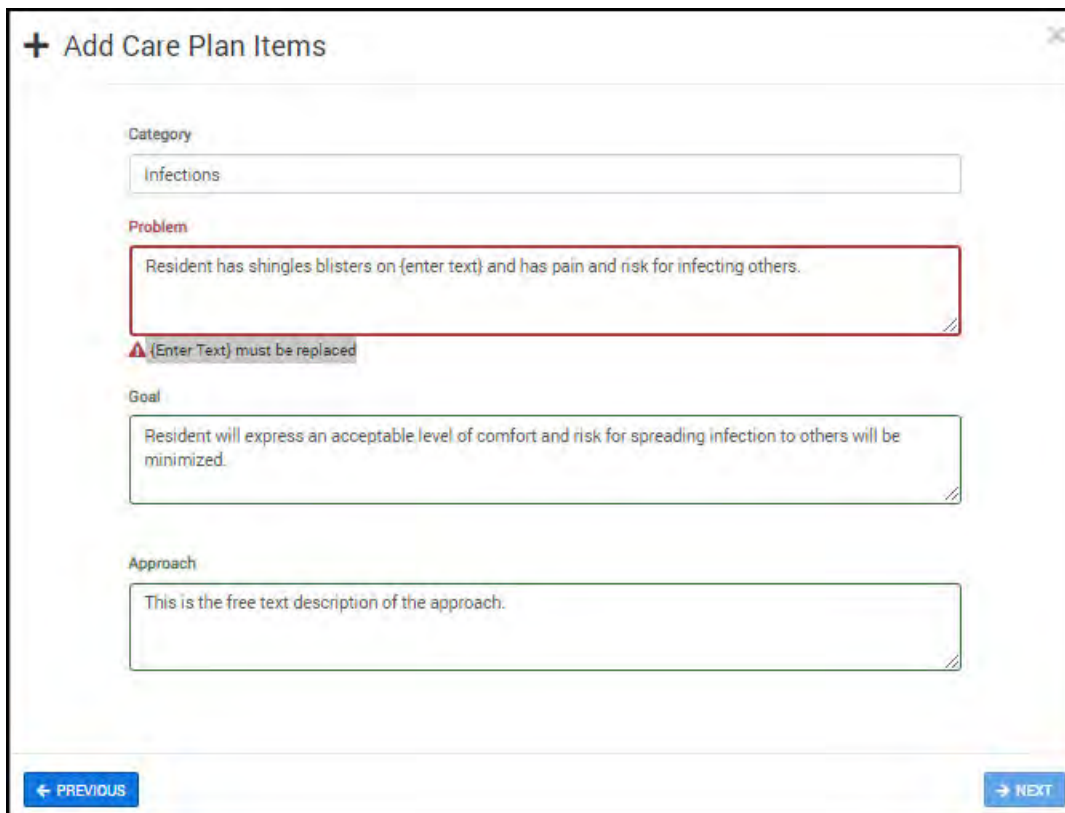
5. Click the approach(es) you want to add to this care plan goal.

Figure 121: Add Care Plan Items – Approaches



6. Click either the **Add One Time** or **Next** button. The Add Care Plan Items window refreshes to allow for customization of the care plan item.
7. If there is customizable text (in {braces}) replace the text with specifics for the resident.
8. Enter free text description in the **Approach** field.

Figure 122: Enter Customizable Text and Approach

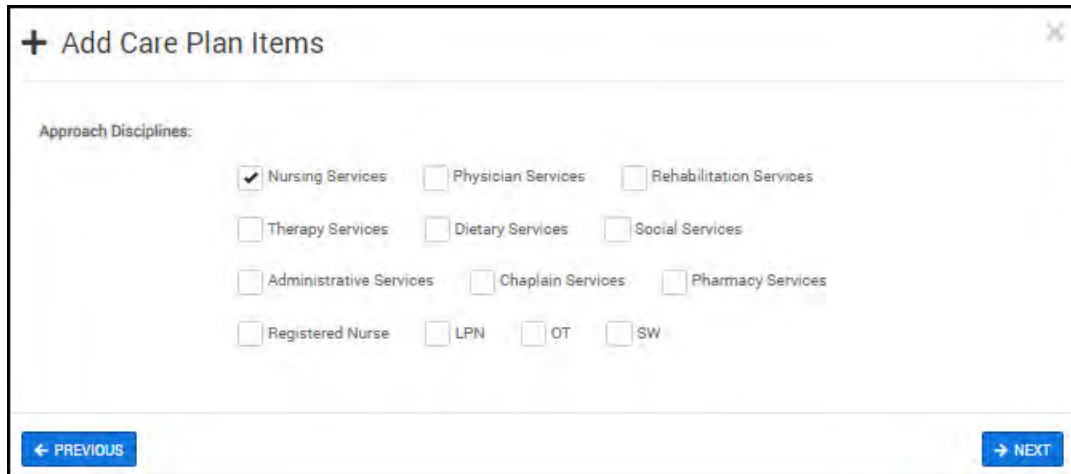


9. Click **Next**.

The Add Care Plan Items window refreshes to provide Approach Discipline check boxes. These are disciplines that need to be alerted of care plan approaches to reach the care plan goals.

10. Select the **Approach Discipline(s)** for this care plan item.

Figure 123: Approach Disciplines for Care Plan Item



The screenshot shows a window titled '+ Add Care Plan Items' with a close button in the top right. Below the title bar, the section 'Approach Disciplines:' contains a grid of 12 checkboxes. The first checkbox, 'Nursing Services', is checked. The other checkboxes are: Physician Services, Rehabilitation Services, Therapy Services, Dietary Services, Social Services, Administrative Services, Chaplain Services, Pharmacy Services, Registered Nurse, LPN, OT, and SW. At the bottom of the window, there are two blue buttons: 'PREVIOUS' on the left and 'NEXT' on the right.

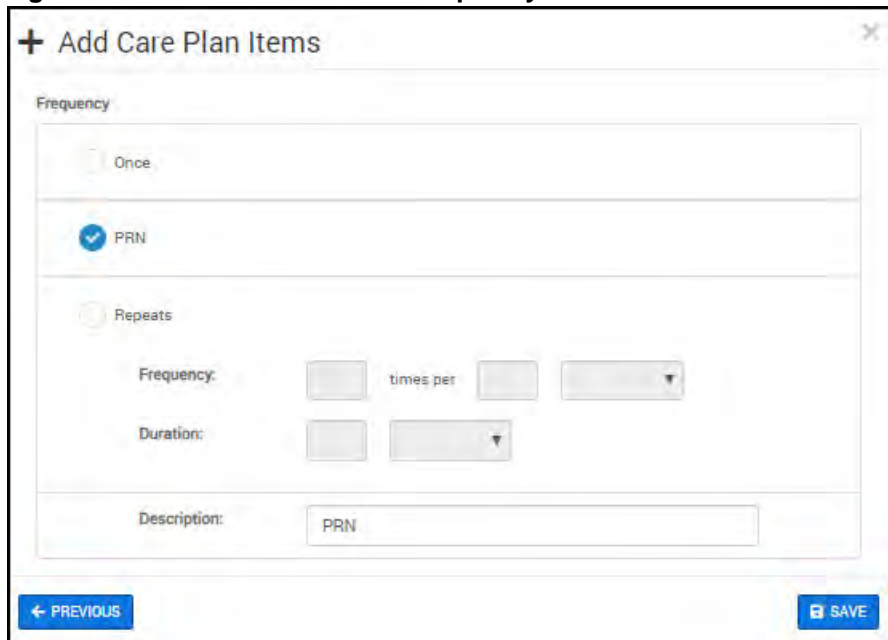
11. Click **Next**.

The Add Care Plan Items window refreshes to set the Frequency of the care plan items.

12. Select one of the following Frequency options:

- **Once**
- **PRN**
- **Repeats** (Enter **Frequency**, **Duration**, and **Description** [not required] for the item.)

Figure 124: Add Care Plan Item Frequency



The screenshot shows the same window as Figure 123, but now the 'Frequency' section is active. It has three radio button options: 'Once', 'PRN', and 'Repeats'. The 'PRN' option is selected. Below the 'Repeats' option, there are input fields for 'Frequency' (with 'times per' text), 'Duration', and a 'Description' field containing the text 'PRN'. At the bottom of the window, there are two blue buttons: 'PREVIOUS' on the left and 'SAVE' on the right.

13. Click **Save**.

The Add Care Plan Items window closes and the Care Plan refreshes to show the new care plan item.

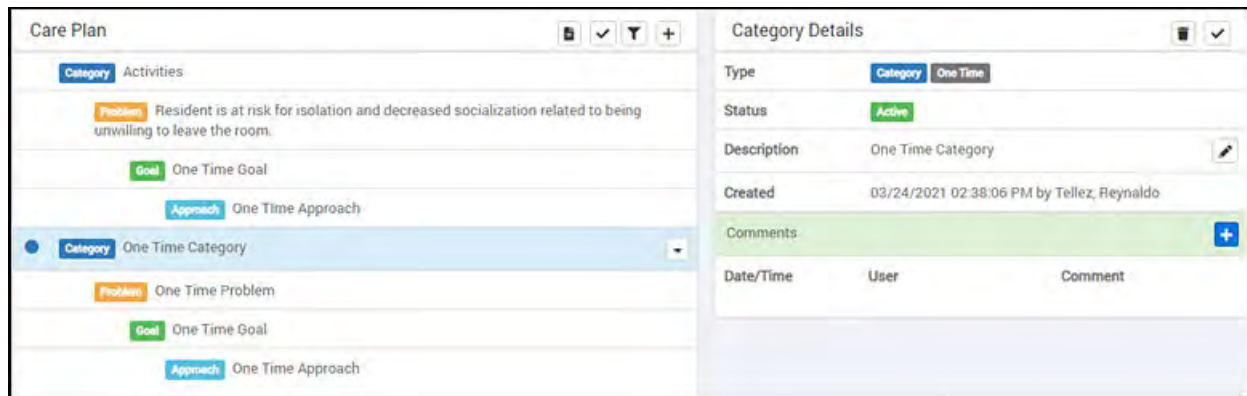
14. Click **Save**. The new category is ready for use with new care plan items. Note about one time Care Plan entries:

If a Category, Problem, Goal, or Approach is entered as a “one time” event, a *One Time* label is added to the Category Details.

Note: When using the “one time” care plan item entry method, the Care Manager default database entries are not available for use. You must manually enter the items in free-text fields.

Click the One Time **Category, Problem, Goal, or Approach** in the Care Plan pane on the Care Plan Details page. The details pane for the selection opens to the right. The One Time label is in the Type field at the top of the details pane.

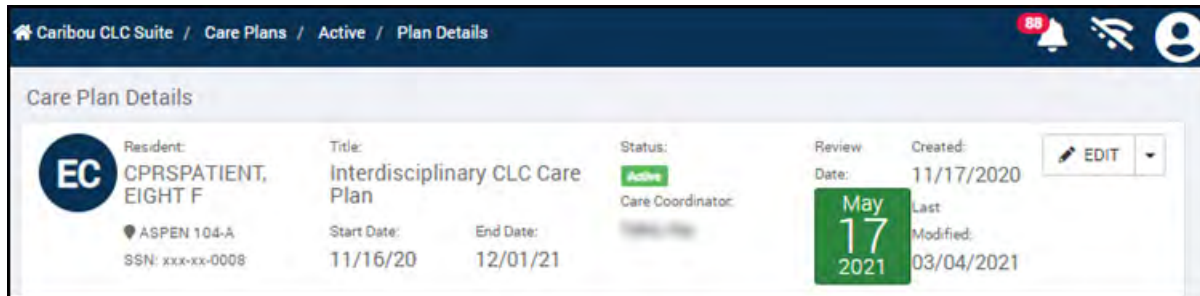
Figure 125: One Time Care Plan Entry



Edit Care Plan Details

To the right of the Care Plan Details resident banner, is the Edit button. Click the **Edit** button to edit the resident's Care Plan.

Figure 126: Care Plan Details Edit Button



The Edit Care Plan page opens. On this page users can edit the following care plan elements:

- Title
- Description
- Status
 - Active
 - Complete
 - On-Hold
 - Entered In Error
- Start Date
- End Date
- Care Plan Coordinator
- Review Date
- Update Review Date check box and day increment slider
- Apply Review Date To All Goals check box

Figure 127: Edit Care Plan Page

The screenshot shows the 'Edit Care Plan' interface for a patient named CPRSPATIENT EIGHT F. The patient's information includes ASPEN, room 104-A, SSN 666-66-0008, and status 'Active - On Ward'. The care plan details are as follows:

- Title:** Interdisciplinary CLC Care Plan
- Start Date:** 11-16-2020
- Description:** This is a new Care Plan for resident CPRSPatient, Eight.
- End Date:** 12-01-2021
- Care Plan Coordinator:** Tellez, Rey
- Status:** Active (selected), Complete, On-Hold, Entered In Error.
- Review Date:** 05-17-2021
- Options:** Update Review Date (checkbox), Apply Review Date To All Goals (checkbox).

Buttons for 'CANCEL' and 'SAVE' are located at the bottom right of the form.

If the review date needs to be updated, check the **Update Review Date** box. A slider bar appears. You can use the slider bar to select increment of days, or use the calendar field to select the next review date.

Figure 128: Change Review Date

The 'Change Review Date' dialog box shows the current review date as 06-21-2021. The 'Update Review Date' checkbox is checked. Below this, a blue instruction bar reads: 'Use slider to adjust day(s), and/or select date picker to change Review Date.' The dialog includes a table with the following data:

Today	Increment	New Review Date
05-11-2021	+90 day(s)	08-09-2021

A slider bar is positioned below the table, and a date picker field shows 08-09-2021 with a calendar icon.

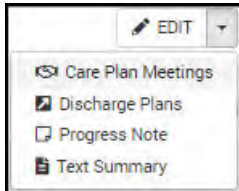
When all changes are complete, click the **Save** button to save the changes. Click **Cancel** to return to the Care Plan Details without saving any changes.

Add a Care Plan Meeting

To add a current care plan meeting:

1. On the Care Plan Details resident banner, click the **Edit** drop-down list and select **Care Plan Meetings**.

Figure 129: Edit Care Plan Meeting Option



The Care Plan Meetings page opens.

Figure 130: Care Plan Meetings Table



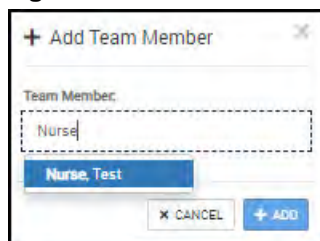
2. At the top of the Care Plan Meetings table, click the blue **Add** button. The page refreshes to show Add New Meeting and Prior Meetings panes.
3. In the Add New Meeting pane, the following Care Plan Meeting fields must be completed:

- **Date** (select or enter date)
- **Team** (add members)

To add team members:

- a. Click the plus sign, and in the resulting pop-up, enter the last name of the team member you want to add.
- b. Select the member from the results and click **Add**.

Figure 131: Add Team Member

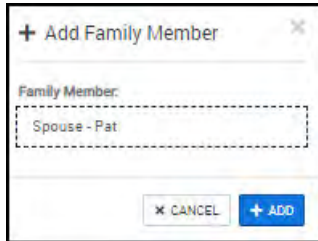


- **Family** (add members)

To add family members:

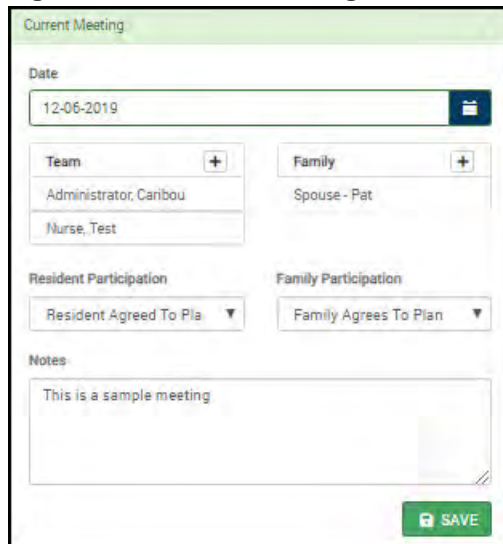
- a. Click the plus sign, and in the resulting pop-up, enter the relationship and name of the resident's family member.
- b. Click **Add**.

Figure 132: Add Family Member



- c. Finish filling out the Current Meeting form. Enter or select the following information:
 - Resident Participation** (select resident participation level)
 - Family Participation** (select family participation level)
 - Notes** (enter free-text notes)

Figure 133: Current Meeting Created or Edited



- d. When all fields have been completed, click **Save**.

This new meeting will be listed as the prior meeting when the next meeting is created.

Edit a Meeting

On the Care Plan Meetings table:

1. Click the **Edit** icon next to the meeting that you want to change.

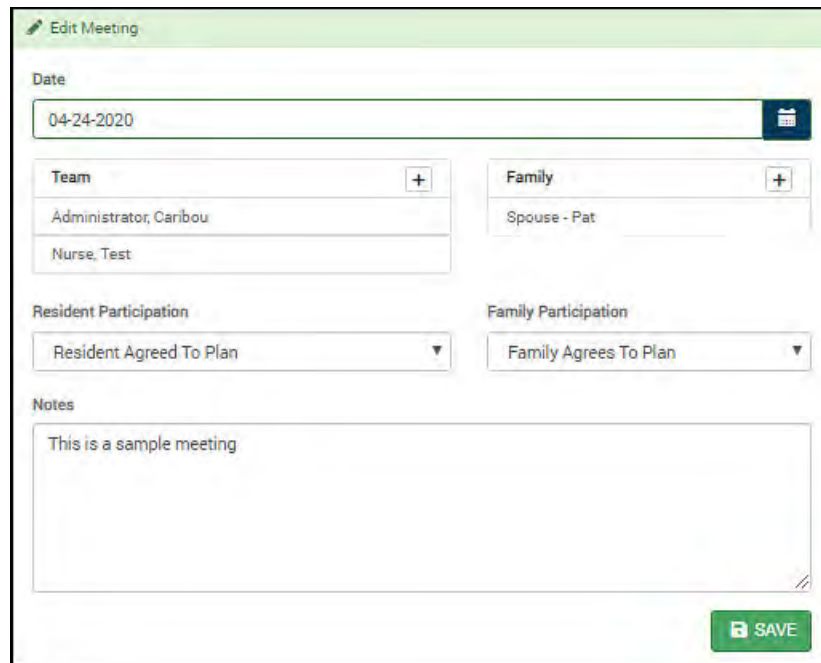
Figure 134: Edit/View Care Plan Meeting Icon



Date	Team	Family	Family Participation	Resident Participation	
04/24/2020	Administrator, Caribou Nurse, Test	Spouse - Pat	Family Agrees To Plan	Resident Agreed To Plan	

2. In the Edit Meeting pane, edit any of the fields necessary.

Figure 135: Edit Meeting Pane



Edit Meeting

Date: 04-24-2020

Team: Administrator, Caribou Nurse, Test

Family: Spouse - Pat

Resident Participation: Resident Agreed To Plan

Family Participation: Family Agrees To Plan

Notes: This is a sample meeting

SAVE

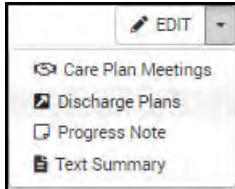
3. Click **Save** to save your changes to the meeting.

Add a Discharge Plan

To add a Discharge Plan:

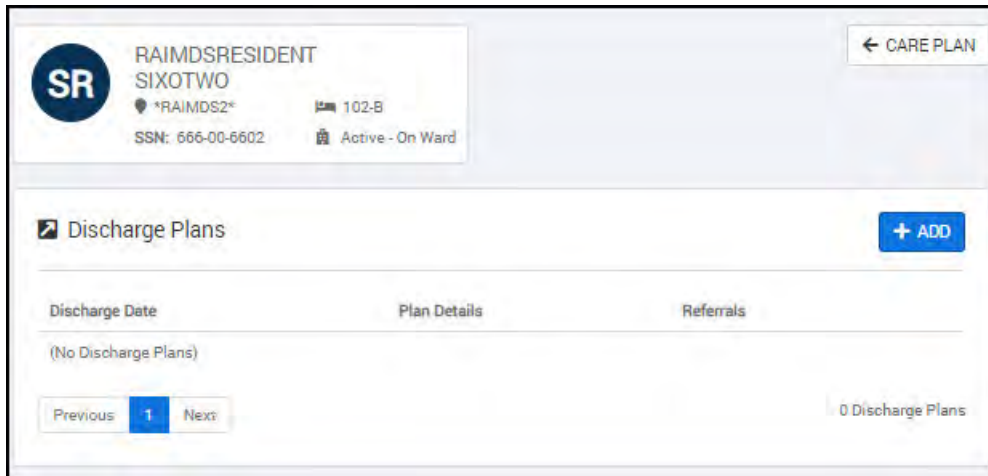
1. On the Care Plan Details resident banner, click the **Edit** drop-down list and select **Discharge Plans**.

Figure 136: Discharge Plan Option



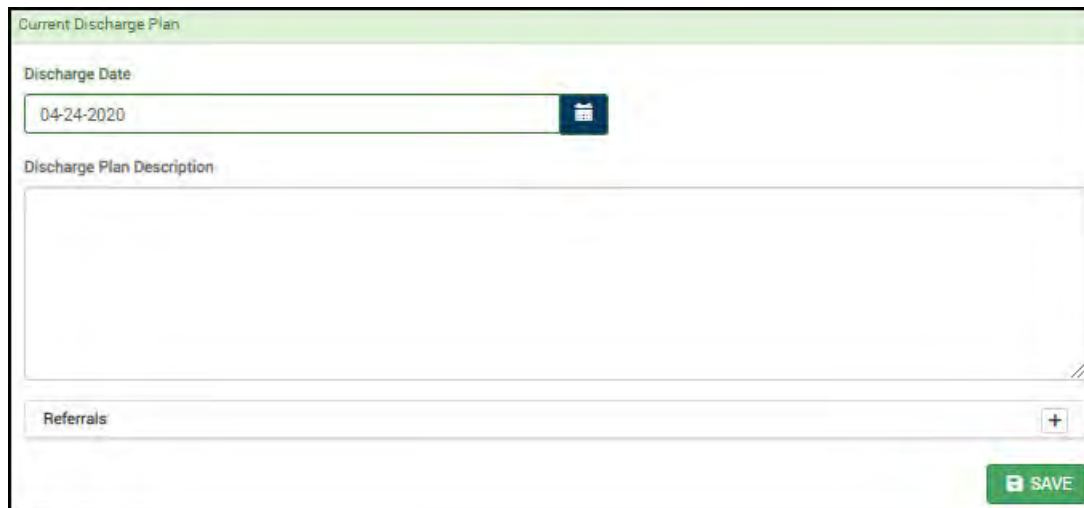
The Discharge Plans page opens. The table shows existing discharge plans or is empty if the resident does not have a discharge plan yet.

Figure 137: Discharge Plans Page



2. Click the blue **Add** button to create a discharge plan for the resident. The Current Discharge Plan pane opens.

Figure 138: Current Discharge Plan Pane



3. Select the **Discharge Date** with the calendar button.

4. In the **Discharge Plan Description** field, enter a free-text description of the discharge plan.
5. Click the **Referrals** plus sign to add referrals to the discharge plan. The Add Referral pop-up opens.

Figure 139: Add a Referral

6. From the **Referral Type** drop-down list, select the type of referral. Options include: **Home Health, Social Services, Case Management Services, Hospice Services, Discharge Planning Services, and Other.**
7. In the **Description** field, enter a description of the referral.
8. Click **Save**. The Referral is added to the bottom of the Current Discharge Plan.

Figure 140: Save the Current Discharge Plan

9. When the discharge plan is complete, click **Save**. The Discharge Plans page refreshes and shows the new discharge plan in the table.

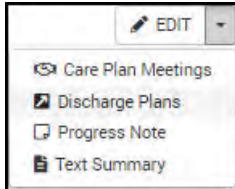
Figure 141: Resident Discharge Plan

View or Edit Discharge Plan

To view or edit a Discharge Plan:

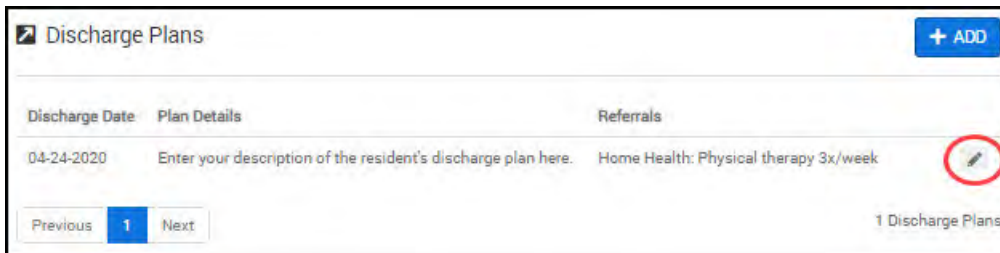
1. On the Care Plan Details resident banner, click the **Edit** drop-down list and select **Discharge Plans**.

Figure 142: Discharge Plan Option



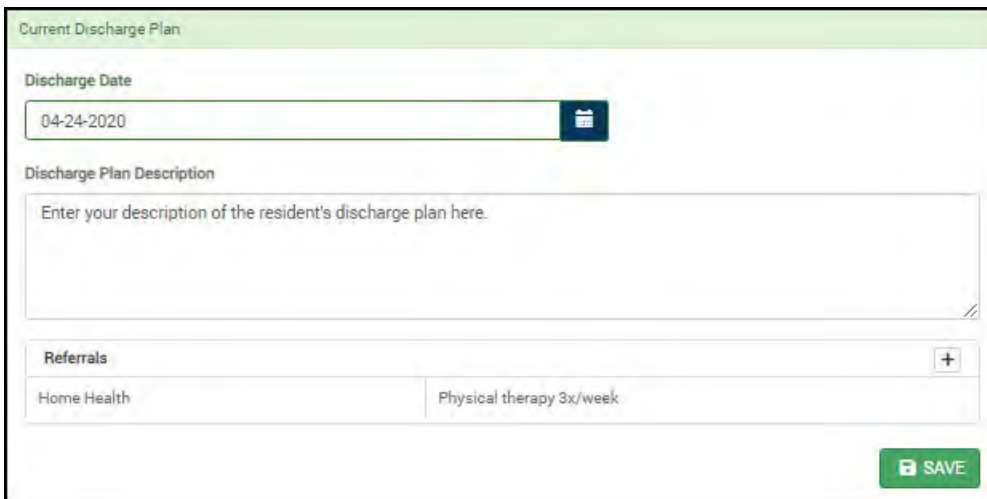
The Discharge Plans page opens. The current and/or prior discharge plans are shown in the table.

Figure 143: Discharge Plans Page



2. Click the **Edit** icon next to the discharge plan you want to view or edit. The Current Discharge Plan pane opens.
3. View the plan or make your changes.

Figure 144: View or Edit Discharge Plan



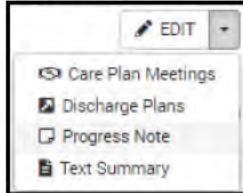
Note: If the resident has a prior discharge plan, it will show in the Prior Discharge Plans pane to the right of to the Current Discharge Plan.

Sign a Progress Note

To sign a Progress Note for this care plan:

1. On the Care Plan Details resident banner, click the **Edit** drop-down list and select **Progress Note**.

Figure 145: Edit > Progress Note Option



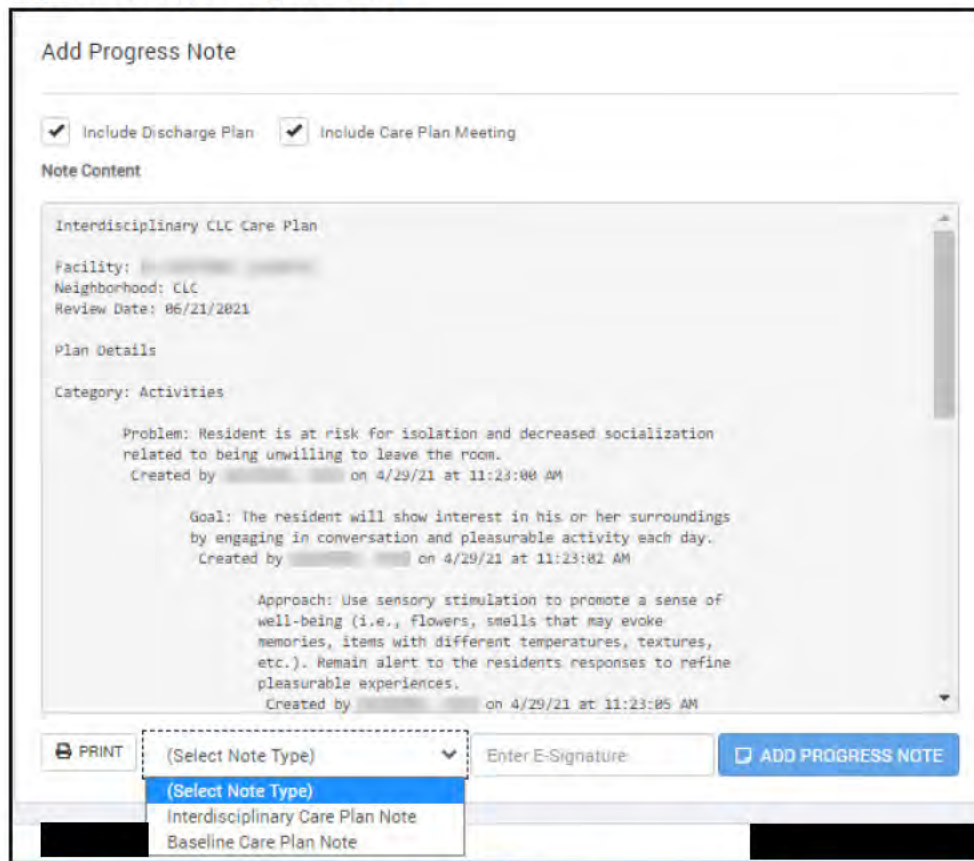
Note: If you're not already connected to [REDACTED], you'll be asked to log in to [REDACTED] with your [REDACTED] to enter this page.

The progress note is available in the Add Progress Note pane.

In the top right corner, a note is shown if there are reviews pending on this note.

2. Review the note.
3. Select the Note Type from the drop-down list. Options are: **Interdisciplinary Care Plan Note** and **Baseline Care Plan Note**.
4. Enter your Electronic Signature.

Figure 146: Sign Progress Note

A screenshot of the "Add Progress Note" form. At the top, there are two checked checkboxes: "Include Discharge Plan" and "Include Care Plan Meeting". Below that is a "Note Content" section with a scrollable text area containing the following text:

Interdisciplinary CLC Care Plan
Facility: [REDACTED]
Neighborhood: CLC
Review Date: 06/21/2021

Plan Details

Category: Activities

Problem: Resident is at risk for isolation and decreased socialization related to being unwilling to leave the room.
Created by [REDACTED] on 4/29/21 at 11:23:00 AM

Goal: The resident will show interest in his or her surroundings by engaging in conversation and pleasurable activity each day.
Created by [REDACTED] on 4/29/21 at 11:23:02 AM

Approach: Use sensory stimulation to promote a sense of well-being (i.e., flowers, smells that may evoke memories, items with different temperatures, textures, etc.). Remain alert to the residents responses to refine pleasurable experiences.
Created by [REDACTED] on 4/29/21 at 11:23:05 AM

At the bottom of the form, there is a "PRINT" button, a dropdown menu for "(Select Note Type)" which is open to show "Interdisciplinary Care Plan Note" and "Baseline Care Plan Note", an "Enter E-Signature" field, and an "ADD PROGRESS NOTE" button.

5. Click **Add Progress Note** to save the note.

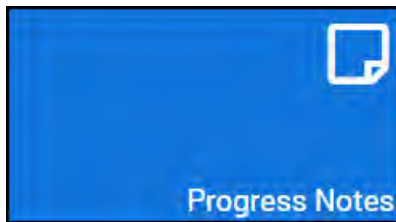
View Previous Progress Notes

On the Care Plan Details page, new progress notes can be added and signed. See [“Sign a Progress Note” on page 90](#) for details. However, if you want to view the previous Progress Notes for a resident, you can do so through the **Progress Notes** tile

To view previous Progress Notes for this care plan:

1. From the [REDACTED] Homepage, click the **Progress Notes** tile.

Figure 147: Progress Notes



The Residents page appears.

2. At the top of the page, enter the resident’s last name in the **Search Residents** field and select the resident’s Neighborhood from the **All Neighborhoods** drop-down list.

Figure 148: Resident Search Fields

Residents				
Twenty	Q	RAIMDS1	▼	Q SEARCH

3. Click **Search**.
4. Select the resident from the search results.

The Progress Notes page for the selected resident opens. (The resident’s banner may include a Covid-19 status.)

Figure 149: Progress Notes Page

Caribou Module	Note Type	Created	Created By
Care Plans	Interdisciplinary Care Plan	02/16/21 10:50 AM	CNA, Certified Nurse Assistant
ADL	ADL Note	01/26/21 08:33 AM	Gr. [REDACTED]
ADL	ADL Note	01/26/21 08:33 AM	CNA, Certified Nurse Assistant
MDS	MDS Assessment Note	01/19/21 10:46 AM	Gr. [REDACTED]
MDS	MDS CAA Narrative Note	01/19/21 10:45 AM	Gr. [REDACTED]
MDS	MDS Care Area Assessment Summary Note	01/19/21 10:44 AM	Gr. [REDACTED]

In the above example, the resident has six Progress Notes.

- To view one of the resident's Progress Notes, click the link in the Note Type column.

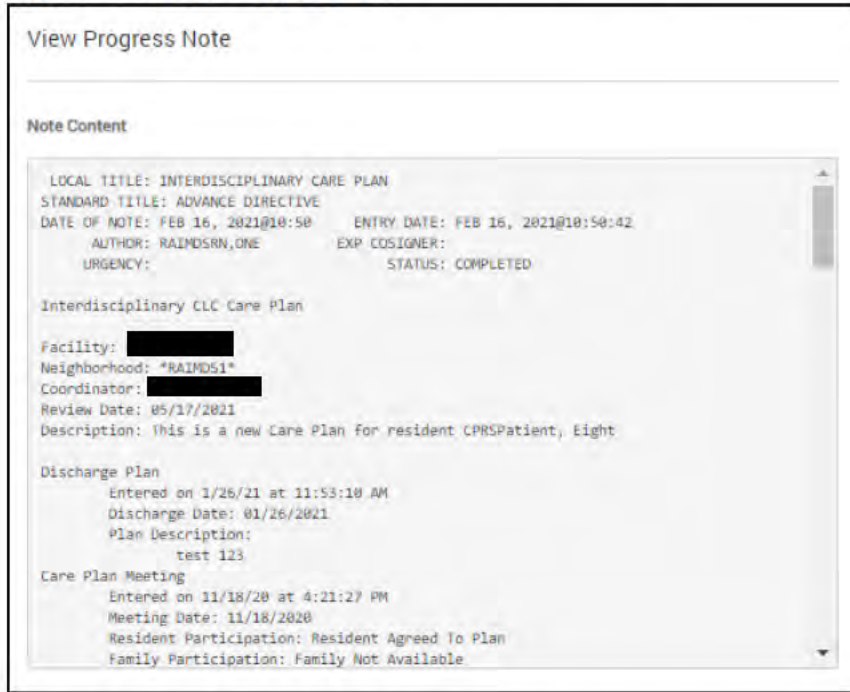
Figure 150: Open Progress Note



The selected Progress Note opens for review.

- If prompted, log into [REDACTED] with your [REDACTED].

Figure 151: View Progress Note



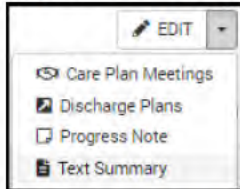
- Review the Progress Note.
- To return to the resident's table of progress notes, click **Return to** in the top right corner of the window. Click the [REDACTED] link in the breadcrumbs at the top of the page to return to the Homepage.

View the Text Summary

To view a Text Summary:

1. On the Care Plan Details resident banner, click the **Edit** drop-down list and select **Text Summary**.

Figure 152: Edit List Text Summary Option



The Care Plan Text Summary opens.

Figure 153: Care Plan Text Summary



2. Review the text summary.
3. Click **Print** to send the text summary to your printer, or click **Close** to return to the Care Plan Details page.

History

This option allows the user to search for a resident and view all of the Care Plan activity for that resident. To access the care plan history for a resident:

1. From the Care Plans page, click the **History** tile.

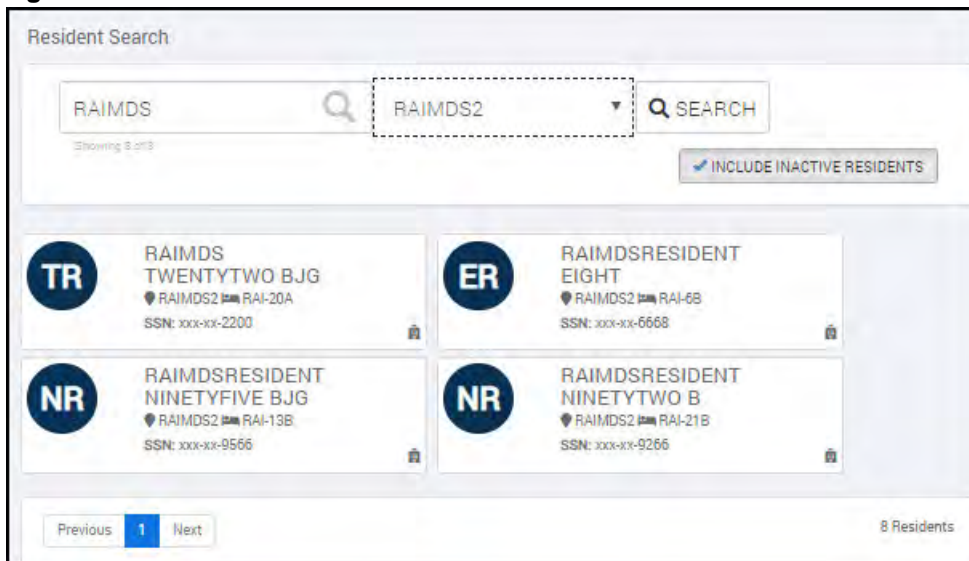
Figure 154: History Tile



The Resident Search page opens.

2. In the **Search Residents** field, enter the first or last name of the resident.
3. Use the **Select Neighborhood** drop-down list to filter the resident search results by the resident's neighborhood.

Figure 155: Resident Search Results



4. Click **Search**.
5. To filter out inactive residents, click the **Include Inactive Residents** button to remove them from the search results.
6. Select the resident for which you want to view the care plan history from the Resident Search results.


The resident's Care Plans History opens.

Figure 156: Care Plans History

Title	Status	Start Date	End Date	Care Coordinator	Review Date	Created	Last Modified	
Interdisciplinary CLC Care Plan	Active	10/08/2019	11/22/2019	Sofia	10/26/2019	10/08/2019	10/30/2019	...
Interdisciplinary CLC Care Plan	Completed	09/19/2019	09/21/2019	Sofia	12/13/2019	09/19/2019	09/20/2019	...
Interdisciplinary CLC Care Plan	Completed	09/19/2019	09/28/2019		12/13/2019	09/19/2019	09/19/2019	...
Interdisciplinary CLC Care Plan	Completed	09/18/2019	09/19/2019	Sofia	09/26/2019	09/18/2019	09/19/2019	...
Interdisciplinary CLC Care Plan	Completed	09/07/2019			09/20/2019	09/07/2019	09/13/2019	...
Interdisciplinary CLC Care Plan	Completed	09/07/2019	09/07/2019		09/20/2019	09/07/2019	09/07/2019	...

The Care Plans History shows the completed and active care plans that have been created for the selected patient. The Data included in the Care Plans History table include:

- Title
- Status
- Start Date
- End Date
- Care Coordinator
- Review Date
- Created
- Last Modified

To the right of the plan for which you want to see details, click the **Plan Details** (ellipsis) icon . The Care Plan Details page opens. Go to [“View an Active Care Plan Details” on page 68](#) for more information on the Care Plan Details page.

Add a Care Plan

Note: If the resident already has an active Care Plan, a new care plan or continuation plan cannot be added.

To add a Care Plan:

1. At the top of the Care Plans History page, click the **Add Care Plan** button.

Figure 157: Add Care Plan Button



The Add Care Plan page opens. Follow the steps in [“Add a Care Plan” on page 65](#) to add a new care plan.

2. After the new care plan is created, the Care Plan Details page opens and the new Care Plan is shown with no Care Plan Items. See [“Add Plan Items” on page 77](#) for steps to add care plan items.

Care Plans Reports

The Reports page allows users to run, view, filter and print or save the following reports:

- Approaches by Discipline
- Approaches by Status
- Goals by Review Date
- Plans Review
- Categories Report

To view a report:

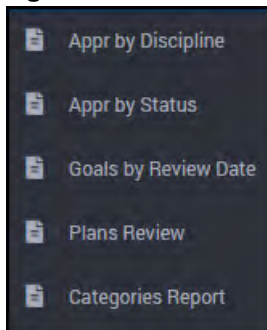
1. From the Care Plans page, click the **Reports** tile.

Figure 158: Reports Tile



2. From the left column, select a report. The report opens to the right.

Figure 159: Care Plan Reports



Filter Reports

The reports may be filtered by several different metrics, and each report is filtered by different combinations of metrics.

To filter the Approaches by Discipline report


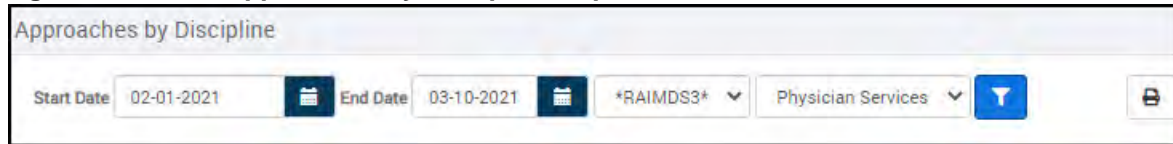
1. From the left column of the Reports page, click **Approaches by Discipline**.
2. From the **Start Date** field, choose a start date with the Calendar button by which to filter the report.
3. From the **End Date** field, choose an end date with the **Calendar** button by which to filter the report.
4. From the **All Neighborhoods** drop-down list, select a neighborhood by which to filter the report.
5. From the **All Disciplines** drop-down list, select a discipline by which to filter the report.
6. Click the **Filter** icon .

Figure 160: Filter Approaches by Discipline Report



To filter the Approaches by Status report



1. From the left column of the Reports page, click **Approaches by Status**.
2. From the **Start Date** field, choose a start date with the Calendar button by which to filter the report.
3. From the **End Date** field, choose an end date with the **Calendar** button by which to filter the report.
4. From the **All Neighborhoods** drop-down list, select a neighborhood by which to filter the report.
5. From the **All Statuses** drop-down list, select a status by which to filter the report.
6. Click the **Filter** icon .

Figure 161: Filter Approaches by Status Report



To filter the Goals by Review Date report


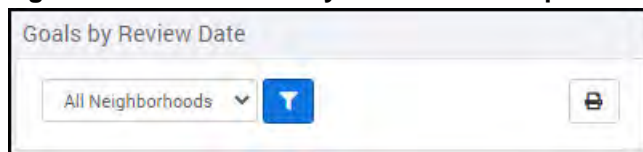
1. From the left column of the Reports page, click **Goals by Review Date**.
2. From the **All Neighborhoods** drop-down list, select a neighborhood by which to filter the report.
3. Click the Filter icon .

Figure 162: Filter Goals by Review Date Report



To filter the Plans Review report


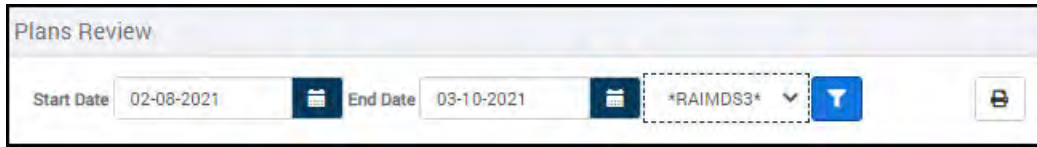
1. From the left column of the Reports page, click **Plans Review**.
2. From the **Start Date** field, choose a start date with the Calendar button by which to filter the report.
3. From the **End Date** field, choose an end date with the **Calendar** button by which to filter the report.
4. From the **All Neighborhoods** drop-down list, select a neighborhood by which to filter the report.
5. Click the **Filter** icon .

Figure 163: Filter Plans Review Report



To filter the Categories report


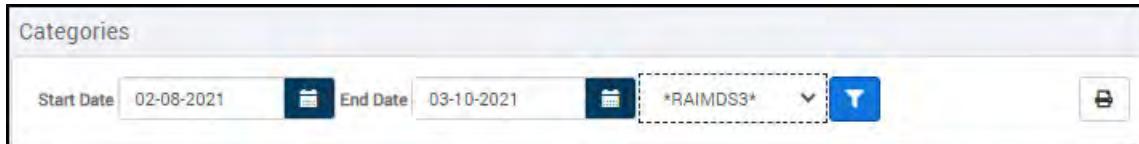
1. From the left column of the Reports page, click **Categories Report**.
2. From the **Start Date** field, choose a start date with the **Calendar** button by which to filter the report.
3. From the **End Date** field, choose an end date with the **Calendar** button by which to filter the report.
4. From the **All Neighborhoods** drop-down list, select a neighborhood by which to filter the report.
5. Click the **Filter** icon .

Figure 164: Filter Categories Report



Print a report

After you have filtered the report to show the information relevant to your needs, you can print the report.

1. Click the **Print** icon at the top of the report. A print dialog window opens to select your print settings.

Figure 165: Print Icon



2. Choose your settings and click **Print**.

Start an MDS Assessment

About MDS Assessments

██████ MDS is a standardized assessment and treatment planning process designed to identify the functional and health care needs of the Veteran and to help develop a plan of care where services are individualized to meet the needs of each resident.

The ██████ MDS has over 800 questions that are part of the assessment. Based on the which assessment type is selected, the relevant questions are populated in the assessment.

There are approximately 26 different types of assessments and over 4,000 combination tests. Some questions have A and B options, where users can choose 1–9 including blank and not assessed, Each question is validated to determine if the answers will be accepted in AITC.

Furthermore, the answers of some questions pre-determine the result for answers in other areas of the assessment.

Assessment types:

- NC – Comprehensive
- NQ – Quarterly
- NP (5 day, 14-day, 30-day, 60-da7, and 90-day) – PPS or Short Stay
- ND – Discharge
- NPE – PPS End of Stay

Tracking Forms:

- NT – Entry Tracking
- DT – Death Tracking

Assessments that can be dually coded:

- NC/NP and/or NPE – Comprehensive/PPS
- NQ/NP and/or NPE – Quarterly/ PPS
- ND/NP and/or NPE – Discharge/PPS

Step 1: Find the Resident Who Needs an Assessment

The easiest method for finding the resident who needs an assessment is to use the Residents tile to search for an active resident:

1. From the ██████████ homepage, click the Residents tile.

Figure 166: Residents Tile



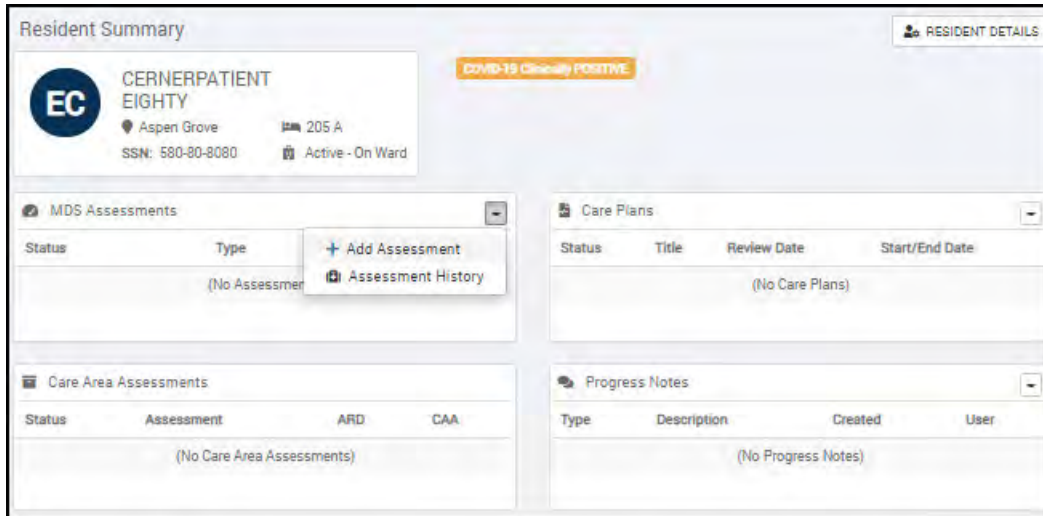
2. You can enter the first, last, or full name of the resident in the **Search Residents field**, and you can filter the results with the **Neighborhoods** filter to find the resident who needs an assessment.
3. Select the desired resident to open the Resident Summary page.

Step 2: Create a New MDS Assessment

Note: Though you can create a new MDS assessment from the MDS Resident History page, this method is more direct.

1. From the Resident Summary page, in the MDS Assessments pane, click the drop-down arrow and select **Add Assessment**.

Figure 167: Add Assessment Option



The Create New Assessment page opens.

Figure 168: Create New Assessment Page

Create New Assessment - CPRSPATIENT, EIGHT F

Current CMS (Specification Version: 2.02, Item Set Version: 1.16, Effective Date: 10/1/2018)

A1900. Admission Date: 03-28-2019 - Original, Ep #1

A2300. ARD: 03-11-2021

A1600. Entry Date: 03-28-2019

A2000. Discharge Date: MM-DD-YYYY

Care Plan Date: 03-11-2021

A0310. Type of Assessment

A. Federal OBRA Reason for Assessment

- 01. Admission assessment (required by day 14)
- 02. Quarterly review assessment
- 03. Annual assessment
- 04. Significant change in status assessment
- 05. Significant correction to prior comprehensive assessment
- 06. Significant correction to prior quarterly assessment
- 99. None of the above

B. PPS Assessment PPS Scheduled Assessments for a Medicare Part A Stay

- 01. 5-day scheduled assessment
- 02. 14-day scheduled assessment
- 03. 30-day scheduled assessment
- 04. 60-day scheduled assessment
- 05. 90-day scheduled assessment

PPS Unscheduled Assessments for a Medicare Part A Stay

- 07. Unscheduled assessment used for PPS

Not PPS Assessment

- 99. None of the above

C. PPS Other Medicare Requirement Assessment - OMRA

0. No

F. Entry/discharge reporting

- 01. Entry tracking record
- 10. Discharge assessment - return not anticipated
- 11. Discharge assessment - return anticipated
- 12. Death in facility tracking record
- 99. None of the above

G. Type of Discharge - Complete only if A0310F = 10 or 11

- 1. Planned
- 2. Unplanned

H. Is this a SNF PPS Part A Discharge (End of Stay) Assessment?

- 0. No
- 1. Yes

Open Assessment After Create? NO YES

Target Date:

CANCEL CREATE

2. From the **A1900. Admission Date** drop-down list, select the resident's admission date.
3. From the **A2300. ARD** field, select the correct assessment reference date from the calendar button.
4. From the **A1600. Entry Date** field, select the correct entry date from the calendar button.
5. From the **A2000. Discharge Date** field, enter the expected discharge date from the calendar button. Enter the discharge date if you're creating a discharge assessment.
6. In the **Care Plan Date** field, use the calendar button to select the date of the resident's care plan.
7. In the A0310. Type of Assessment section, select:
 - a. A **Federal OBRA Reason for Assessment**
 - b. A **PPS Assessment**
 - c. A **PPS Other Medicare Requirement Assessment - OMRA**

- d. A **Type of Discharge** (Complete only if A0310 = 10 or 11)
 - e. An **Entry/discharge reporting** type
 - f. **Yes** or **No** for the question, **“Is this a SNF PPS Part A Discharge (End of Stay) Assessment?”**
8. At the bottom of the page, select **Yes** to open the assessment after creation, or **No** to create the assessment without opening it.
 9. Click the **Create** button.

If you chose Yes to open the assessment in step 8, the resident’s assessment opens to the Overview page and you can continue to complete the assessment. If you chose not to open the assessment after creation, the resident’s assessment can be completed at another time through the **Work in Progress** tile. [See “Access an Open MDS Assessment” on page 105.](#)

Figure 169: Resident Assessment Overview

The screenshot displays the Resident Assessment Overview page, which is divided into several sections:

- Overview:** Shows assessment details such as Admitted: 05-23-2018, Location: (), Date Of Birth: (), Type: Quarterly 5-day, Status: Work In Progress, and ARD: 06-16-2021.
- Section Navigation:** A vertical list of sections from A to Z, with Section A, Section I, and Section S highlighted in blue.
- Assessment Header:** Contains key information:
 - Assessment Type: Quarterly 5-day
 - Assessment Status: Work In Progress
 - Assessment Reference Date (ARD): 06-16-2021
 - RN Verify By Date: 06-30-2021
 - Assessment Complete By Date: 06-30-2021
 - CAA Complete By Date: (blank)
 - Item Set: Nursing Home Quarterly (NQ)
 - Item Set Version: 1.17
 - Specification Version: 3.00
 - Quality Measures Version: 12.1 (10/01/2018)
 - PDPM Score: (blank)
 - Created: 06-16-2021
 - Completed: (blank)
 - Type of Record (A0050): 1. Add new record
 - Overall Completion: 23%
- Signatures & Sections:** A table with columns for Signature, Title, and Sections. The first row shows a signature for Z0500 with a Pending status. Below it is a table for sections A through L.
- Assessment Progress:** A vertical list of sections from A to Z, with progress indicators for Section A, Section I, and Section S, all marked as 'in progress'.

MDS Assessment Entry and Navigation

This section explains how the MDS team can complete the MDS Assessment by performing the following tasks:

- Access an open MDS assessment.
- Understand the MDS overview.
- Navigate the MDS assessment
- Use the MDS assessment functions.
- E-sign and save Section Z.

Within [REDACTED], administrative controls define the user's read and write access for MDS assessments, reports, and editing. Audit tracking of the "who," "when," and "what," of assessment updates shows on the pages. [REDACTED] adheres to the Resident Assessment Instrument/Minimum Data Set (RAI/MDS) 3.0 standards set forth by Centers for Medicare & Medicaid Services (CMS). Section I of the MDS assessment is ICD-10 ready using the [REDACTED] Lexicon. Section V is directly linked to 20 CMS-recommended Care Area Assessment (CAA) forms with areas for multiple users to complete and sign. CAAs are saved as TIU Notes and are viewable in CPRS. The Care Area Assessment (CAA) connects to the MDS assessments and integrates with the web Care Plans.

The [REDACTED] MDS includes the ability to create an "on the fly" Significant Change MDS assessment. Users can view validation warnings and make corrections before the MDS coordinator signs the assessment as completed

Access an Open MDS Assessment

To access an open MDS Assessment:

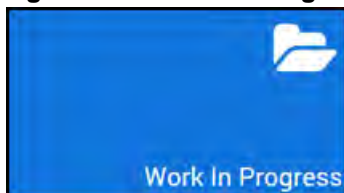
1. From the [REDACTED] homepage, click the **MDS** tile.

Figure 170: MDS Tile



1. From the **MDS** dashboard, click the **Work in Progress** tile.

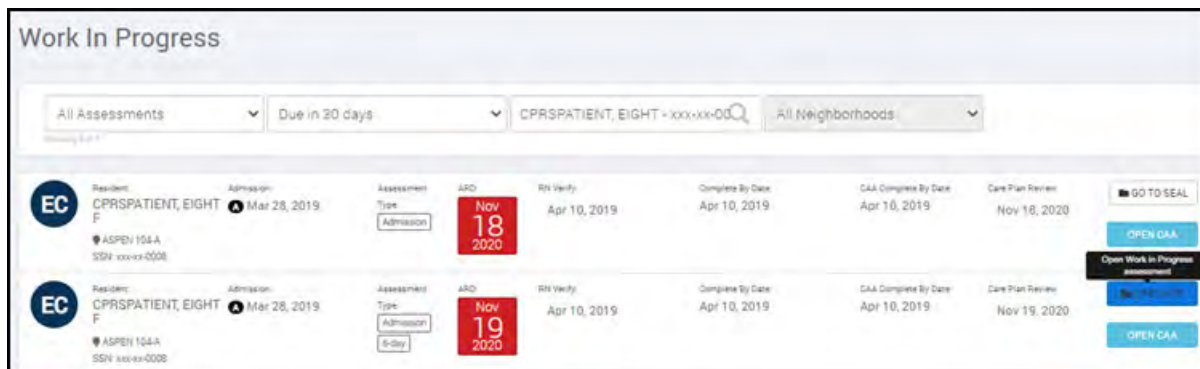
Figure 171: Work In Progress Tile



The Work in Progress window opens.

2. Use the filter options to choose an assessment to open.
3. Click the **Open WIP** button to the right of the assessment to be opened.

Figure 172: Open WIP Button



The Assessment Overview appears.

Assessment Overview

The Assessment Overview page shows an overview of the resident's assessment. The MDS sections (A–Z) appear along the left side of the window and can be clicked for direct access to the different sections.

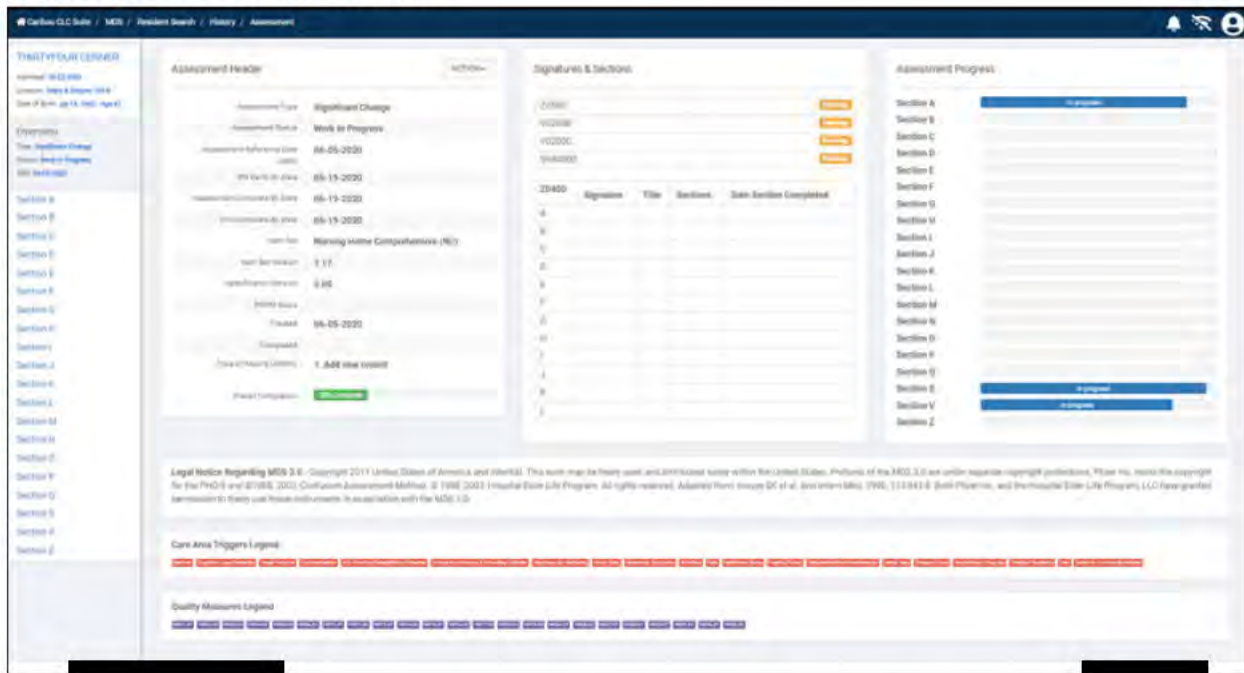
To the right of the MDS sections column, is the Assessment Header. This section includes the assessment details and provides an Overall Completion meter that shows at a glance the percentage of the assessment that is complete. The data in this column includes:

- Assessment Type
- Assessment Status
- Assessment Reference Date (ARD)
- RN Verify By Date
- Assessment Complete By Date
- CAA Complete By Date
- Item Set (CMS)
- Item Set Version (CMS)
- Specification Version
- Quarterly Measures Version
- PDPM Score
- Created date
- Completed date
- Type of Record
- Overall Completion meter

To the right of the Assessment Header section, is the Signatures & Sections pane. When completed this pane contains all of the required signatures and sections.

To the right of the Signatures & Sections pane, is the Assessment Progress section. This section shows the status of completion for each individual section (A–Z) of the assessment.

Figure 173: Assessment Overview



Below the main three panes on the page, is the Legal Notice, the Care Area Triggers Legend, and the Quality Measures Legend.

To return to the Assessment Overview from any section of the assessment, click the Overview pane in the left column.

Figure 174: Overview Pane



Resident Inquiry

Click the **Resident** name field at the top of the page to open a Resident Inquiry.

Figure 175: Resident Name Field



The Resident Inquiry is the Resident's Demographics page, which shows the resident's identifying data, status, admission information, and location.

Figure 176: Resident Inquiry

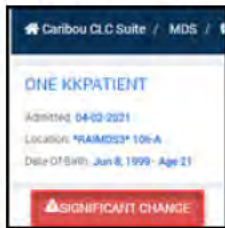
Resident's Demographics			
First Name:	Last Name:	Middle Name:	Suffix:
EIGHT	CPRSPATIENT	F	
Gender:	Date of Birth:	Age:	Date of Death:
FEMALE	02-01-1955	66	
Social Security Number:	Race/Ethnicity:	MaritalStatus:	Status:
666-66-0008	UNKNOWN BY PATIENT,WHITE	MARRIED	Active - On Ward
Admission Date:	Admission Type:	Admitting Diagnosis:	Attending Physician:
03-28-2019	DIRECT	NHCU	CPRSATTENDING,ONE
Neighborhood:	Room Bed:	Transfer Type:	Treating Specialty:
ASPEN	104-A	DIRECT	REHAB MEDICINE OBSERVATION

Significant Change Assessment Alert

MDS provides a page of changes in the data entered by users for informational purposes only and does not make the decision or assumption that a resident has had a significant change. As always, analyze the provided information to determine if the resident will benefit from a significant change in status assessment.

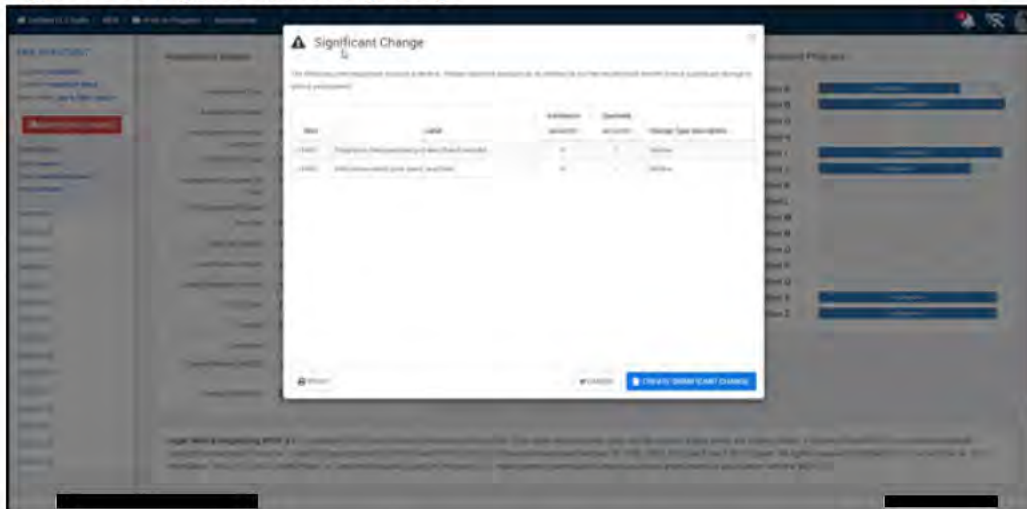
MDS includes an alert when entries are made that indicate a decline or improvement in resident function.

Figure 177: Significant Change Button



After a data analysis and a determination made by the resident's clinician, click the **Create Significant Change** button to recode the assessment and modify the ARD.

Figure 178: Significant Change Page



The following table itemizes the MDS items that trigger the Significant Change button. The tables include both decline and improvement items.

Table 2: Significant Decline Triggers

MDS Item	Section	Change
B0100	Comatose	From 0 (no) to 1 (yes) or 2
B0600	Speech	From 0 (no) to 1 (yes) or 2
C1000	Cognitive Skills for Daily Decision Making	From lower to higher number (0,1,2,3)
D0200	Mood A, B, C, D, E, F, G, H, I – symptom presence and frequency (Resident interview)	From lower to higher number (0,1,2,3)
D0500	Mood A, B, C, D, E, F, G, H, I, J – symptom presence and frequency (Staff Assessment)	From lower to higher number (0,1,2,3)
G0110	ADL Self Performance A, B, C, D, E, F, G, H, I, J	From lower to higher number (0,1,2,3)
H0100	Bladder and Bowel Appliances	From Z to A, B, C, D)
H0300	Urinary Continence	From 0 to 1,2,3)
H0400	Bowel Continence	From 0 to 1,2,3)
J0300	Pain Presence	From 0 to 1
J1400	Prognosis/Life Expectancy	From 0 to 1
J1800	1 New Fall	From 0 to 1
J1900	C Major Injury	From unchecked to checked
K0300	Unplanned Weight Loss	From 0 to 2
K0310	Unplanned Weight Gain	From 0 to 2
M0800	New or Worsening Pressure Ulcer (A, B, C)	From a low number to a high number
O0100K	Hospice Care	From unchecked to checked
P0100B	Trunk Restraint	From unchecked to checked
P0100G	Chair That Prevents Rising	From unchecked to checked

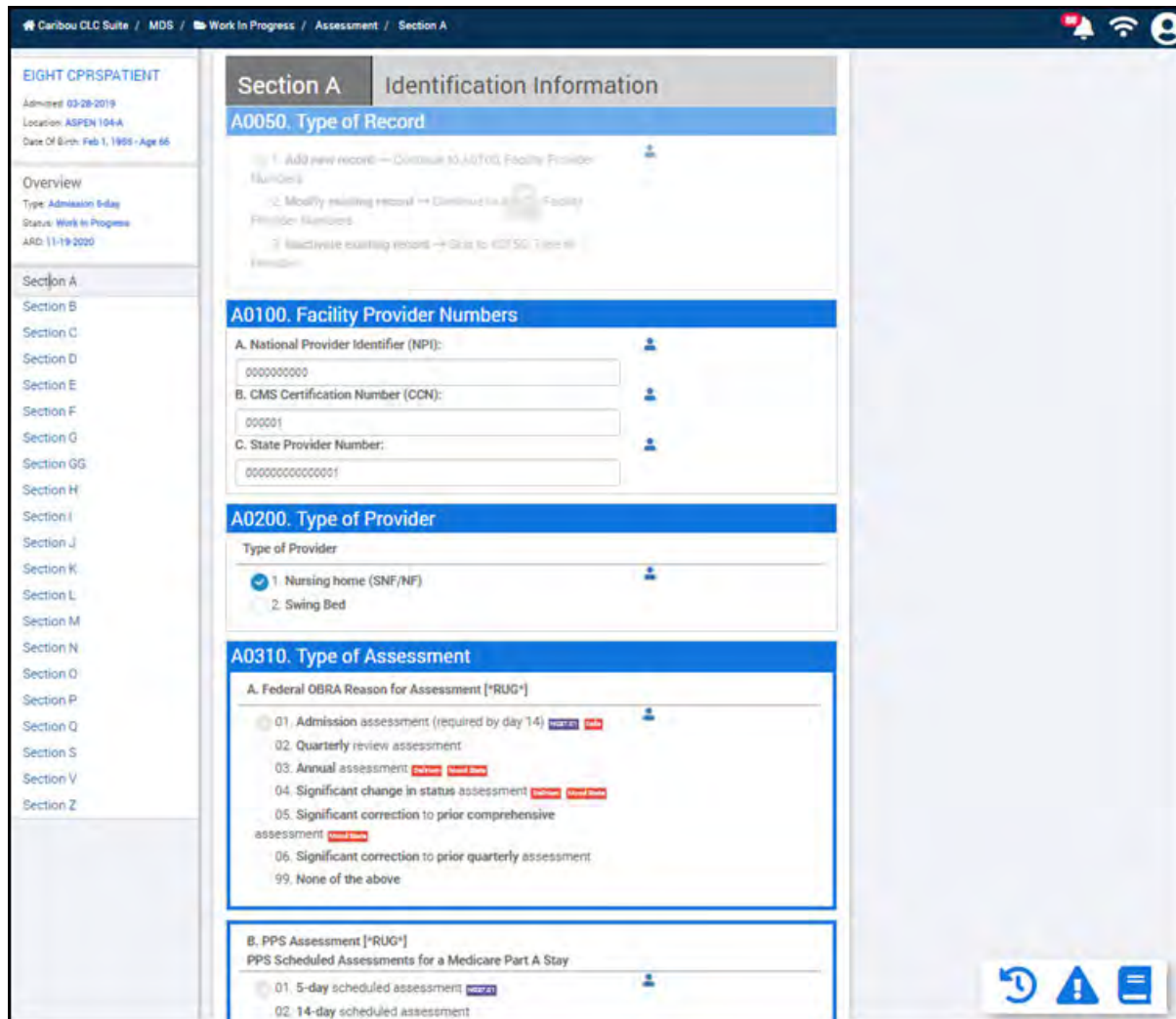
Table 3: Significant Improvement Triggers

MDS Item	Section	Change
B0100	Comatose	From 1 (yes) to 0 (no)
B0600	Speech	From 1 or 2 to 0
C1000	Cognitive Skills for Daily Decision Making	From high to low number (0,1,2,3)
D0200	Mood A, B, C, D, E, F, G, H, I – symptom presence and frequency (Resident interview)	From high to low number (0,1,2,3)
D0500	Mood A, B, C, D, E, F, G, H, I, J – symptom presence and frequency (Staff Assessment)	From high to low number (0,1,2,3)
G0110	ADL Self Performance A, B, C, D, E, F, G, H, I, J	From high to low number (0,1,2,3,4)
H0100	Bladder and Bowel Appliances	From A, B, C, D to Z
H0300	Urinary Continence	From 0 to 1,2,3)
H0400	Bowel Continence	From high to low number (0,1,2,3)
J0300	Pain Presence	From 1 to 0
J1400	Prognosis/Life Expectancy	From 1 to 0
M0900A	Healed Pressure Ulcers	A=1
O0100K	Hospice Care	From checked to unchecked
P0100B	Trunk Restraint	From checked to unchecked
P0100G	Chair That Prevents Rising	From checked to unchecked

Navigating Through the MDS Assessment

The MDS assessment sections are accessed from the links listed on the left side of the window.

Figure 179: Assessment Sections



You can click through the different sections from the left column as needed.

MDS Assessment Tools

Save Section

Click the **Save Section** icon to save the entered data. The number in the red circle above the save icon indicates the number of changes that will be saved.

Figure 180: Save Section Icon



Section History

Click the **Section History** icon to see the last two assessment answers.

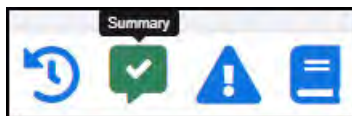
Figure 181: Section History Icon



Summary

Click the **Summary** icon to see the Daily Care Manager ADL summary for the patient in a pop-up.

Figure 182: Summary Icon



Note: If you don't see the Summary icon in a section, then that section does not have a summary.

Validation Results

Click the **Validation Results** icon to see validation errors in data entry.

Figure 183: Validation Results Icon



RAI MDS Manual

Click the **RAI MDS Manual** icon to go to the specific MDS section of the RAI manual.

Figure 184: RAI MDS Manual Icon



MDS – Care Manager Shift Charting

A seven day report of resident shift charting is available to assist with the data entry of the MDS assessment. .

The shift charting events are included in the following MDS sections:

- Section C
- Section D
- Section E
- Section F
- Section H
- Section K

The ADL charting entries are mapped to the following MDS sections:

- Section G

Save Sections

Each section has auto-save functionality and a **Save** icon on the bottom right of the page to save each section as it is completed. Auto-save occurs after 10 seconds of idle time.

Figure 185: Save Icon



Sign Section Z

When the assessment is ready to be finished, perform the following steps to complete the assessment:

1. Click **Section Z** to open the last section of the MDS assessment.
2. On Section Z0400, click the **Add Signature** button.

Figure 186: Section Z

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting

I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature	Title	Sections	Date Section Completed	
A.				✓ ADD SIGNATURE
B				✓ ADD SIGNATURE
C				✓ ADD SIGNATURE

The Add Signature dialog box appears.

Figure 187: Add Signature Dialog Box

Add Signature

User: Administrator, Durango

Title: RPT

Signature:

Signature Date: 07-04-2016

Sections and/or items: O

Suggested:
A: A0050, A0200, A0310A, A0310B, A0310C, A0100A

CANCEL SIGN

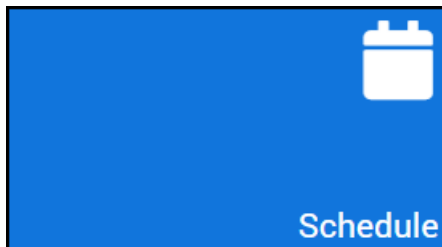
3. In the **Title** field, leave the default text or enter a new title.
4. Enter the **Sections and/or items** completed. Items that are completed are listed below the **Sections and/or items** field.
5. Enter your password in the **Signature** field.
6. Select the **Signature Date**.
7. Click the **Sign** button.

MDS Schedule

RAI Coordinators can work their schedule (OBRA, PPS, or the combination OBRA/PPS schedule) with the user-friendly, point of access Caribou Schedule.

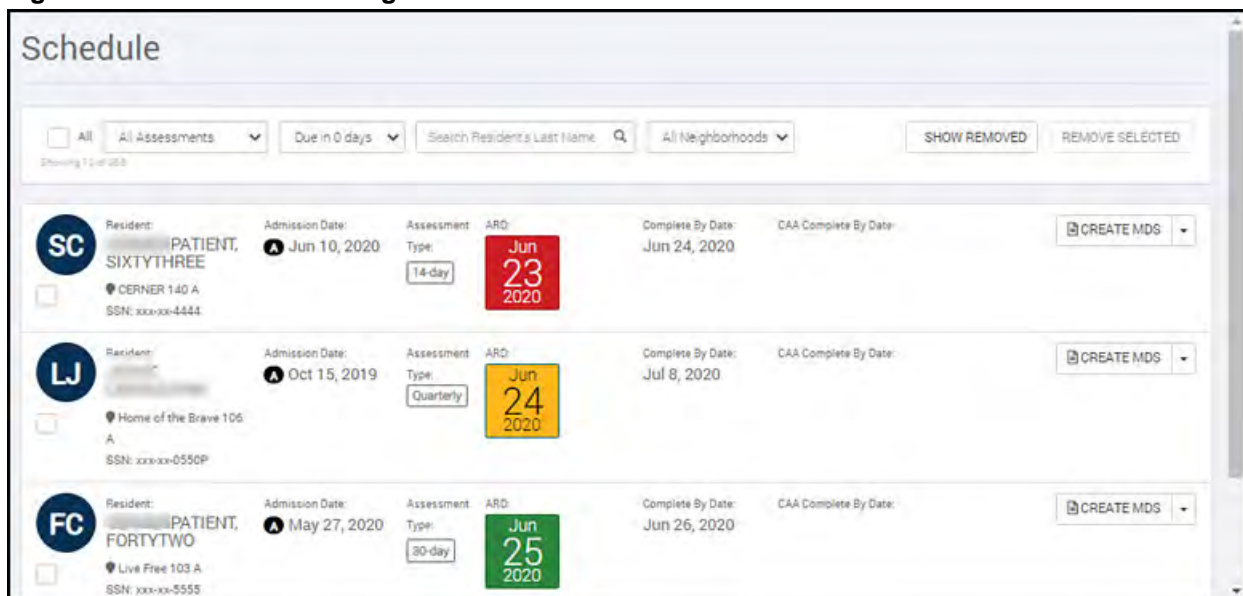
Click the **Schedule** tile to open the MDS schedule to view all of the OBRA and/or PPS assessments that are scheduled.

Figure 188: Schedule Tile



The Schedule page opens to show all of the assessments that are ready to be created. Assessment types with ARDs that have a red background indicate that they are overdue. Assessments that are due to be filed today have a yellow ARD background. Assessments with ARDs that have a green background indicate that they are not yet due.

Figure 189: MDS Schedule Page



The screenshot shows the 'Schedule' page with the following elements:

- Filters: All, All Assessments, Due in 0 days, Search Resident's Last Name, All Neighborhoods, SHOW REMOVED, REMOVE SELECTED.
- Table of assessments:

Resident	Admission Date	Assessment Type	ARD	Complete By Date	CAA Complete By Date	Action
SC Resident: PATIENT, SIXTYTHREE CERNER 140 A SSN: xxx-xx-4444	Jun 10, 2020	14-day	Jun 23 2020 (Red)	Jun 24, 2020		CREATE MDS
LJ Resident: [REDACTED] Home of the Brave 105 A SSN: xxx-xx-0550P	Oct 15, 2019	Quarterly	Jun 24 2020 (Yellow)	Jul 8, 2020		CREATE MDS
FC Resident: PATIENT, FORTYTWO Live Free 103 A SSN: xxx-xx-5555	May 27, 2020	30-day	Jun 25 2020 (Green)	Jun 26, 2020		CREATE MDS

The Schedule page can be filtered by the assessment type, due date, the resident's last name, and the resident's neighborhood. Each entry includes the:

- Resident's Name, Neighborhood, and SSN Number
- Admission Date or Discharge Date
- Assessment Type
- ARD Date
- Completed By Date
- CAA Completed By Date

Filter the Schedule Page

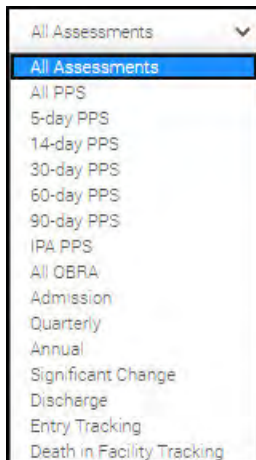
The Schedule page can be filtered by the assessment type, the assessment due date, the resident's last name, and the resident's neighborhood. One or all of the filters can be applied to the page.

Filter by Assessment Type

To filter the Schedule page by assessment type:

1. At the top of the Schedule page, click the **All Assessments** drop-down list.
2. Select the assessment type you'd like to filter the Schedule page by. The options include:
 - **All Assessments**
 - **All PPS**
 - **5-day PPS**
 - **14-day PPS**
 - **30-day PPS**
 - **60-day PPS**
 - **90-day PPS**
 - **IPA PPS**
 - **All OBRA**
 - **Admission**
 - **Quarterly**
 - **Annual**
 - **Significant Change**
 - **Discharge**
 - **Entry Tracking**
 - **Death in Facility Tracking**

Figure 190: Filter Assessments by Assessment Type



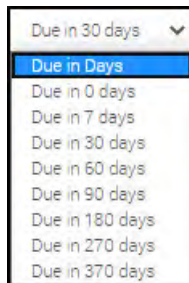
The Schedule page refreshes to show only assessments that meet the assessment type that you chose.

Filter by Due Date

To filter the Schedule page by due date:

1. At the top of the Schedule page, click the **Due in Days** drop-down list.
2. Select the due date option you'd like to filter the Schedule page by. The options include:
 - **Due in Days**
 - **Due in 0 days**
 - **Due in 7 days**
 - **Due in 30 days**
 - **Due in 60 days**
 - **Due in 90 days**
 - **Due in 180 days**
 - **Due in 270 days**
 - **Due in 370 days**

Figure 191: Due Date Filter Options



The Schedule page refreshes to show only assessments that meet the due date that you chose.

Filter Assessments by Resident's Last Name

To filter the Schedule page by Resident name:

1. At the top of the Schedule page, in the **Search Resident's Last Name** field, enter the first few letters of the Resident's name, or enter the entire last name. A search result will drop down.

Figure 192: Filter for a Specific Resident



2. Select the correct resident from the results. The Schedule page refreshes to show only the assessment for the selected resident.

Filter Assessments by Neighborhood

To filter the Schedule page by neighborhood:

1. At the top of the Schedule page, click the **All Neighborhoods** drop-down list.
2. Select the neighborhood you'd like to filter the Schedule page by. The options are specific to your location.

The Schedule page refreshes to show assessments from the selected neighborhood.

Show Removed

If you are looking for an assessment that has been removed from the Schedule page, click the **Show Removed** button to the right of the filter options.

Figure 193: Show Removed Assessments



You can combine the Show Removed option with any or all of the filter options described previously.

Remove an Assessment

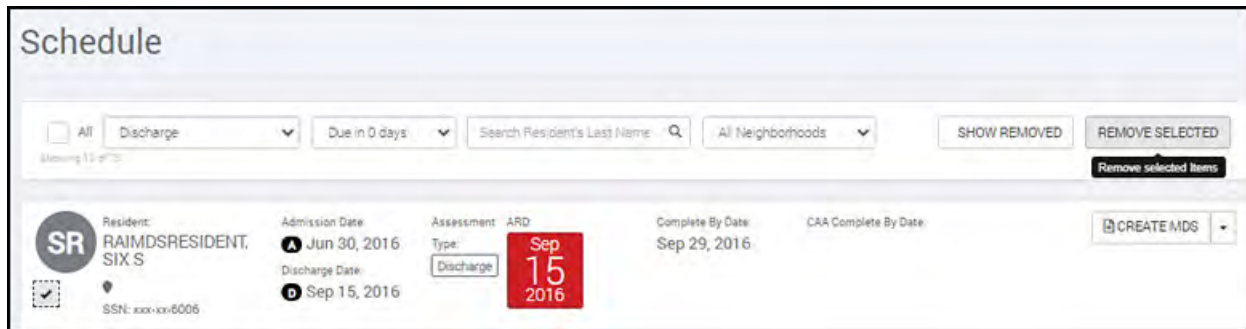
One or more assessments can be removed from the Schedule page.

Remove One or More Assessments

To remove one or more assessments:

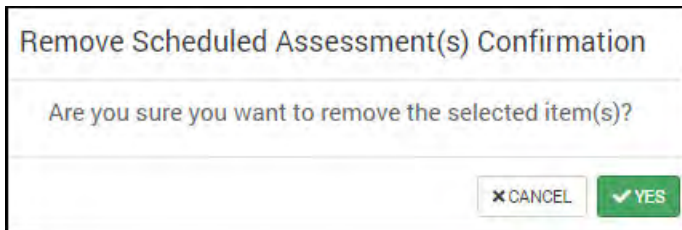
1. Select the check box to the left of the assessments you want to remove.
2. After all assessments to be removed have been selected, at the top right corner of the page, click the **Remove Selected** button.

Figure 194: Remove Selected Assessment



A pop-up appears that asks, "Are you sure you want to remove the selected items?"

Figure 195: Confirm Removal



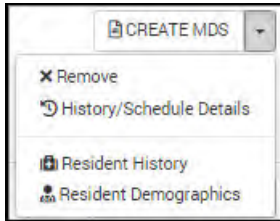
3. Click **Yes** to confirm the removal, or click **Cancel** to return to the Schedule page without removing the selected assessments.

Remove One Assessment

To remove a single assessment:

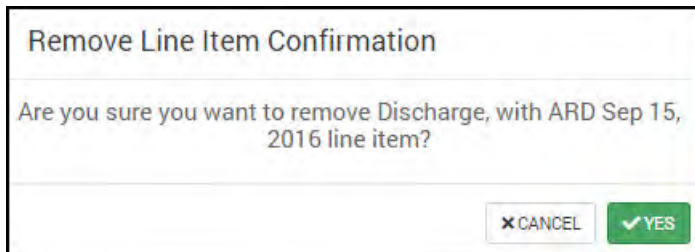
1. On the right side of the page, click the **Create MDS** drop-down button for the assessment you want to remove. The Create MDS drop-down menu opens.

Figure 196: Create MDS Drop-down Menu



2. Select the **Remove** option. A Confirmation window that asks, “Are you sure you want to remove [assessment type] with ARD [date] line item?”

Figure 197: Remove Line Item Confirmation



3. Click **Yes** to remove the assessment, or click **Cancel** to return to the Schedule page without removing the assessment.

The Schedule page refreshes and the selected assessment has been removed.

Create an MDS Assessment

You can create an MDS assessment from the Schedule page. The MDS that is created is the type of assessment listed for the resident. For example, If the resident’s assessment type on the Schedule page is a 5-day assessment, the MDS assessment you create will be a 5-day assessment.

To create an MDS assessment:

1. Search or [“Filter the Schedule Page”](#) to find the resident you need to assess.
2. On the right side of the Resident’s Schedule data, click the **Create MDS** button.

Figure 198: Create MDS

FR	Resident: RAIMDSRESIDENT, FIFTYFIVE FF	Admission Date: Feb 01, 2016	Assessment Type: Discharge	ARD: Jul 01 2016	Complete By Date: Jul 15, 2016	CAA Complete By Date:	CREATE MDS
	SSN: xxx-xx-6655	Discharge Date: Jul 01, 2016					Create MDS Discharge Assessment

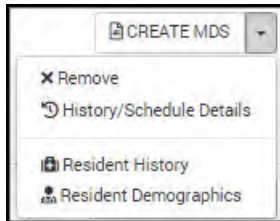
Note: See [“Navigating Through the MDS Assessment”](#) on page 112 for more information on completing an MDS assessment.

View Assessment History/Schedule Details

You can view a resident's assessment history and schedule details from the Schedule page. To view a resident's history and schedule details:

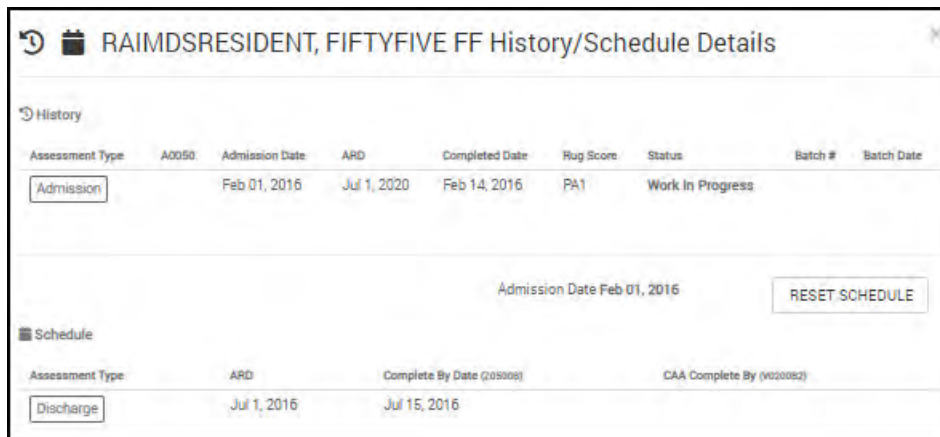
1. [“Filter the Schedule Page”](#) to find the resident for whom you want to view the assessment history.
2. On the right side of the resident's entry, click the **Create MDS** drop-down button. The drop-down menu opens.

Figure 199: Create MDS Drop-down Menu



3. Select the **History/Schedule Details** option. The History/Schedule Details window appears.

Figure 200: History/Schedule Details Pop-up



The pop-up window shows the resident's History and Schedule. The Resident's History shows the:

- Assessment Type
- A0050
- Admission Date
- ARD
- Completed Date
- RUG Score
- Status
- Batch #
- Batch Date

The Resident's Schedule shows the:

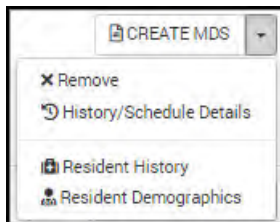
- Assessment Type
- ARD
- Completed By Date
- CAA Completed By

Reset a Resident's Schedule

In rare cases, you may need to reset a resident's assessment schedule. Resetting the schedule allows you to set the date for a resident's OBRA schedule to start from. To perform a schedule reset:

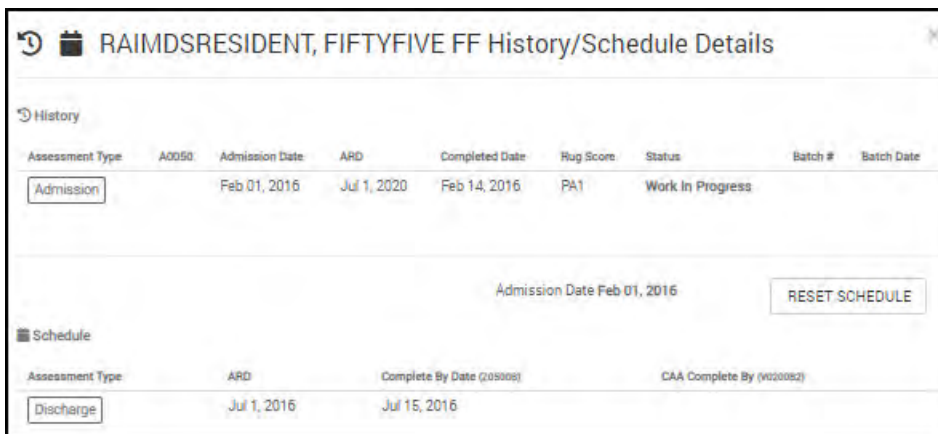
1. ["Filter the Schedule Page"](#) to find the resident for whom you want to view the assessment history.
2. On the right side of the resident's entry, click the **Create MDS** drop-down button. The drop-down menu opens.

Figure 201: Create MDS Drop-down Menu



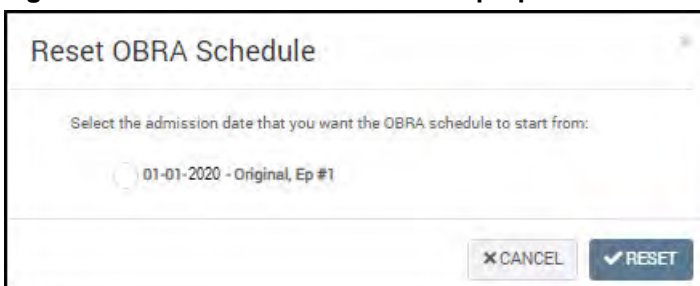
3. Select the **History/Schedule Details** option. The History/Schedule Details pop-up window appears.

Figure 202: History/Schedule Details Pop-up



4. On the History/Schedule Details window, click the **Reset Schedule** button. The Reset OBRA Schedule pop-up appears.

Figure 203: Reset OBRA Schedule Pop-up



5. From the choices provided in the Reset OBRA Schedule pop-up, select the admission date that you want the OBRA schedule to start from.
6. Click the **Reset** button to restart the resident's schedule. The resident's schedule is reset and the Schedule page refreshes.

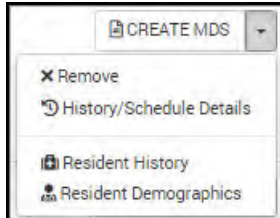
Access Resident History Options

You can quickly access the Resident’s history page from the Schedule page. On the Resident History page you can edit the resident’s assessment, access the residents CAA, view the resident’s audit trail and more.

To access the Resident History:

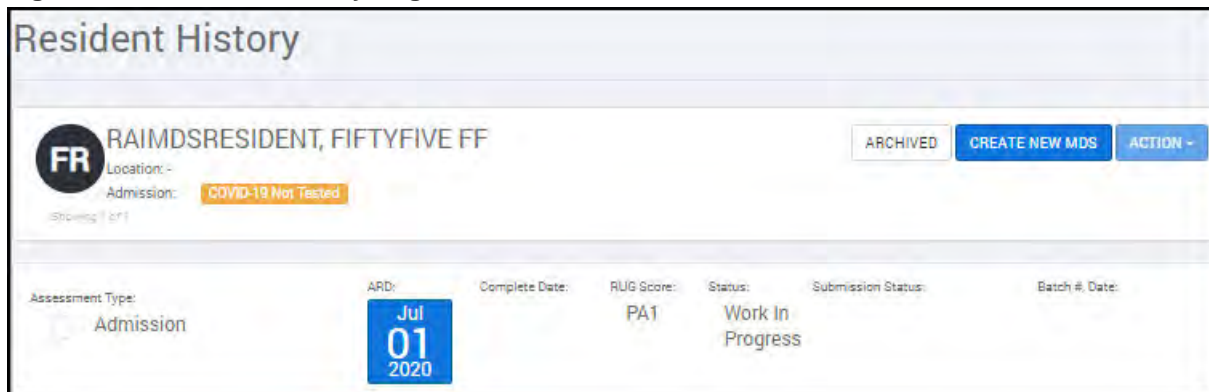
1. [“Filter the Schedule Page”](#) to find the resident for whom you want to access their history.
2. On the right side of the resident’s entry, click the **Create MDS** drop-down button. The drop-down menu opens.

Figure 204: Create MDS Drop-down Menu



3. Select the **Resident History** option. The Resident History page opens.

Figure 205: Resident History Page



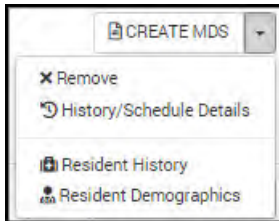
Note: See [“Resident History Tasks”](#) on page 129 for more information on the tasks that can be completed from this page.

View Resident Demographics

You can view a resident's demographics from the Schedule page. The Demographics include the resident's demographics, the resident's episodes, and the resident's bed history. To access this information:

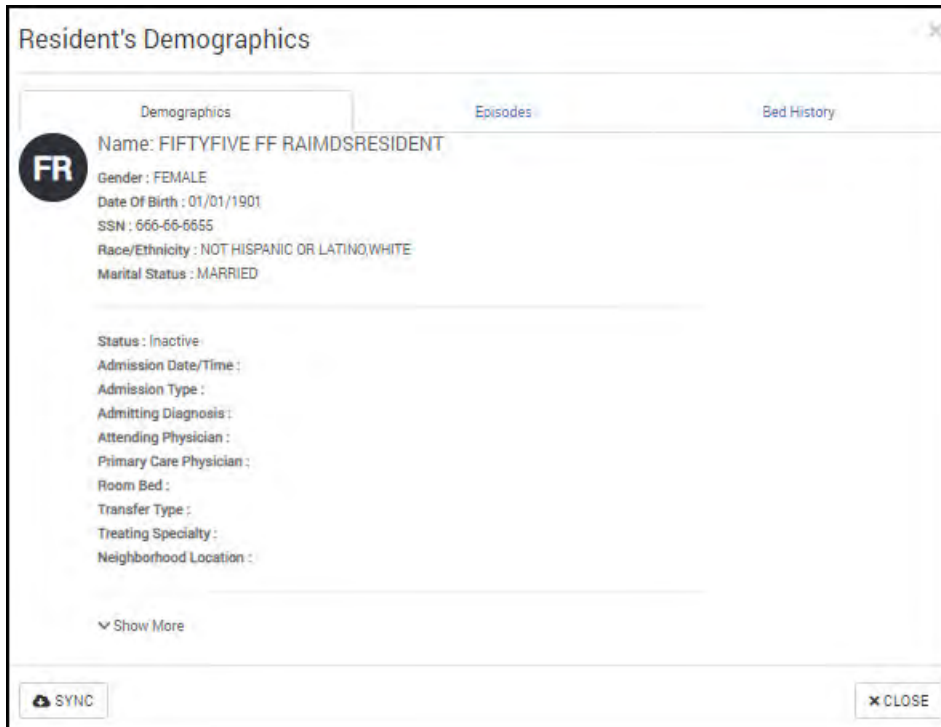
1. [“Filter the Schedule Page”](#) to find the resident for whom you want to access their history.
2. On the right side of the resident's entry, click the **Create MDS** drop-down button. The drop-down menu opens.

Figure 206: Create MDS Drop-down Menu



3. Select the **Resident Demographics** option. The Resident's Demographics window opens.

Figure 207: Resident's Demographics Tab



4. The Demographics tab shows the resident's demographic information.
5. Click the **Episodes** tab to see the resident's episodes and the accompanying data.

Episode data in the left pane includes:

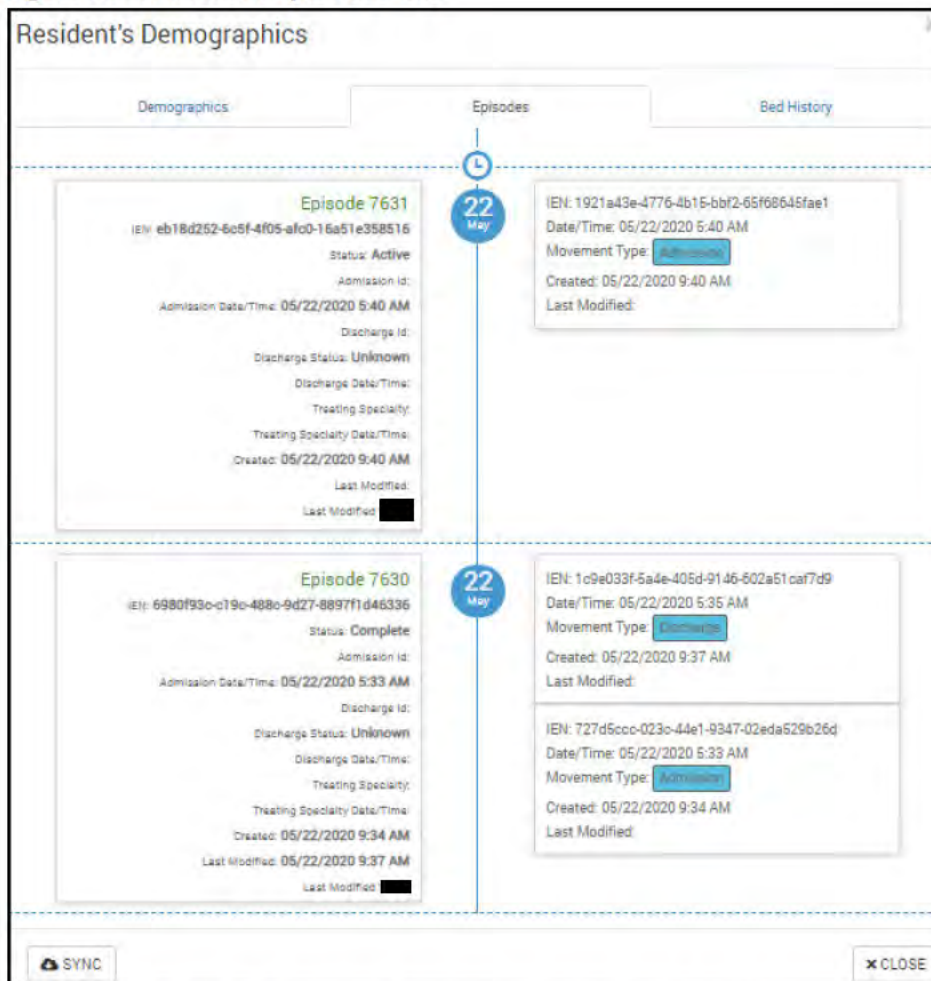
- IEN
- Status
- Admission ID
- Admission Date and Time
- Discharge ID

- Discharge Status
- Discharge Date and Time
- Treating Specialty
- Treating Specialty Date and Time
- Created Date and Time
- Last Modified
- Last Modified VistA

Episode data in the right pane includes:

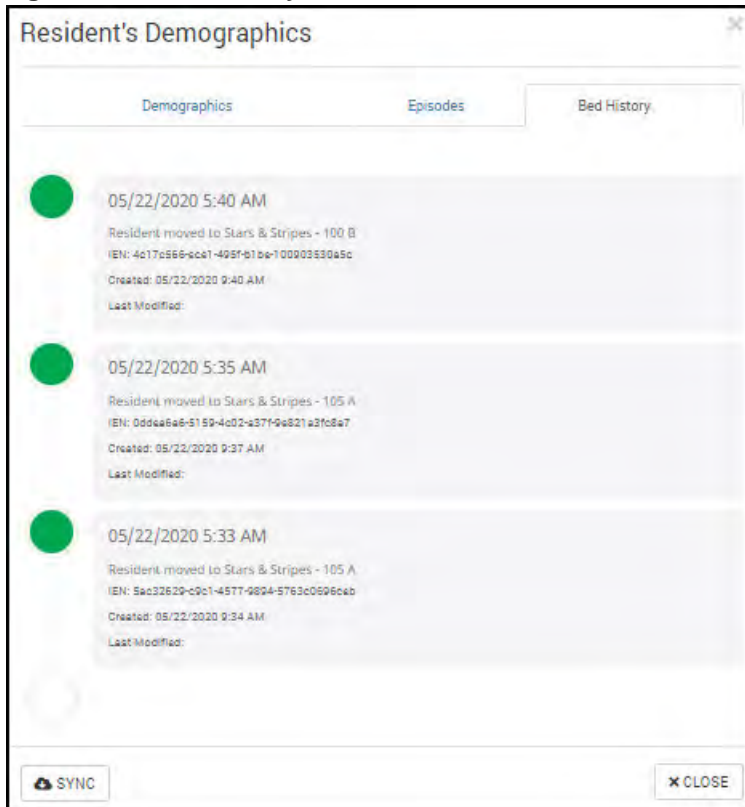
- IEN
- Date and Time
- Movement Type
- Created date and time
- Last Modified

Figure 208: Resident Episodes Tab



6. Click the **Bed History** tab to review the resident's bed history.

Figure 209: Bed History Tab



The resident's bed history shows each bed the resident has been assigned to. The information includes:

- Date and time
- Where the resident was moved to
- IEN
- Created date and time
- Last Modified

7. Click the **Close** button to close the Resident's Demographics window and return to the Schedule page.

Note: If you need to update the Resident Demographics, click the **Sync** button at the bottom of the page.

Note: If you're not already connected to [REDACTED], you'll be asked to log in to [REDACTED] with your [REDACTED] to enter this page.

Resident History Tasks

The Resident History page allows you to see the resident's archived items, create a new MDS, or take many other actions, like editing the resident's MDS assessment, viewing their CAA, or archiving their assessment. This chapter describes the tasks that can be completed from the Resident History page.

Open a Resident's History

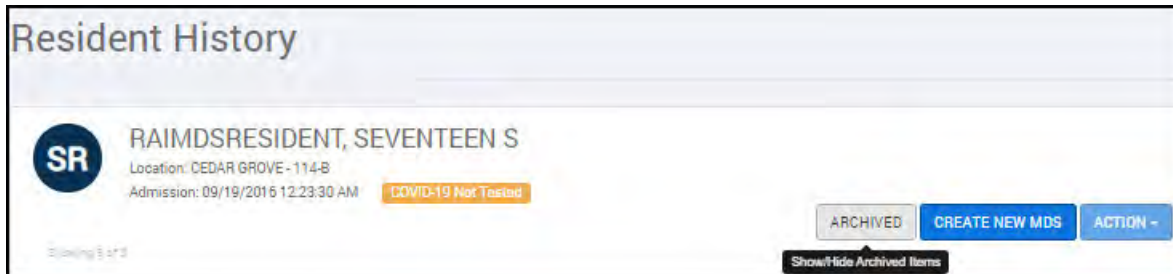
Follow these steps to open the Resident History page from the MDS tile, or go to [page 125](#) for steps from the Schedule page.

1. From the [REDACTED] homepage, click the **MDS** tile.
2. Click the **Resident Search & History** sub-tile.
3. Enter the first, last, or full name of the resident in the **Search Residents** field, and you can filter the results with the **Neighborhoods** filter to find the resident who needs an assessment.
4. Select the desired resident to open the Resident Summary page.

Show or Hide Archived Assessments

To the right of the Resident's name, location, and admission date and time, is the **Archived** button. Click this button to show the resident's archived items. To hide the resident's archived items, click the **Archived** button again.

Figure 210: Archived Button



Create a New MDS Assessment

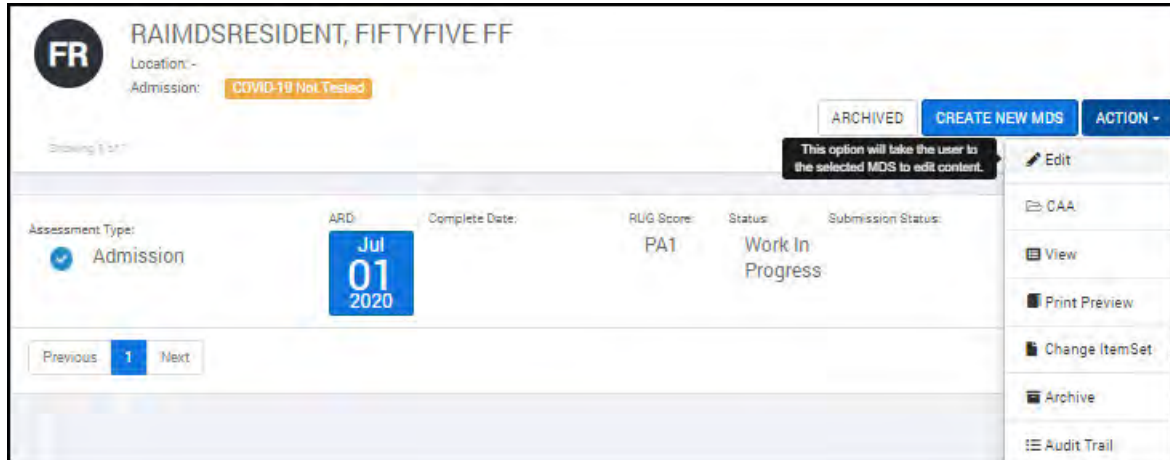
Next to the Archived button, is the **Create New MDS** button. Click this button to create a new MDS assessment for the resident. For more information, follow the steps in [“Step 2: Create a New MDS Assessment” on page 101.](#)

Edit a Resident's MDS Assessment

To edit a resident's MDS assessment:

1. On the Resident History page, select the circle under Assessment Type for the assessment you want to edit.
2. Click the **Action** button to open the drop-down menu.

Figure 211: Edit MDS Assessment Option



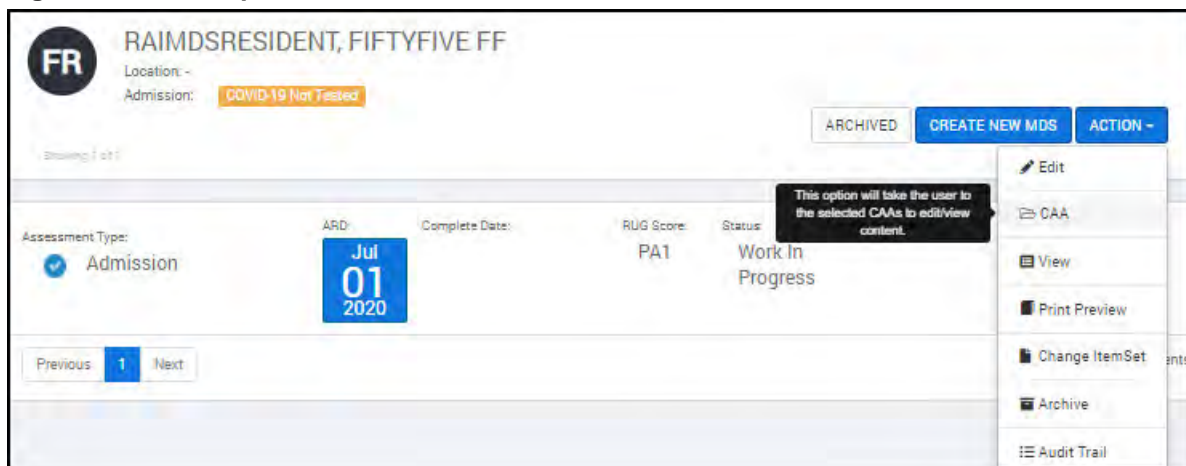
3. Select the **Edit** option. The assessment opens for editing, updating, or completion. [See “Navigating Through the MDS Assessment” on page 112.](#) for more information on completing an MDS assessment.

Edit or Review a Resident's CAAs

To edit or review a resident's CAA:

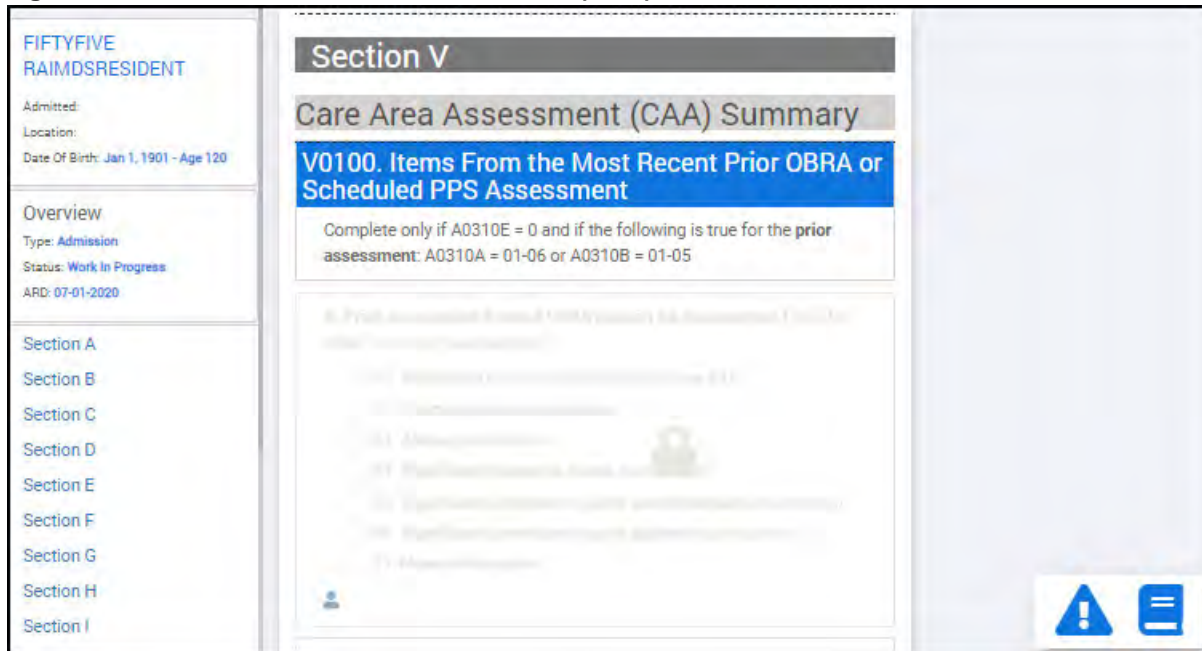
1. On the Resident History page, select the circle under Assessment Type for the assessment you want to edit.
2. Click the **Action** button to open the drop-down menu.

Figure 212: CAA Option



3. Select the **CAA** option. The Care Area Assessment, Section V of the Assessment, opens.

Figure 213: Section V Care Area Assessment (CAA)



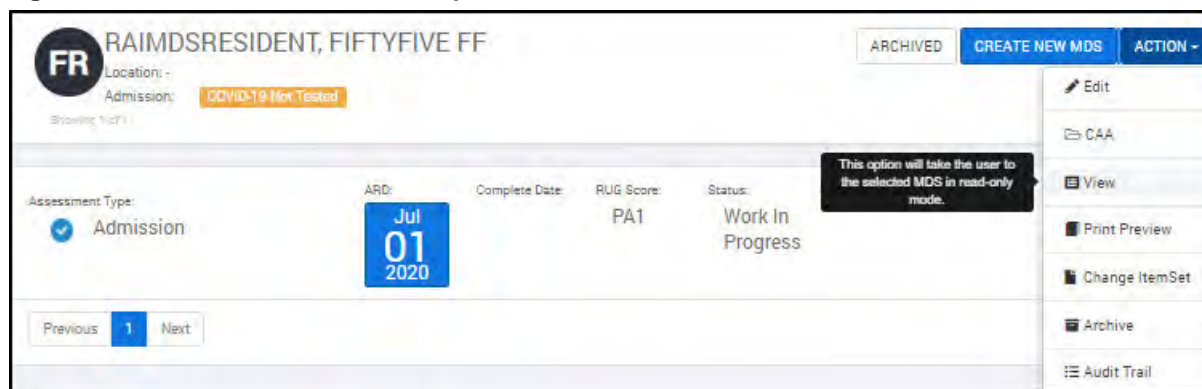
Note: Complete only if A0310E=0 and if the following is true for the **prior assessment:** A0310A = 01-06 or A0310B = 01-05

View an MDS Assessment

To view a resident's MDS Assessment:

1. On the Resident History page, select the circle under Assessment Type for the assessment you want to edit.
2. Click the **Action** button to open the drop-down menu.

Figure 214: View the Assessment Option



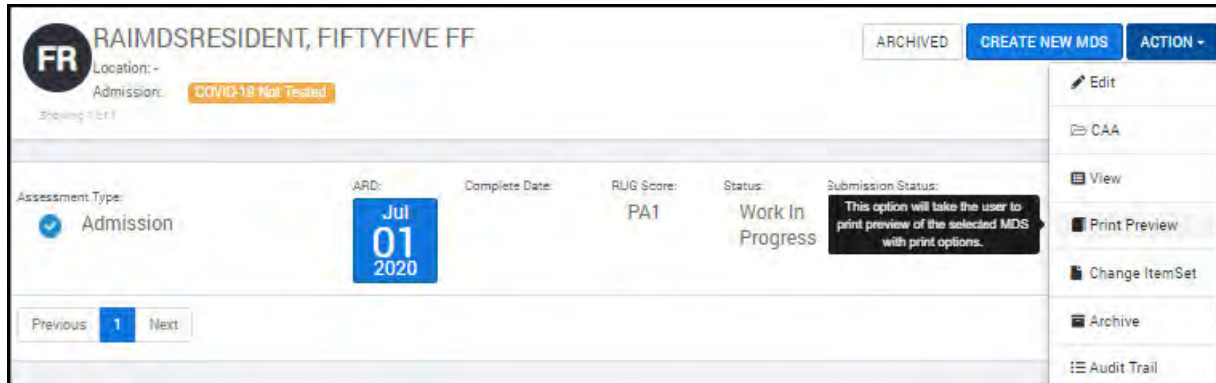
3. Select the **View** option. The resident's MDS assessment opens in "read-only" mode. You can view the assessment, but it cannot be edited.

Print an MDS Assessment

To print a resident's MDS Assessment:

1. On the Resident History page, select the circle under Assessment Type for the assessment you want to print.
2. Click the **Action** button to open the drop-down menu.

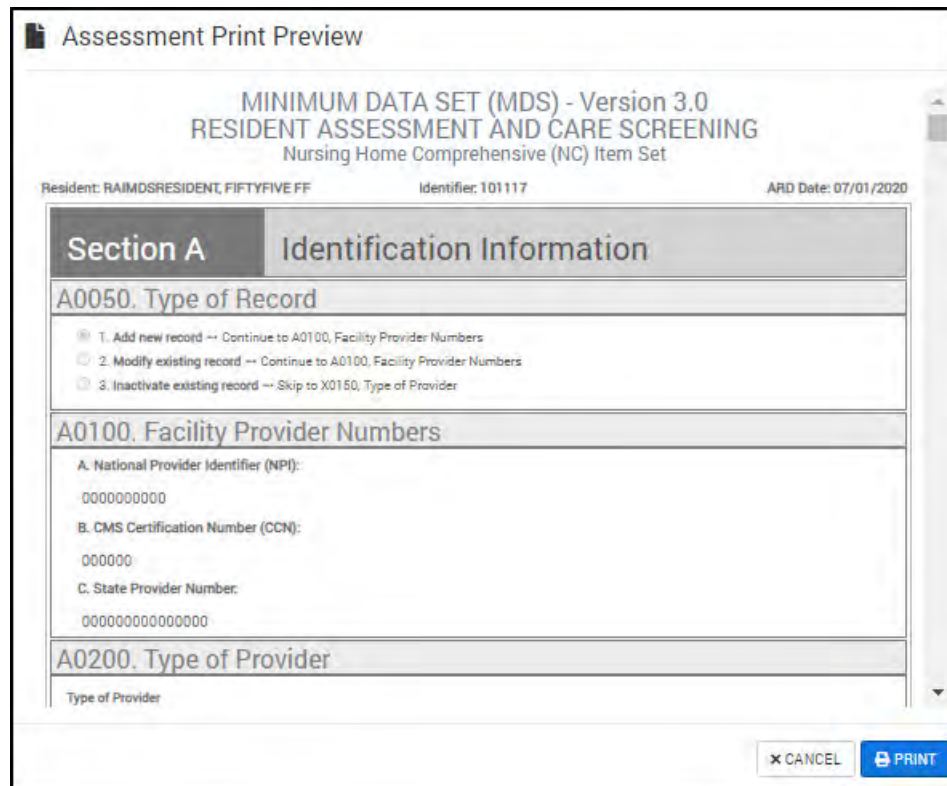
Figure 215: Print Preview Option



The screenshot shows the Resident History page for a resident named RAIMDSRESIDENT, FIFTYFIVE FF. The page includes a header with the resident's name, location, and admission status (COVID-19 Not Tested). Below the header, there is a table with columns for Assessment Type, ARD, Complete Date, RUG Score, Status, and Submission Status. The Assessment Type is set to Admission, and the ARD is Jul 01 2020. The Status is Work In Progress. A tooltip is visible over the Print Preview option in the Action menu, stating: "This option will take the user to print preview of the selected MDS with print options." The Action menu also includes options for Edit, CAA, View, Change ItemSet, Archive, and Audit Trail.

3. Select the **Print Preview** option. The Assessment Print Preview window opens.

Figure 216: Assessment Print Preview



The screenshot shows the Assessment Print Preview window. The title is "Assessment Print Preview". The main content is the MDS form, titled "MINIMUM DATA SET (MDS) - Version 3.0 RESIDENT ASSESSMENT AND CARE SCREENING Nursing Home Comprehensive (NC) Item Set". The resident information is displayed at the top: Resident: RAIMDSRESIDENT, FIFTYFIVE FF, Identifier: 101117, ARD Date: 07/01/2020. The form is divided into sections, with Section A highlighted. Section A is titled "Identification Information" and contains the following sections:

- A0050. Type of Record: Three radio button options: 1. Add new record -- Continue to A0100, Facility Provider Numbers; 2. Modify existing record -- Continue to A0100, Facility Provider Numbers; 3. Inactivate existing record -- Skip to X0150, Type of Provider.
- A0100. Facility Provider Numbers: Three text input fields: A. National Provider Identifier (NPI): 0000000000; B. CMS Certification Number (CCN): 000000; C. State Provider Number: 0000000000000000.
- A0200. Type of Provider: A text input field labeled "Type of Provider".

At the bottom right of the form, there are two buttons: "CANCEL" and "PRINT".

Sections A–Z are shown in the Assessment Print Preview

4. Click the **Print** button to print the assessment. Click **Cancel** to return to the Resident History window.

MDS Change Item Set

To perform a Change Item Setup in the resident's assessment:

1. On the Resident History page, select the circle under Assessment Type for the assessment you want to edit.
2. Click the **Action** button to open the drop-down menu.

Figure 217: Change ItemSet Option

The screenshot shows the MDS Resident History page for a resident named RAIMDSRESIDENT, FIFTYFIVE FF. The resident's location is listed as 'Location: -' and their admission status is 'COVID-19 Not Tested'. The assessment type is 'Admission', with an ARD of 'Jul 01 2020'. The RUG Score is 'PA1' and the status is 'Work In Progress'. The submission status is 'Work In Progress'. A tooltip indicates that the 'Change ItemSet' option will take the user to the selected MDS Change ItemSet modal to update Section A selections. The action menu includes options for Edit, CAA, View, Print Preview, Change ItemSet, Archive, and Audit Trail.

3. Select the **Change Item Set** option. The Change Item Set pop-up window opens.

Figure 218: Change Item Set Pop-up Window

The screenshot shows the 'Change Item Set' pop-up window. It displays the following information:

- A1900. Admission Date:** 02-13-2019 - Most Recent, Ep
- A2300. ARD:** 06-18-2021
- A1600. Entry Date:** 02-13-2019
- A2000. Discharge Date:** MM-DD-YYYY
- Care Plan Date:** 06-18-2021
- A0310. Type of Assessment:**
 - A. Federal OBRA Reason for Assessment:** 01. Admission assessment (required by day 14) is selected.
 - B. PPS Assessment PPS Scheduled Assessments for a Medicare Part A Stay:** 01. 5-day scheduled assessment is selected.
 - C. PPS Other Medicare Requirement Assessment - OMRA:** (Dropdown menu)
 - F. Entry/discharge reporting:** 99. None of the above is selected.
 - G. Type of Discharge - Complete only if A0310F = 10 or 11:** 1. Planned is selected.
 - H. Is this a SNF PPS Part A Discharge (End of Stay) Assessment?:** 0. No is selected.
- Not PPS Assessment:** 99. None of the above is selected.

At the bottom, there is a question 'Open Assessment After Change?' with 'NO' and 'YES' (selected) buttons. The 'Target Date' is 06-18-2021. There are 'CANCEL' and 'CHANGE' buttons.

4. Make your changes to the assessment. Changing Section A will change the MDS Assessment type.

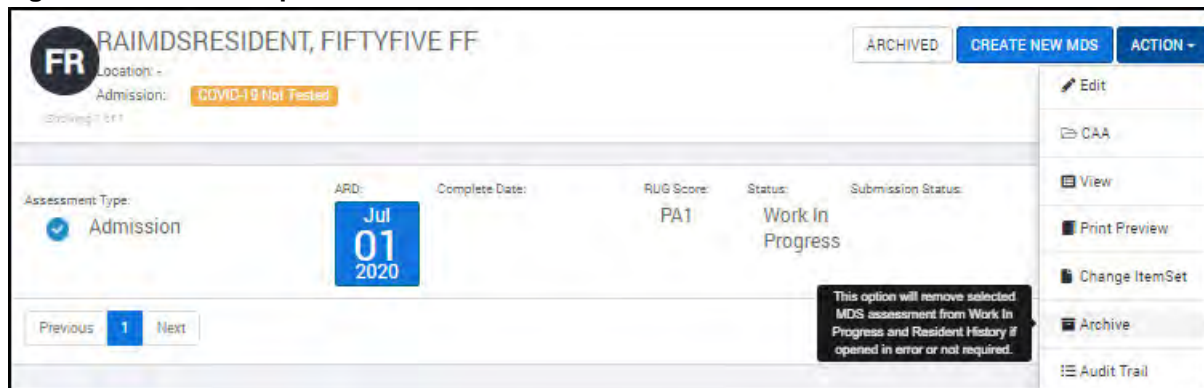
5. Click the **Change** button to save your changes. The page refreshes to the resident’s assessment overview.

Archive an Assessment

Archiving removes the assessment from the Work In Progress and Resident History pages. To archive an assessment:

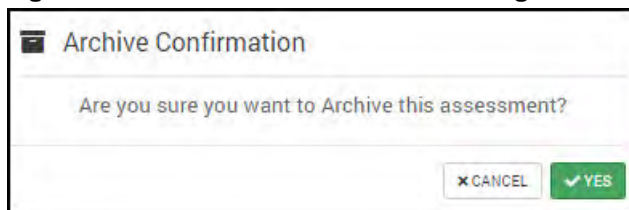
1. On the Resident History page, select the circle under Assessment Type for the assessment you want to archive.
2. Click the **Action** button to open the drop-down menu.

Figure 219: Archive Option



3. Select the **Archive** option. A confirmation pop-up message appears, asking, “Are you sure you want to Archive this assessment.”

Figure 220: Archive Confirmation Message



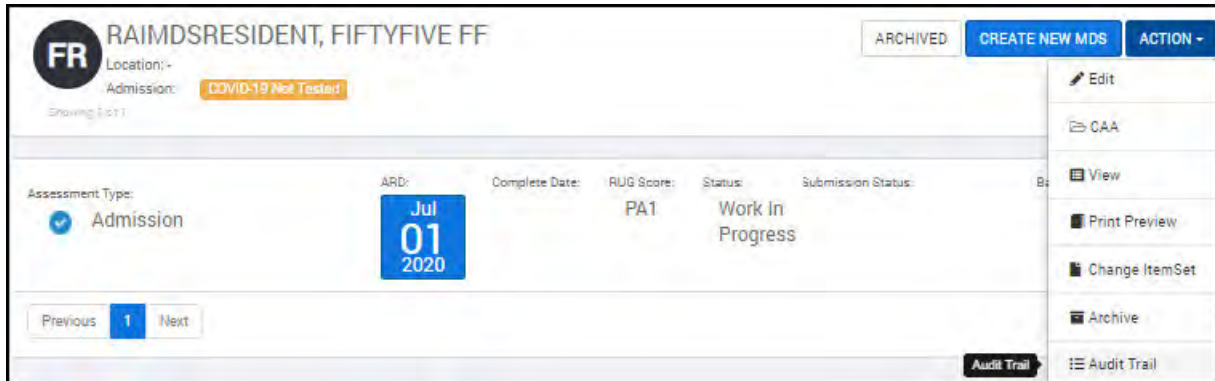
4. Click **Yes** to archive the assessment, or click **Cancel** to return to the Resident History page without archiving the selected assessment.

Access the Audit Trail

To view the assessment audit trail:

1. On the Resident History page, select the circle under Assessment Type for the assessment you want to audit.
2. Click the **Action** button to open the drop-down menu.

Figure 221: Audit Trail Option



3. Select the **Audit Trail** option. The Assessment Audit Trail window pops-up.

Figure 222: Assessment Audit Trail

The screenshot shows the Assessment Audit Trail window with a table of assessment items and their selection history. The table has four columns: Item, Description, Datetime, and User. The User column shows 'Daniel' for all items. The table contains 14 rows of data. At the bottom, there is a pagination control showing 'Previous', '1', '2', '3', '4', '5', '6', '7', '8', '9', '10', '...', '14', 'Next' and '277 Items'. A 'CLOSE' button is located at the bottom right.

Item	Description	Datetime	User
A0050	1	12-09-2020 09:00:32am	Daniel
A0100A	0000000000	12-09-2020 09:00:32am	Daniel
A0100B	000000	12-09-2020 09:00:32am	Daniel
A0100C	0000000000000000	12-09-2020 09:00:32am	Daniel
A0200	1	12-09-2020 09:00:32am	Daniel
A0310A	01	12-09-2020 09:00:32am	Daniel
A0310B	99	12-09-2020 09:00:32am	Daniel
A0310C	0	12-09-2020 09:00:32am	Daniel
A0310F	99	12-09-2020 09:00:32am	Daniel
A0310H	0	12-09-2020 09:00:32am	Daniel
A0410	3	12-09-2020 09:00:32am	Daniel
A0500A	FIFTYFIVE	12-09-2020 09:00:32am	Daniel
A0500B	F	12-09-2020 09:00:32am	Daniel
A0500C	RAIMDSRESIDENT	12-09-2020 09:00:32am	Daniel
A0600A	666666655	12-09-2020 09:00:32am	Daniel

The audit trail shows all selection in the resident's assessment.

4. Review the pages of the audit trail and click **Close** when you are finished. The Resident History page returns.

MDS Batch and Transmit

This section explains how the RAC can create batches and transmit them. Users can:

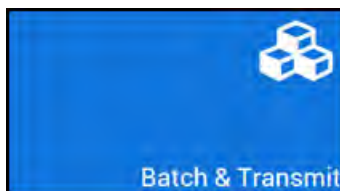
- Identify completed MDS assessments that are ready for batching.
- Select assessments for a batch.
- Create a batch.
- Download a batch

Create and Download a Batch

Perform the following steps to create and download a batch for transmission.

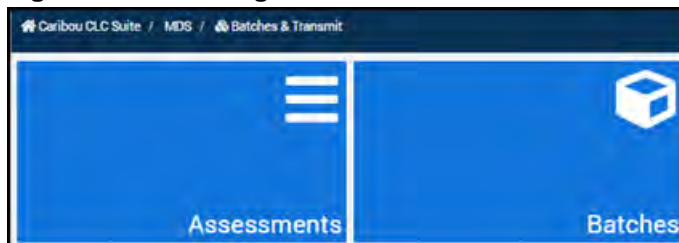
1. From the MDS menu, click the **Batch & Transmit** tile.

Figure 223: Batch & Transmit Tile



The Batches & Transmit window appears.

Figure 224: Batching Tiles



2. Click the **Assessments** tile to view the completed MDS assessments.

The Assessments window opens.

Figure 225: Completed Assessments

Assessment ID	Assessment Type	Completion Date	Item Set	RUC
ASPEN 12-01-2018 RAIMDSRESIDENT, TWENTYFOUR M	Admission 5-day	Dec 29 2020 Completed Feb 22, 2021	NC	PA1
ASPEN 07-03-2019 RAIMDSREGRESSION, ONEONINE	Entry Tracking	Feb 17 2021 Completed Feb 17, 2021	NT	PPM
ASPEN 01-01-2018 RAIMDSRESIDENT, SIXTEN	Interim Payment Assessment	Feb 22 2021 Completed Feb 22, 2021	IPA	KGB

3. Select the check boxes for the assessments that are ready for batching.
4. Click the **Create Batch** button. The Create New Batch pop-up window appears.

Note: The maximum file size is 5MB.

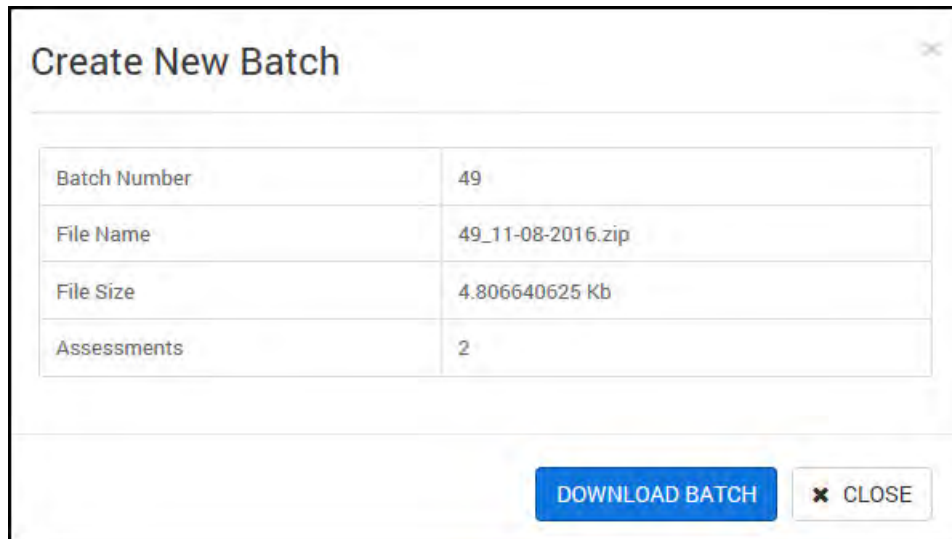
Figure 226: Create New Batch Window



5. Click the **Create** button.

The Create New Batch window opens.

Figure 227: Batch Created



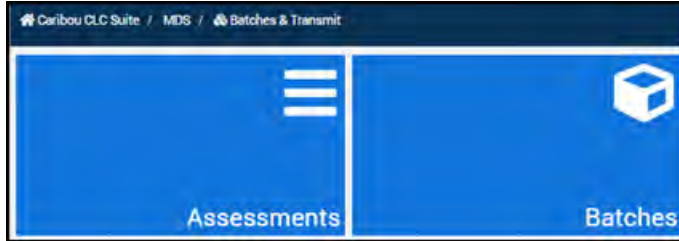
6. Click the **Download Batch** button to save the batch to a specific location.

View Batch Listings

Perform the following steps to view batches:

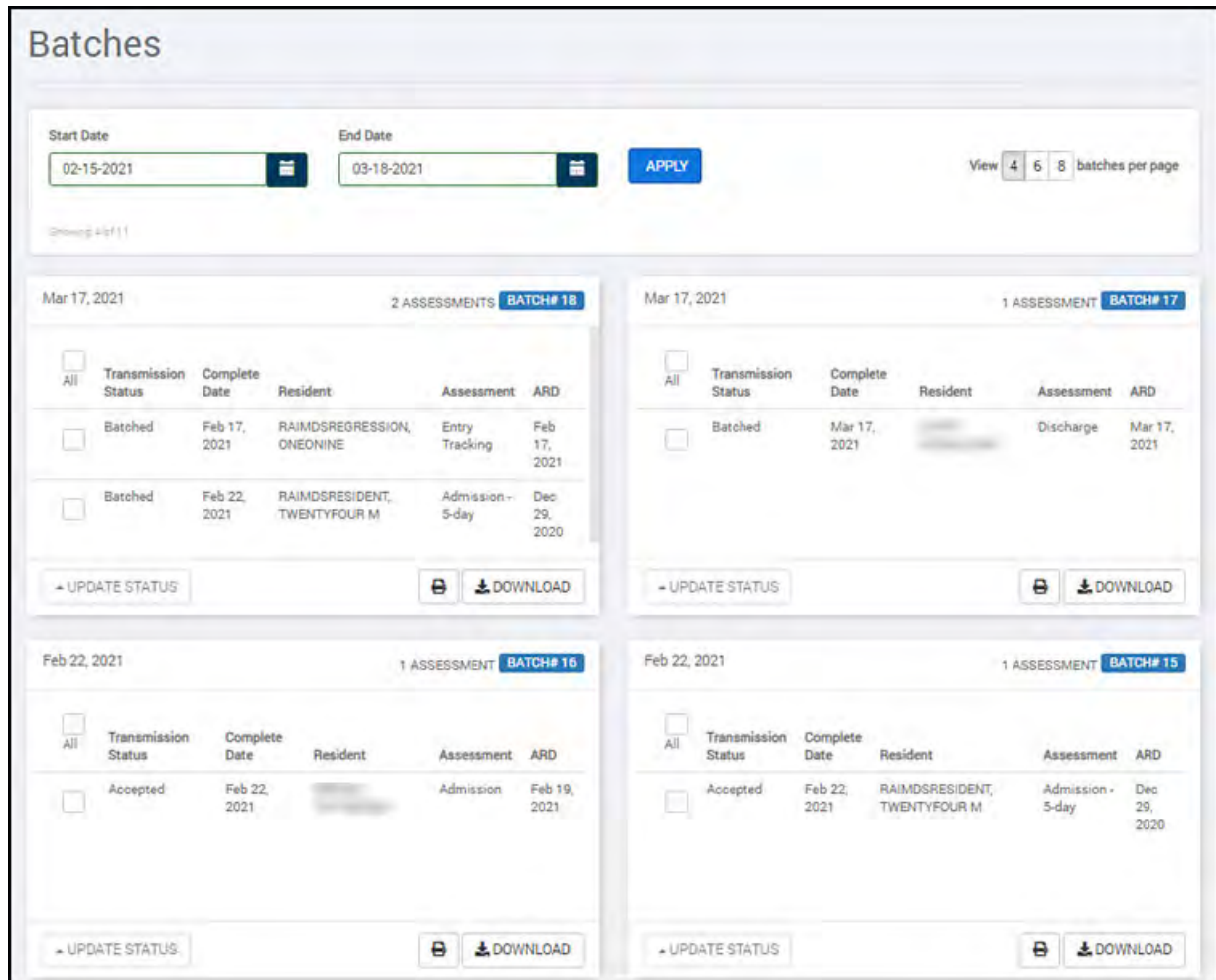
1. On the Batches & Transmit page, click the **Batches** tile.

Figure 228: Batching Tiles



The Batches window opens.

Figure 229: Batches Window



This window shows the batch transmission status, complete dates, residents, assessment types, ARDs, and the number of assessments that are in each batch. Each batch can be downloaded, printed or updated with the buttons at the bottom of each card. Downloaded batch files that are saved to your share drive can be transmitted from the AITC page.

See more batches

At the top of the Batches page, you can set the number of batches per page you want to view. The options are **4**, **6** or **8**.

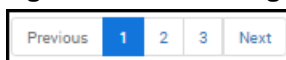
Figure 230: Batches Date Fields



You can change the date range of the batches shown by adjusting the start and end dates and clicking the **Apply** button.

If there are more batches available than the number shown on the first page, click the **Next** or page number button at the bottom of the page to scroll through additional pages.

Figure 231: Batch Pages



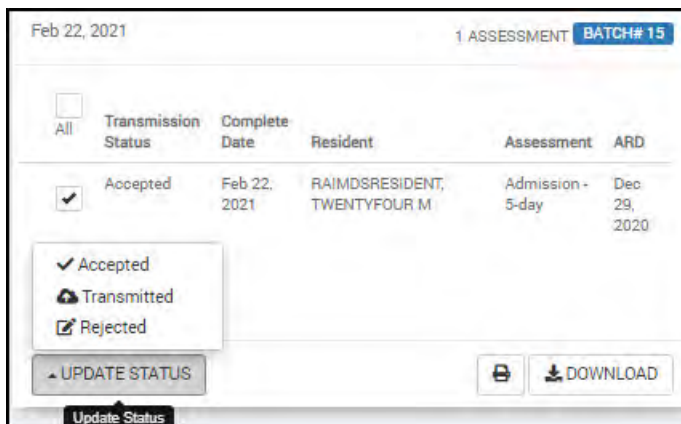
Print or Download a Batch

From any of the Batches cards, click the Print  button to print the batch data. This only prints the same info as is seen on the Batch card. Click the **Download** button to download a copy of the Batch card.

Update Batch Transmission Status

To update the batch transmission status, check the box for one or multiple batches and click the **Update Status** button on the left bottom of the card. The update choices are: **Accepted**, **Transmitted**, and **Rejected**.

Figure 232: Update Batch Status



The Batches page refreshes and the Transmission Status of the batch reflects your update status choice.

MDS Reports and Forms

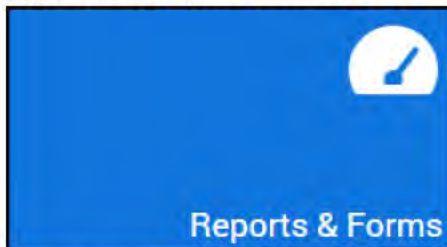
MDS contains reporting capability for the following reports:

- MDS
 - ADT
 - CMS 802
 - QM (Quality Measures) – Summary
 - QM (Quality Measures) – Facility Characteristics
 - QM (Quality Measures) – Short Stay Details
 - QM (Quality Measures) – Long Stay Details
 - MDS Ad-Hoc reports
 - RUG-IV Reimbursement
- Care Manager
 - ADL Charts
 - Events
- Care Plans
 - Approaches by Discipline
 - Approaches by Status
 - Goals by Review Date
 - Plans Review
 - Categories Report
- Master Resident List
- Manuals and Forms

Open the Reports and Forms Dashboard

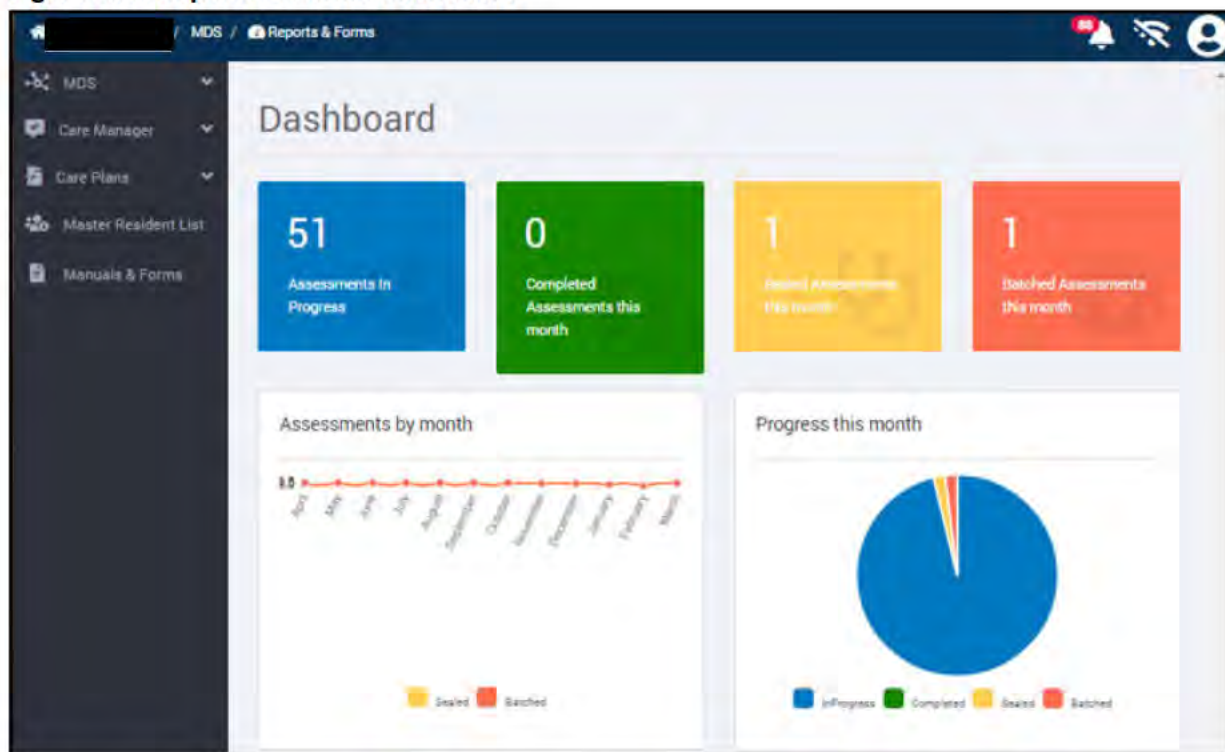
From the MDS page or the [REDACTED] homepage, click the **Reports & Forms** tile.

Figure 233: Reports & Forms Tile



The Reports Dashboard appears.

Figure 234: Reports & Forms Dashboard



The Dashboard has a column on the left where an individual report can be selected. The Dashboard itself contains four information tiles and two graphs. The information tiles identify:

- The number of assessments in progress
- The number of assessments that have been completed this month
- The number of assessments sealed this month
- The number of assessments batched this month

The graph on the left side of the page shows the assessments by month and the graph on the right side of the page depicts the assessments progress this month.

ADT Report

The ADT Report page includes an ADT Summary and an ADT Report.

Note: If you're not already connected to [REDACTED], you'll be asked to log in to [REDACTED] with your [REDACTED] to enter this page.

ADT Summary

The ADT Summary shows the Admissions, Discharges, and Transfer for the last 72 hours.

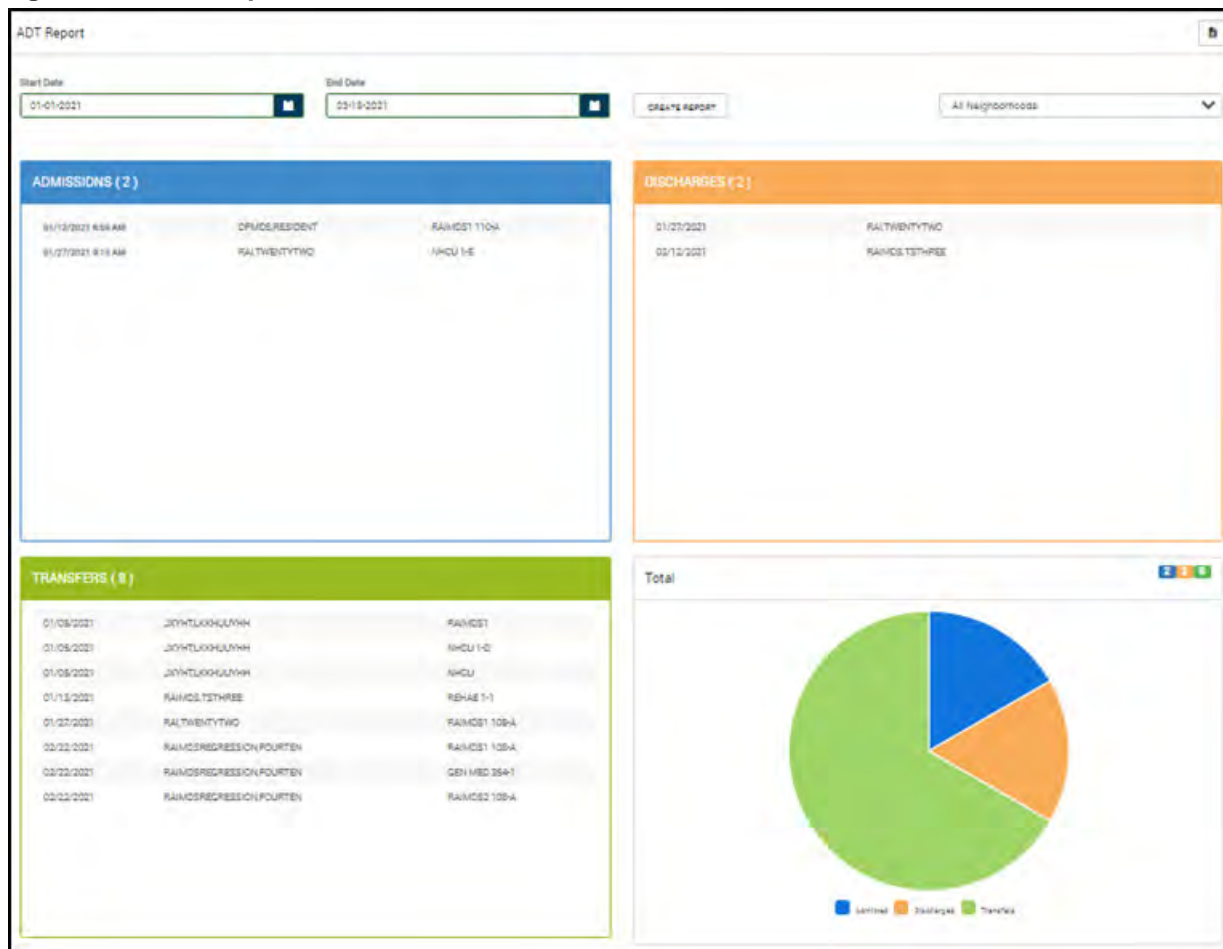
Figure 235: ADT Summary



ADT Report

The ADT Report can be adjusted for a custom date range and filtered by neighborhood. the report shows panes for Admissions, Discharges, Transfers, and a pie chart of the total for all three.

Figure 236: ADT Report



The Admissions, Discharges, and Transfers panes include the date of the event, the resident name, and the resident's neighborhood.

To change the report range, choose the correct **Start Date** and **End Date**, and click the **Create Report** button.

To view the report in a spreadsheet, click the **Excel**  icon. The report downloads as a .csv file.

CMS-802 Report

802 Report shows the latest MDS data for each resident. Follow these instructions to create and review the CMS-803 report:

1. Click the **Reports & Forms** tile.
2. Click the **CMS-802 Reports** button on the left. There are several options on the 802 page.
3. Click the **Action** button to select one of the following options at the top of the window to work with the CMS-802 report:
 - Click **Create New** to create a new report.
 - Click the **Select Existing** button to select and open an existing report.
 - Click the **Adjust Page Size** button to resize the report to the user's screen preference.
 - Click **Add Row** to add a row to the report (after a report has been created or opened from save).
 - Click **Save** to save the report.
 - Click **Print** to print the report.
 - Click **Export** to send the report to an Excel[®] spreadsheet.
 - Click **Instructions** to read the Roster/Sample Matrix Instructions for Providers from CMS.

Fields are modifiable.

Figure 237: CMS-802 Report

CMS-802 Roster/Sample Matrix

ACTION

- Create New
- Select Existing
- Adjust Page Size
- Add Row
- Save
- Print
- Export
- Instructions

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16		
Resident Name	Resident Room Number	Date of Admission if Admitted within the past 30 Days	Alzheimer's / Dementia	MD, ID or RC & NO PASARR Level II	Medications: Insulin (I), Anticoagulant (AC), Antibiotic (ABX), Diuretic (D), Opioid (O), Hypnotic (H), Antianxiety (AA), Antipsychotic (AP), Antidepressant (AD), Respiratory (RESP)	Pressure Ulcer(s) (highest stage I, II, III, IV, U, S), Facility Acquired (FA)	Worsened Pressure Ulcer(s) (any stage)	Excessive Weight Loss Without Prescribed Weight Loss Program	Tube Feeding: Enteral (E) or Parenteral (P)	Dehydration	Physical Restraints	Fall (F), Fall with Injury (FI), or Fall w/Major Injury (FMI)	Indwelling Catheter	Dialysis: Peritoneal (P), Hemo	Hospice	End of Life Care / Comfort Care	Tracheostomy

All information entered by computer should be verified by a staff member knowledgeable about the resident population.

Quality Measures Reports

The MDS 3.0 Quality Measures Report contains four components: **Summary**, **Facility Characteristics**, **Short Stay Detail** and **Long Stay Detail**. It uses the same measures available from AITC (Austin Information Technology Center), CMS (Centers for Medicare and Medicaid Services), and NQF (National Quality Forum).

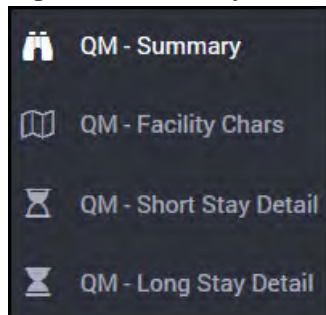
Quality Measures Reporting uses the facility MDS assessments to calculate measures. Assessments must be in “Accepted” submission status within the software. Each facility has its own stand-alone unique report.

Follow these instructions to review the Quality Measures report:

1. Click the **Reports & Forms** tile.
2. On the left side of the **Dashboard** page, click the corresponding **Quality Measures** report that you want to view.

Each component of the QM report provides a date range selection, **Create Report**, **Print**, and **Export to Word** option.

Figure 238: Quality Measures Report Options



Quality Measures Summary Report

The Summary report provides a listing of measures with numerator/denominator values based on accepted assessments within the selected date range. The Summary report includes both Long and Short Stay assessment types. To open the Summary report, click the **QM-Summary** option on the left column. Additional report options include:

- **Start and End Date fields** – Select the date range for the report
- **Create Report** – Create a new report.
- **Print** – Print the report
- **Word** – Export the report to a Microsoft® Word® file

Figure 239: Summary Report

Quality Measures - Summary

Start Date

End Date

MDS 3.0 Facility Level Quality Measure Report

Facility ID: 00000000000	Report Period: 12/22/2020 - 03/23/2021
Facility Name: ██████████	Run Date: 03/22/2021
City/State: ██████████	QM Version: 12.1

Note: Dashes represent a value that could not be computed
 Note: S = short stay, L = long stay
 Note: | = incomplete; data not available for all days selected
 Note: * = is an indicator used to identify that the measure is flagged

Measure	Measure ID	Num	Denom	Facility Observed %	Facility Adjusted %	National Average
Short Stay						
Percent of Residents With Pressure Ulcers That Are New or Worsened (Short Stay)	N002.03	0	3	0%	0%	1.4%
Long Stay						
Percent of High-Risk Residents with Pressure Ulcers (Long Stay)	N015.02	0	0	0%	-	7.38%
Percent of Residents Who Used Antianxiety or Hypnotic Medication (Long Stay)	N036.01	0	1	0%	-	19.49%

This report may contain privacy protected data and should not be released to public.

The Summary report includes the following data: Facility ID, Report Period, Facility Name, Run Date, City/State, and QM Version. Both the Short Stay and Long Stay reports contain the following metrics: the Measure, Measure ID, Number, Denomination, Facility Observed %, Facility Adjusted %, and National Average.

Facility Characteristics Report

The Facility Characteristics report provides the Numerator/Denominator counts and the measure percentage of accepted assessment data within the date range selected. To open the Facility Characteristics report, click the **QM-Facility Characteristics** option on the left column. Additional report options include:

- **Start and End Date fields** – Select the date range for the report
- **Create Report** – Create a new report.
- **Print** – Print the report
- **Word** – Export the report to a Microsoft Word file

Figure 240: Facility Characteristics Report

Facility ID:	Report Period:
00000000000	12/22/2020 - 3/23/2021
Facility Name:	Run Date:
[REDACTED]	03/22/2021
City/State:	QM Version:
[REDACTED]	12.1

	Num	Denom	Measure Percent
Gender			
Male	3	4	75%
Female	1	4	25%
Age			
< 25 years old	0	4	0%

The Facility Characteristics report includes the following data: Facility ID, Report Period, Facility Name, Run Date, and City/State.

Short Stay Detail Report

The Short Stay Detail report provides the specific resident and assessment ARD detail that is contained in the report based on the selected date range. To open the report, click the **QM – Short Stay Detail** option on the left side of the window.

Additional report options include:

- **Start and End Date fields** – Select the date range for the report
- **Create Report** – Create a new report
- **Print** – Print the report
- **Word** – Export the report to a Microsoft Word file

Figure 241: Short Stay Detail Report

Quality Measures - Short Stay Detail

Start Date

End Date

MDS 3.0 Facility Level Quality Measure Report - Resident Detail (Short Stay)

Facility ID: 00000000000	Report Period: 12/22/2020 - 3/23/2021
Facility Name: ██████████	Run Date: 03/22/2021
City/State: ██████████	QM Version: 12.1

Resident Name	A0310A/B/F	Pressure Ulcers New or Worsened N002.03(S)	Quality Measure Count
Data		C	C
████████████████████	03/99/99		0
RAIMDSRESIDENT, TWENTYFOUR	01/01/99		0
████████████████████	01/99/99		0

The Short Stay Resident Detail report includes the following data: Facility ID, Report Period, Facility Name, Run Date, City/State, QM version, Resident Name, A0310A/B/F, Pressure Ulcers New or Worsened N002.03(S), and Quality Measure Count.

Long Stay Detail Report

The Long Stay Detail report provides the specific resident and assessment ARD detail that is contained in the report based on the selected date range. To open the Long Stay Detail report, click the **QM-Long Stay Detail** option on the left side of the window.

Additional report options include:

- **Start and End Date fields** – Select the date range for the report
- **Create Report** – Create a new report
- **Print** – Print the report
- **Word** – Export the report to a Microsoft Word file

Figure 242: Long Stay Detail Report

Quality Measures - Long Stay Detail

Start Date

End Date

PRINT WORD

CREATE REPORT

MDS 3.0 Facility Level Quality Measure Report - Resident Detail (Long Stay)

Facility ID: 00000000000	Report Period: 3/1/2020 - 3/23/2021
Facility Name: ██████████	Run Date: 03/22/2021
City/State: ██████████	QM Version: 12.1

		High-Risk With Pressure Ulcers N015.02 (L)	Used Anti-Anxiety/Hypnotic Medication N036.01 (L)	Quality Measure Count
Resident Name	A0310A/B/F			
Data	C	C	C	C
04/99/99				0

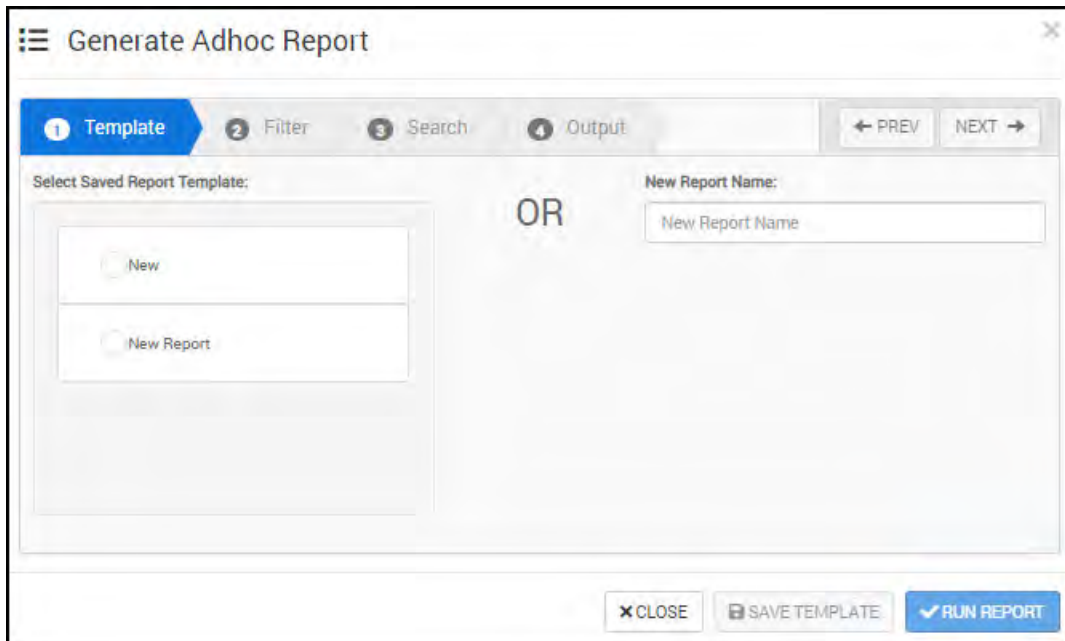
The Long Stay Resident Detail report includes the following data: Facility ID, Report Period, Facility Name, Run Date, City/State, QM version, Resident Name, A0310A/B/F, High-Risk With Pressure Ulcers N015.02(L), Used Anti-Anxiety/Hypnotic Medication N036.01(L), and Quality Measure Count.

MDS Ad Hoc Report

MDS provides Ad hoc reporting capability for user-defined data selections pulled from all MDS assessments. To create an Ad Hoc report:

1. Click the **Reports & Forms** tile.
2. Click **Ad-hoc Report** on the left side of the window.
3. Click the **Create Report** button. The Generate Adhoc Report wizard opens.

Figure 243: Generate Ad Hoc Report Wizard



The screenshot shows a window titled "Generate Adhoc Report" with a close button in the top right corner. The window has a progress bar at the top with four steps: 1. Template (highlighted in blue), 2. Filter, 3. Search, and 4. Output. To the right of the progress bar are "PREV" and "NEXT" navigation buttons. The main content area is divided into two sections by the word "OR". The left section is labeled "Select Saved Report Template:" and contains a list of two items: "New" and "New Report", each with a radio button. The right section is labeled "New Report Name:" and contains a text input field with the placeholder text "New Report Name". At the bottom of the window, there are three buttons: "CLOSE" (with an 'x' icon), "SAVE TEMPLATE" (with a save icon), and "RUN REPORT" (with a checkmark icon).

4. Click the radio button to run a report from a previously made template, or enter the name of a new report that can be saved as a template or used for a one time run. Previously made templates are unique to your facility.

5. Click the **Next** button to enter **Filter** choices.
 - Filter options include: **Assessment Status**, **ARD Range**, **Resident Type**, and **Neighborhood** drop-down list fields.

Figure 244: Filter Options for Ad Hoc Report

The screenshot shows a dialog box titled "Generate Adhoc Report" with a close button (X) in the top right corner. The dialog has a progress bar at the top with four steps: 1. Template (green), 2. Filter (blue), 3. Search, and 4. Output. Below the progress bar are "PREV" and "NEXT" buttons. The "Filter" tab is active and contains the following fields:

- Assessment Status:** A dropdown menu with "All" selected. The dropdown list is open, showing "All", "Work In Progress", and "Complete".
- ARD Range Start Date:** A date input field with "12-01-2020" and a calendar icon.
- ARD Range End Date:** A date input field with "02-23-2021" and a calendar icon.
- Resident Type:** A dropdown menu with "All Residents" selected.
- Neighborhood:** A dropdown menu with "All Neighborhoods" selected.

At the bottom of the dialog are four buttons: "DELETE" (red), "CLOSE" (grey), "SAVE TEMPLATE" (grey), and "RUN REPORT" (blue).

6. Choose the **Assessment status**, **ARD range**, **Resident Type**, and **Neighborhood**.
7. Click **Next** to open the Search tab. This tab provides search items from which to select. Up to four MDS assessment section items can be selected for the report.
8. From the Sections pane, select the assessment sections you want to include in the report.
9. Select the assessment subsections to include in the report

Figure 245: Search Options for Ad Hoc Report

Generate Adhoc Report

1 Template 2 Filter 3 Search 4 Output

← PREV NEXT →

Sections

Section A ▾

- A0050
- A0100A
- A0100B
- A0100C
- A0200
- A0310A

Selected Items

A0050: 1

A0310A: 01

A0310B: 99

B0300: 57

4 of 4

DELETE

✕ CLOSE

SAVE TEMPLATE

✓ RUN REPORT

10. In the **Selected Items** pane, in the **Item Value** fields, enter the item's numerical value.
11. Click **Next** to open the Output tab. The Output options allow the user to select what output columns the report will have.

Figure 246: Output Options for Ad Hoc Report

The screenshot shows the 'Generate Adhoc Report' window with a progress bar at the top indicating steps: 1. Template, 2. Filter, 3. Search, and 4. Output. The 'Output' step is active. Below the progress bar, there are 'PREV' and 'NEXT' navigation buttons. The main area is titled 'Select Output Columns' and contains three columns of checkboxes for selecting report columns. The 'Race' checkbox is highlighted with a dashed box. At the bottom left, there is a legend for sorting options: 'No Sorting Applied', 'Ascending Sort', 'Descending Sort', 'No Order Assigned', 'Sort Order 1', and 'Sort Order 2'. At the bottom right, there is an 'Items Per Page' dropdown menu set to 100. At the very bottom, there are buttons for 'DELETE', 'CLOSE', 'SAVE TEMPLATE', and 'RUN REPORT'.

12. Use the legend in the bottom left corner of the page to select how the data in the report columns is shown. (The legend does not control the order of the report columns.) Column order can be manipulated within the report or .xls file. Select the data you want to show in the report.

13. Click the **Run Report** button.


The Ad hoc report is shown with the resident's information and the chosen items that were selected to be on the report. Click the **Excel**  icon above the report table to export the report to an Excel spreadsheet.

Figure 247: Ad Hoc Report

The screenshot shows the 'Ad-hoc Report' interface. At the top right, there is a 'CREATE REPORT' button. Below it, the report title 'EW Test Report' is displayed with a lock icon. The main content is a table with the following data:

First Name	Last Name	Active	Neighborhood	Room Bed	Gender	Race	DOB	Marital Status	Status	TreatingSpecialty	ARD	B0300	B1200	G0110A1	G011001
THIRTYNINE	PATIENT	Yes			MALE		Mar 21, 1959		Sealed		May 28, 2020	0	1	1	2

At the bottom left, there are 'Previous', '1', and 'Next' navigation buttons. At the bottom right, it says '1 Assessments'.

RUG IV Reimbursement Report

The RUG IV Reimbursement report provides a list of RUG scores, Number of Assessments Completed, Nursing, Index, daily RUG rate, and total dollars per day. The report utilizes assessments that have a status of complete. The report does not contain WIP assessments. The daily RUG rate is directly related CMS RUG rate Urban/Rural tables.

Note: [REDACTED] uses the [REDACTED] system for reimbursement and it may differ from the CMS RUG rate Urban/Rural tables.

To create the Reimbursement report:

1. Click the **Reports & Forms** tile on the MDS Dashboard.
2. Click the **RUG-IV Reimbursement** option on the left.
3. Enter a **Start Date** and **End Date** range.
4. Filter the report by **Neighborhood** or keep the default to **All Neighborhoods**.
5. Click **Create Report**.

Figure 248: Reimbursement Report

RUG-IV Score	Number of Assessments Completed	Nursing Index per RUG-IV (HRS/PPD) (RN,LPN, CNA)	RUG-IV Reimbursements per Day	Total Dollars per Day
RA1	2	0.54	209.83	403.66
RA2	1	0.99	508.23	508.23

There are a few report options available:

- Enter some search criteria in the **Search** field above the report table to search the report for an individual entry.
- Click the **Copy** button above the report table to copy the report to your clipboard.
- Click the **Print** button above the report table to send the report to your printer.
- Click the **Excel** button above the report table to send the report to an Excel spreadsheet.

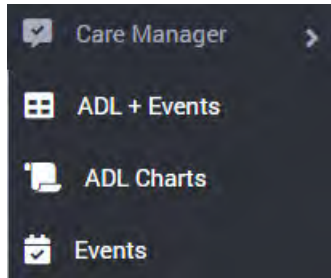
Care Manager Reports

There are three Care Manager reports available in the Reports & Forms section. The available reports are:

- ADL + Events report
- ADL Chart report
- Events report

Choose a Care Manager report from the left column.

Figure 249: Care Manager Reports from the Reports Page



Note: To run ADL and Events reports for a single resident, go to [“Care Manager Reports” on page 60](#).

ADL & Events Report

Note: This report can also be run from the Care Manager section of [redacted]. Go to [“ADL & Events Report” on page 60](#).

1. From the Reports & Forms page, open the **Care Manager** reports and select **ADL + Events**.
2. Search for and select the resident for whom you want to run the report.
3. Select the **Start** and **End Date** for the report.
4. From the **Neighborhood** list, select the neighborhood for the report.
5. Click the **Run Report** button.

The ADL and Events report can span multiple days and can be printed.

Figure 250: ADL & Events Report

Date		Bed Mobility		Eating		Toileting		Transfer		Hygiene		Bathing		Dressing		Walk in Room		Walk in Corridor		Locomotion on Unit		Locomotion off Unit	
		Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support
06-21-2021	12 AM - 8 AM	0	1	0	0	1	1	1	1	1	0	1	0	1	0	1	1	1	1	1	1	0	1
06-16-2021	8 AM - 4 PM	2	2	1	1	2	2	2	2	1	1	1	1	5	2	4	2	4	2	4	3	5	5
06-15-2021	8 AM - 4 PM	0	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
06-14-2021	8 AM - 4 PM	0	1	1	1	3	3	2	2	3	3	3	3	2	2	2	2	2	2	2	2	2	2
ADL Score		1	2	1	1	7	3	7	2	1	3	3	3	7	2	7	2	7	3	7	3	7	2

Start Hour	Locations	Room Environment	Safety Equipment	Comfort Status	Position	Possessions	Comments	Created By	Created
7	Bed in Room		W/C - Arm-Tip, Floor Mats			Oilases			06/21/2021 7:45AM
12		Lights	Side Rails - Left						06/16/2021 12:10PM

ADL Charts Report

1. From the Reports & Forms page, click **Care Manager** and **ADL Charts** to open Care Manager Report – ADL.
2. Select the **Start** and **End Date** for the report
3. From the list, select the **Neighborhood** for the report.
4. Click **Run Report**.

The ADL report shows the resident’s ADL charting for the date range selected in the report.

Figure 251: Care Manager Report – ADL

ADL Charts Showing 7 residents

Start Date: 03-01-2021 End Date: 03-23-2021 All Neighborhoods [RUN REPORT](#) [PRINT](#)

RAIMDS, REGFOUR BJG, 87 years old, All Neighborhoods

Date	Bed Mobility		Eating		Toileting		Transfer		Hygiene		Bathing		Dressing		Walk in Room		Walk in Corridor		Locomotion on Unit		Locomotion off Unit	
	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support
03-23-2021	8 AM - 4 PM																					
	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
ADL Score																						

CPRSPATIENT, EIGHT F, 66 years old, All Neighborhoods

Date	Bed Mobility		Eating		Toileting		Transfer		Hygiene		Bathing		Dressing		Walk in Room		Walk in Corridor		Locomotion on Unit		Locomotion off Unit	
	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support	Self	Support
03-22-2021	4 PM - 12 AM																					
	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
03-15-2021	8 AM - 4 PM																					
	2	2	2	2	1	1	1	1	1	1	2	2	2	2	1	1	1	1	1	1	2	2
03-15-2021	4 PM - 12 AM																					
	3	2	3	2	3	2	3	2	3	3	3	3	3	3	4	2	4	3	4	2	4	3

Events Report

1. From the Reports & Forms page, click **Care Manager** and **Events** to open Care Manager Report – Events.
2. Select the **Start** and **End Date** for the report
3. From the **Select Neighborhood** list, select the Neighborhood for the report.
4. From the **Select Event** list, check the events to include in the report.

Figure 252: Care Manager Report – Events Parameters

The screenshot shows the 'Events' report configuration page. At the top, there are four main sections: 'Start Date', 'End Date', 'Select Neighborhood', and 'Select Event'. The 'Start Date' is set to '03-01-2021' and the 'End Date' is '03-23-2021'. The 'Select Neighborhood' dropdown is set to 'All Neighborhoods'. The 'Select Event' dropdown is set to 'Nutrition, Mobility, Bowel, Ba...'. Below these sections, there is a list of events with checkboxes: 'Rounding' (unchecked), 'Nutrition' (checked), 'Mobility' (checked), 'Mood, Behavioral & Cognitive' (unchecked), 'Bladder' (unchecked), 'Bowel' (checked), and 'Bathing and Oral Care' (checked). To the right of the event list are two buttons: 'RUN REPORT' and 'PRINT'.

5. Click **Run Report**.

The Events report shows the event charting for the events, date range, and neighborhood that was selected. The report is sorted by resident, with the latest events charting listed at the top of the report.

Figure 253: Care Manager Reports – Events

Meal	Method	Location	Amount	Comments	Created By	Created
Lunch	TPN	Dining Room	100 %			03/02/2021 1:43PM
Lunch	PO	Dining Room	75 %	Lunch comment		03/01/2021 9:15AM
Breakfast	NPO	Other	0 %	Resident did not eat		03/01/2021 9:15AM

Mood Observation	Behavioral	Cognitive	Significant Change	Comments	Created	Created By
Sad/Feeling Down, Angry/Hostile	Delusions (Delusion detail)	Alert & Disoriented, Confused	No		03/02/2021 1:43PM	
Angry/Hostile	Physical To Others (Physical detail), Verbal To Others (Verbal detail)	Alert & Oriented	Yes	Mood comment (Sig Change)	03/01/2021 9:16AM	

No Bowel Movement	# of Times	Scheduled	Continen	Appliances	Size	Texture	Comments	Created	Created By
true	0	Yes					No BM	03/02/2021 1:45PM	
false	1	Yes	Mostly Continent	Incontinent / Adult Briefs (1)	BM Output - Large	Liquid	Bowel comment	03/01/2021 9:18AM	

Attire	Bath Type	Oral Care	Oral Education Provided	Dental Condition	Types of Oral Care Provided	Comments	Created	Created By
Personal Attire	Shower	Independent	No	Full Dentures			03/02/2021 1:50PM	
Pajamas/Gown	Partial Bath	Refused, No Oral Care Provided	Yes	Partial Teeth		No Oral Care provided	03/01/2021 9:18AM	

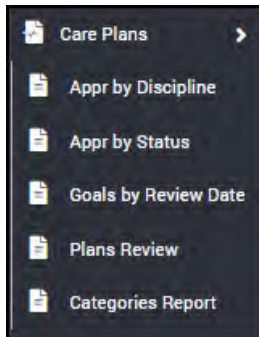
Care Plans Reports

There are five Care Plans report types available:

- Approach by Discipline
- Approach by Status
- Goals by Review Date
- Plans Review
- Categories Report

From the Reports & Forms page, click the **Care Plans** option on the left column to access these reports.

Figure 254: Care Plans Reports



Approach by Discipline

The Approaches by Discipline report can be filtered by date range, neighborhood, and discipline. It includes the following data:

- Discipline
- Resident
- Neighborhood
- Room-Bed
- Problem
- Goal
- Approach
- Date













In the report, the discipline is abbreviated. This is a key to the abbreviations:

- PHS – Physician Services
- NRS – Nursing Services
- RHB – Rehabilitation Services
- SCL – Social Services
- THR – Therapy Services
- DTY – Dietary Services
- ADM – Administrative Services
- CHP – Chaplain Services
- PHR – Pharmacy Services

To run the report:

1. Choose a **Start Date** and **End Date**.
2. From the **All Neighborhoods** list, select a neighborhood or leave the default of **All Neighborhoods**.
3. From the **All Disciplines** list, select a discipline or leave the default of **All Disciplines**.
4. Click the **Filter** icon.

Figure 255: Approaches by Discipline Report

Approaches by Discipline									
Start Date		12-01-2020	End Date		03-23-2021	All Neighborhoods	Dietary Services		
Discipline	Resident	Neighborhood	Room-Bed	Problem	Goal	Approach	Date		
	RAIMDSRESIDENT, SIXOTHREE	ASPEN	110-B	Resident confuses night and day; related to psychiatric diagnosis of test.	Resident's perceptions will be valid and a sense of well-being established as noted by the absence of off-putting behaviors.	Use lighting as a means to help orient day from night.	1/22/21		
  	RAIMDSRESIDENT, SIXOTHREE	ASPEN	110-B	Resident finds it difficult or is unable to understand related to test with actual/or risk for anxiety, confusion, frustration, feeling of isolation, sense of hopelessness, and unmet needs.	Resident will be able to relate effectively within his or her environment.	Anticipate the resident's needs and pay attention to non-verbal cues.	2/10/21		
 	RAIMDSREGRESSION FOURTEN	CEDAR GROVE	108-A	Resident has poor cognitive functioning related to test with actual/or risk for decreased social activity, reduced quality of life, and isolation.	Resident will show pleasure during activities by smiling and/or exhibiting a relaxed demeanor.	Use purposeful touch.	1/13/21		
 	RAIMDSREGRESSION FOURTEN	CEDAR GROVE	108-A	Resident has poor cognitive functioning related to test with actual/or risk for decreased social activity, reduced quality of life, and isolation.	Resident will show pleasure during activities by smiling and/or exhibiting a relaxed demeanor.	Engage the resident's senses with pleasant smells and having him or her touch a variety of different textured items.	1/13/21		
 	RAIMDSREGRESSION FOURTEN	CEDAR GROVE	108-A	Resident has poor cognitive functioning related to test with actual/or risk for decreased social activity, reduced quality of life, and isolation.	Resident will show pleasure during activities by smiling and/or exhibiting a relaxed demeanor.	Provide opportunities for exercise within the resident's physical abilities.	1/13/21		

To print the report, click the **Print** icon that is to the right of the filter icon.

Approaches by Status

The Approaches by Status report can be filtered by date range, neighborhood, and status. The Status options in the drop-down list are:

- All Statuses
- Active
- Resolved
- Inactivated
- Completed
- On Hold
- Entered in Error

The Approaches by Status report includes the following data:

- Discipline
- Resident
- Neighborhood
- Room-Bed
- Problem
- Goal
- Approach
- Date

To run the report:

1. Choose a **Start Date** and **End Date**.
2. From the **All Neighborhoods** list, select a neighborhood or leave the default of **All Neighborhoods**.
3. From the **All Statuses** list, select a status or leave the default of **All Statuses**.
4. Click the **Filter** icon.

Figure 256: Approaches by Status Report

Discipline	Resident	Neighborhood	Bed	Problem	Goal	Approach	Date
MRS	RAIMDSRESIDENT, ASPEN SIXOTHREE	ASPEN SIXOTHREE	110-B	Resident has verbal/aggressive behavior: screaming, cursing, negativism, constant requests for attention, verbal sexual advances, etc. related to test.	Resident's overall comfort, safety, sense of well-being, and self-sufficiency will be supported by lessening/eliminating causes of agitation and behavior will be reduced in frequency and intensity.	Discuss behavior boundaries with resident and family as appropriate and agree on acceptable behaviors.	1/22/21
MRS	RAIMDSRESIDENT, ASPEN SIXOTHREE	ASPEN SIXOTHREE	110-B	Resident has verbal/aggressive behavior: screaming, cursing, negativism, constant requests for attention, verbal sexual advances, etc. related to test.	Resident's overall comfort, safety, sense of well-being, and self-sufficiency will be supported by lessening/eliminating causes of agitation and behavior will be reduced in frequency and intensity.	Allow resident to plan a daily schedule for care and activity that allows control within acceptable boundaries.	1/22/21

In the report, the discipline is abbreviated. This is a key to the abbreviations:

- PHS – Physician Services
- NRS – Nursing Services
- RHB – Rehabilitation Services
- SCL – Social Services
- THR – Therapy Services
- DTY – Dietary Services
- ADM – Administrative Services
- CHP – Chaplain Services
- PHR – Pharmacy Services

To print the report, click the **Print** icon that is to the right of the filter icon.

Goals by Review Date Report

The Goals by Review Date report can only be filtered by **Neighborhood**. Select the neighborhood you would like to be reflected in the report and click the **Filter** icon. The data included in the report are:

- Goal Review Date
- Plan Date
- Resident
- Neighborhood
- Room-Bed
- Problem
- Goal

Figure 257: Goal by Review Date Report

Goal Review Date	Plan Date	Resident	Neighborhood	Room-Bed	Problem	Goal
2/21/21	11/23/20	RAIMDS, REGTHREE B.JG	CEDAR GROVE	105-A	Resident had coronary artery disease with a risk for fatigue, weakness, poor endurance, cardiac symptoms.	Resident will participate in daily routine with no worsening cardiac symptoms as ability allows daily.
3/3/21	12/3/20	RAIMDS, TSTONE	*NHCU*	1-A	Resident had coronary artery disease with a risk for fatigue, weakness, poor endurance, cardiac symptoms.	Resident will participate in daily routine with no worsening cardiac symptoms as ability allows daily.
3/16/21	12/16/20	DOE, JANE	*NHCU*		Resident has angina related to ts with a risk for myocardial infarction, decline in function.	Resident's angina will be controlled and/or relieved and the potential for myocardial complications will be minimized.
3/16/21	1/11/21	DOE, JANE	*NHCU*		Potential for acute confusional state that is different from normal baseline related totest.	Delirium symptoms will be promptly recognized and addressed.
3/16/21	1/11/21	DOE, JANE	*NHCU*		Resident has a risk for losing more fluid than is taken in related to decreased thirst perception, lack of awareness to drink, and difficulty swallowing.	Resident's muocous membranes will be moist; urine will be light in color.
3/16/21	2/16/21	DOE, JANE	*NHCU*		Resident has shingles blisters on test and has pain and risk for infecting others.	Resident will express an acceptable level of comfort and risk for spreading infection to others will be minimized.

To filter the report, select the neighborhood you want reflected in the report and click the **Filter** icon.

To print the report, click the **Print** icon that is to the right of the filter icon.

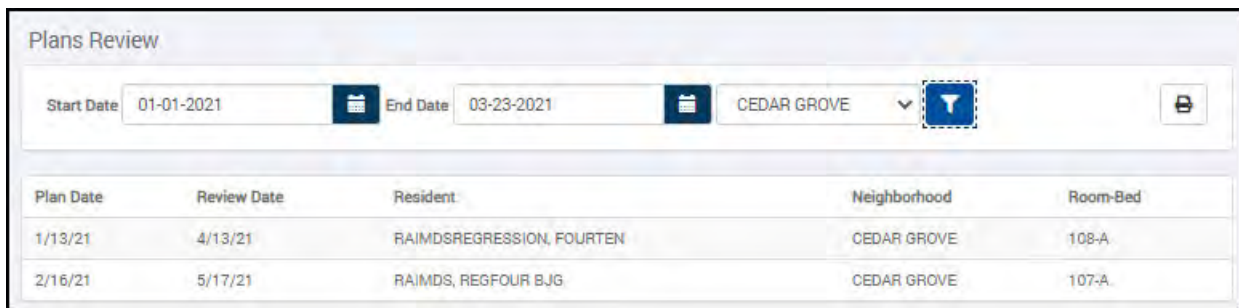
Plans Review Report

The Plans Review report can be filtered by date range and neighborhood. The data included in the report are:

- Plan Date
- Review Date
- Resident
- Neighborhood
- Room-Bed

To filter the report, select the data range and the neighborhood you want to reflect in the report and click the **Filter** icon.

Figure 258: Plans Review Report



The screenshot shows a web interface for a 'Plans Review' report. At the top, there are filter controls: 'Start Date' set to '01-01-2021', 'End Date' set to '03-23-2021', and a dropdown menu for 'Neighborhood' set to 'CEDAR GROVE'. A blue filter icon is highlighted with a dashed box. To the right of the filter icon is a print icon. Below the filters is a table with the following data:

Plan Date	Review Date	Resident	Neighborhood	Room-Bed
1/13/21	4/13/21	RAIMDSREGRESSION, FOURTEN	CEDAR GROVE	108-A
2/16/21	5/17/21	RAIMDS, REGFOUR BJG	CEDAR GROVE	107-A

To print the report, click the **Print** icon that is to the right of the filter icon.

Categories Report

The Categories report can be filtered by date range and neighborhood. The data included in the report are:

- Category
- Plan Date
- Resident
- Neighborhood
- Room-Bed

To filter the report:

1. Select the **Start** and **End Dates**.
2. Select the **Neighborhood**.
3. Click the **Filter** icon.

Figure 259: Categories Report

Categories				
Start Date	01-01-2021	End Date	03-23-2021	All Neighborhoods
Category	Plan Date	Resident	Neighborhood	Room-Bed
Delirium	1/11/21	DOE, JANE	*NHCU*	
Dehydration/Fluid Maintenance	1/11/21	DOE, JANE	*NHCU*	
Dental Care	1/12/21	DPMDS, RESIDENT	ASPEN	110-A
Activities	1/13/21	RAIMDSREGRESSION, FOURTEN	CEDAR GROVE	108-A
Communication	1/13/21	RAIMDSREGRESSION, FOURTEN	CEDAR GROVE	108-A
Behavioral Symptoms	1/22/21	RAIMDSRESIDENT, SIXOTHREE	ASPEN	110-B
Activities	1/26/21	RAIMDSRESIDENT, SIXOTHREE	RAIMDS4	
Communication	2/10/21	RAIMDSRESIDENT, SIXOTHREE	ASPEN	110-B
ADL Functional/Rehabilitation Potential	2/16/21	RAIMDS, REGFOUR BJG	CEDAR GROVE	107-A
Infections	2/16/21	DOE, JANE	*NHCU*	
Activities	2/22/21	RAIMDSRESIDENT, TWENTYFOUR M	ASPEN	101-B
Infections	3/5/21	OPRSPATIENT, EIGHT F	ASPEN	104-A

To print the report, click the **Print** icon that is to the right of the filter icon.

Master Resident List

The Master Resident List report provides a listing of residents, locations, SSN, DOB, Age, Gender, and Status. This report can be filtered by neighborhood or by column.

To create a Master Resident List:

1. Click the **Reports & Forms** tile on the MDS Dashboard.
2. Click the **Master Resident List** option on the left.
3. Click **Create Report** button.
4. Filter the report by **Neighborhood** or leave it defaulted to **All Neighborhoods**.
5. Click the **Confirm** button.
6. To sort by column, drag the column header to the designated space.

Figure 260: Master Resident List Report

<input type="checkbox"/>	Neighborhood	Room Bed	Last Name	First Name	Middle Name	SSN	DOB	Age	Gender	Status
	Stars & Stripes	100 B	CERNER	THIRTYFOUR		xxx-xx-9658	7/14/1952	67	MALE	Active
	Stars & Stripes	100 A	CERNER	TWENTYFOUR		xxx-xx-3645	9/25/1957	62	MALE	Active
	Stars & Stripes	135 A	CERNERPATIENT	FIFTYNINE		xxx-xx-6565	7/15/1948	71	MALE	Active
	Stars & Stripes	104-A	CPRSPATIENT	EIGHT	F	xxx-xx-0008	2/1/1955	65	FEMALE	Active
	Stars & Stripes	106-B	RAIMDSRESIDENT	FIFTY	F	xxx-xx-6050	1/1/1901	119	FEMALE	Active
	Stars & Stripes	120-A	RAIMDSRESIDENT	ONEHUNDREDONE	B	xxx-xx-6101	6/15/1914	106	MALE	Active
	Stars & Stripes	118-B	RAIMDSRESIDENT	REGRESSIONTWO	B	xxx-xx-2021	9/11/1933	86	FEMALE	Active
	Stars & Stripes	112-B	RAIMDSRESIDENT	SIXSIX		xxx-xx-6606	1/1/1901	119	FEMALE	Active
	Stars & Stripes	119-A	RAIMDSRESIDENT	TEN	T	xxx-xx-6010	1/1/1901	119	MALE	Active
	Stars & Stripes	113-B	RAIMDSRESIDENT	THIRTYONE	T	xxx-xx-6631	1/1/1901	119	FEMALE	Active
	Stars & Stripes		RAIMDSRESIDENT	TWOTHIRTYTWO	DD	xxx-xx-6232	1/1/1901	119	FEMALE	Active

There are a few report options for users:

- Export To button
- Column Chooser button
- Column sorting

Export the report


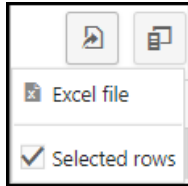
Click the **Export To**  button to export the entire report to an Excel spreadsheet, or to export selected rows from the report to an Excel spreadsheet. A drop-down menu opens.

Figure 261: Export To Options



To export the entire report, click the **Excel file** option. The report is immediately exported to an Excel spreadsheet which can be found in your **Downloads** folder.

To export selected rows of the report:

1. Click the **Selected rows** button.
2. Hold down the **Ctrl** key on the keyboard while you select the rows in the report you want to export to an Excel spreadsheet.

Figure 262: Rows Selected for Export



The image shows a table with columns: Neighborhood, Room Bed, Last Name, First Name, and an additional column with 'F'. A dropdown menu is open over the table, showing 'Excel file' and 'Selected rows' options. The 'Selected rows' option is checked. The table has the following data:

	Neighborhood	Room Bed	Last Name	First Name	
<input type="checkbox"/>	Stars & Stripes	100 B	CERNER	THIRTYFOU	
<input checked="" type="checkbox"/>	Stars & Stripes	100 A	CERNER	TWENTYFOUR	
<input type="checkbox"/>	Stars & Stripes	135 A	CERNERPATIENT	FIFTYNINE	
<input checked="" type="checkbox"/>	Stars & Stripes	104-A	CPRSPATIENT	EIGHT	F
<input type="checkbox"/>	Stars & Stripes	106-B	RAIMDSRESIDENT	FIFTY	F
<input checked="" type="checkbox"/>	Stars & Stripes	120-A	RAIMDSRESIDENT	ONEHUNDREDONE	B
<input checked="" type="checkbox"/>	Stars & Stripes	118-B	RAIMDSRESIDENT	REGRESSIONTWO	B
<input type="checkbox"/>	Stars & Stripes	112-B	RAIMDSRESIDENT	SIXOSIX	

3. After all of the rows you want to export are selected, click the **Export To** button and select the **Excel file** option.

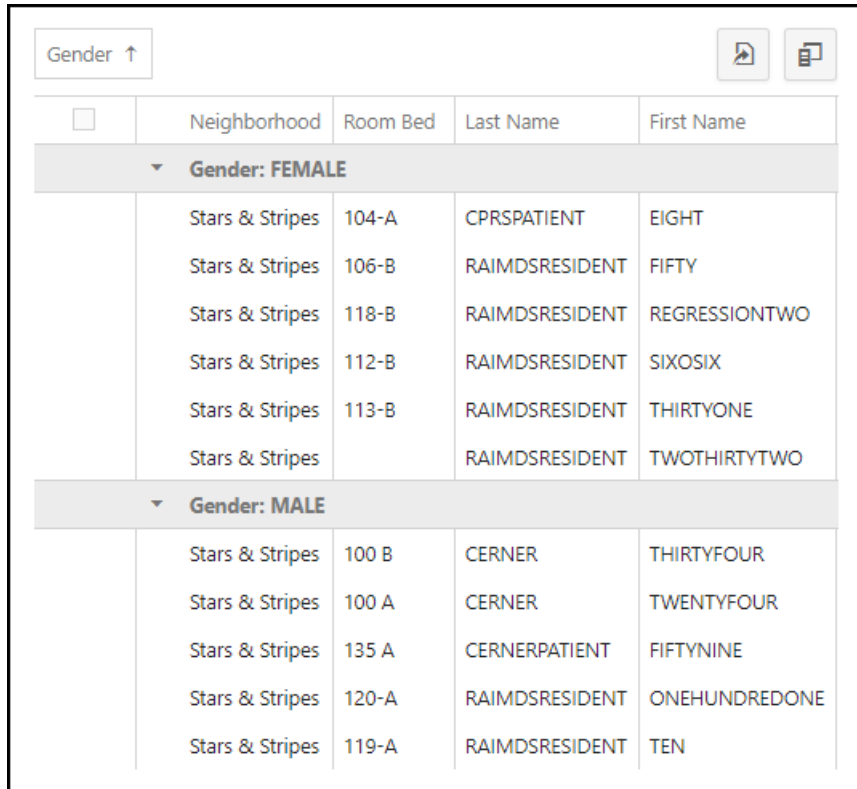
The selected rows are immediately exported to an Excel spreadsheet, which can be found in your **Downloads** folder.

Report Modification

You can modify the report by grouping the report data by a selected column, or by hiding some of the report columns.

To sort the report by a column, drag a column header to the top of the report to group the report data by that column.

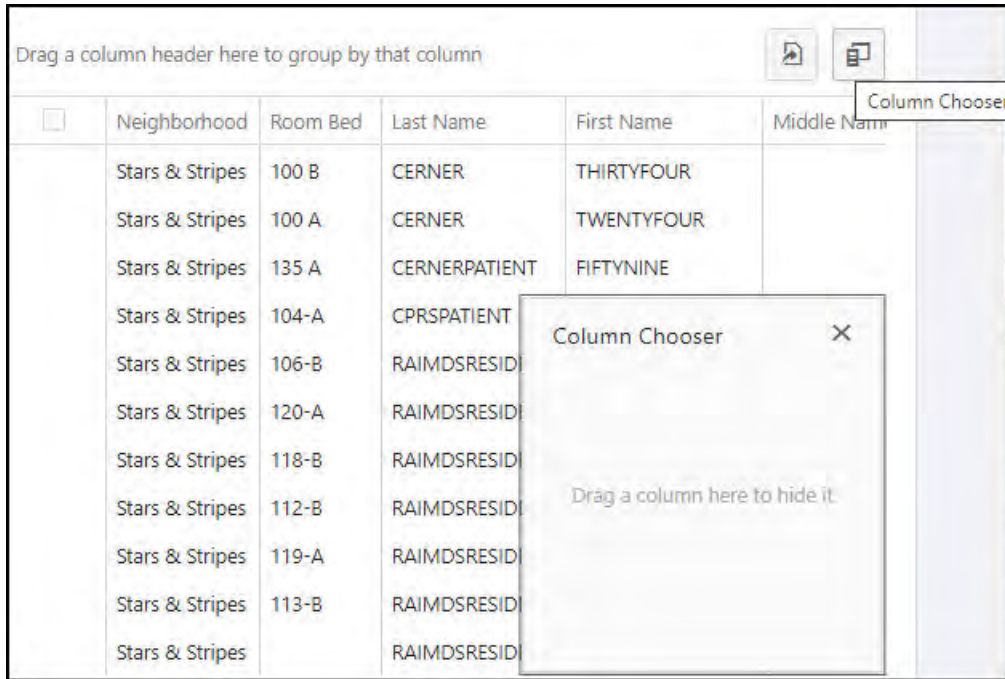
Figure 263: Report Grouped by the Gender Column



<input type="checkbox"/>	Neighborhood	Room Bed	Last Name	First Name
▼ Gender: FEMALE				
	Stars & Stripes	104-A	CPRSPATIENT	EIGHT
	Stars & Stripes	106-B	RAIMDSRESIDENT	FIFTY
	Stars & Stripes	118-B	RAIMDSRESIDENT	REGRESSIONTWO
	Stars & Stripes	112-B	RAIMDSRESIDENT	SIXOSIX
	Stars & Stripes	113-B	RAIMDSRESIDENT	THIRTYONE
	Stars & Stripes		RAIMDSRESIDENT	TWOTHIRTYTWO
▼ Gender: MALE				
	Stars & Stripes	100 B	CERNER	THIRTYFOUR
	Stars & Stripes	100 A	CERNER	TWENTYFOUR
	Stars & Stripes	135 A	CERNERPATIENT	FIFTYNINE
	Stars & Stripes	120-A	RAIMDSRESIDENT	ONEHUNDREDONE
	Stars & Stripes	119-A	RAIMDSRESIDENT	TEN

To modify the report by hiding some of its columns, click the **Column Chooser** button. The Column Chooser pane opens. Drag the column(s) you want to hide from the report into the Column Chooser pane.

Figure 264: Column Chooser Pane

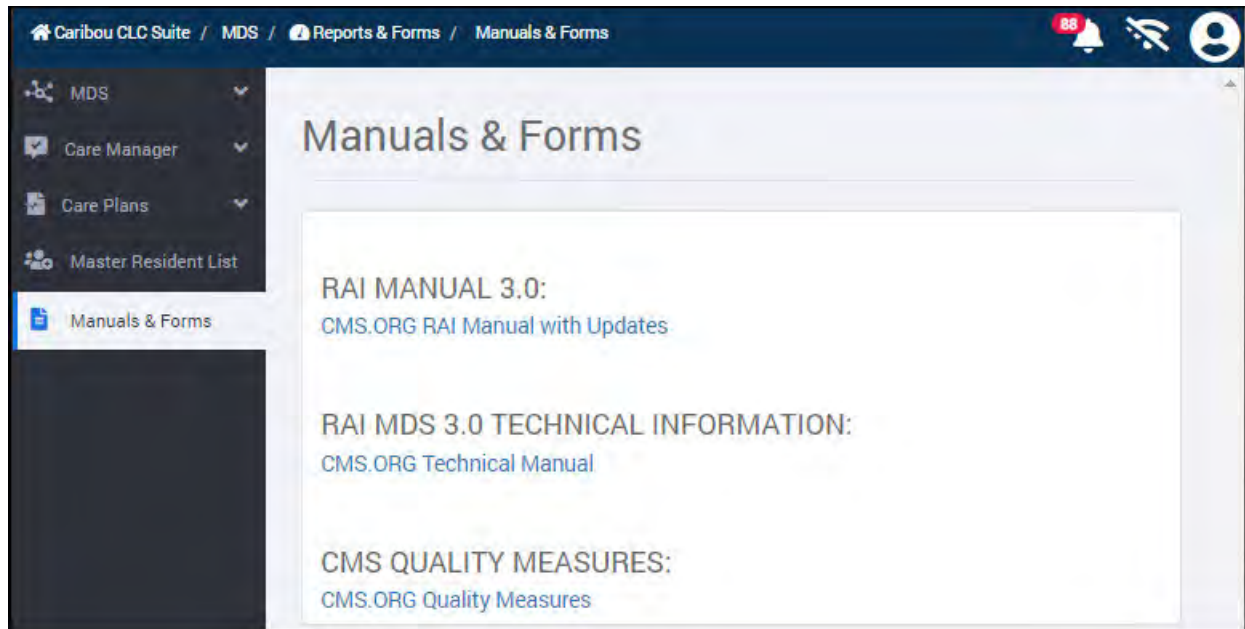


To restore a column that you've hidden in the Column Chooser, drag the column header back to the report and release it. You can drag the column headers right or left to re-order the report.

Manuals and Forms

The manuals and forms option provides links to the current RAI manual and blank MDS assessment forms.

Figure 265: Manuals and Forms



Keyboard Shortcuts

Pressing the combination of the **Shift** key and the **?** key opens a list of keyboard shortcuts. These shortcuts allow users to navigate through the various views of the application without the use of a mouse.

Note: For accessibility mode, there are some known issues with Job Access with Speech (JAWS). Substitute with NVDA while these issues are being fixed.

Table 4: Caribou CLC Suite Keyboard Shortcuts

Keys	Action
?	Show/hide this help menu
Ctrl + Alt + s	Open Schedule page
Ctrl + Alt + w	Open Work in Progress (WIP) page
Ctrl + Alt + y	Open Resident Search & History page
Ctrl + Alt + b	Open Batch & Transmit page
Ctrl + Alt + r	Open Reports & Forms page
Ctrl + Alt + z	Open Admin page
Ctrl + Alt + u	Open User menu
Ctrl + Alt + n	Open Notifications menu
Ctrl + Alt + v	Open Sync menu

Appendix A – Acronyms

Table 5: Acronym Definitions

Acronym	Definition
ADL	Activities of Daily Living
ADT	Admission Discharge Transfer
AITC	Austin Information Technology Center
ARD	Assessment Reference Date
CAA	Care Area Assessment
CLC	Community Living Center
CNA	Certified Nursing Assistant
CP	Care Plan
CPRS	Computerized Patient Record System
DOB	Date of Birth
█	████████████████████
IEN	Internal Entry Number
IRM	Information Resource Management
JAWS	Job Access With Speech screen reader software program
MB	Megabyte
MDS	Minimum Data Set
OBRA	Omnibus Budget Reconciliation Act
OTC	Over The Counter
PCE	Patient Care Encounter
PPS	Prospective Payment System
RAC	Resident Assessment Coordinator
RAI	Resident Assessment Instrument
RUG	Resource Utilization Group
SSN	Social Security Number
TIU	Text Integration Utility
█	████████████████████
█	██
█	██

Acronym	Definition
WIP	Work in Progress
XLS	Excel® Spreadsheet file