

## RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare <small style="text-align: right;">F75</small>	Medicaid <small style="text-align: right;">F76</small>	Other <small style="text-align: right;">F77</small>	Total Residents <small style="text-align: right;">F78</small>
<b>ADL</b>	<b>Independent</b>	<b>Assist of One or Two Staff</b>		<b>Dependent</b>
Bathing	F79	F80		F81
Dressing	F82	F83		F84
Transferring	F85	F86		F87
Toilet Use	F88	F89		F90
Eating	F91	F92		F93

### A. Bowel/Bladder Status

- F94** \_\_\_ With indwelling or external catheter
- F95** Of the total number of residents with catheters, how many were present on admission \_\_\_?
- F96** \_\_\_ Occasionally or frequently incontinent of bladder
- F97** \_\_\_ Occasionally or frequently incontinent of bowel
- F98** \_\_\_ On urinary toileting program
- F99** \_\_\_ On bowel toileting program

### B. Mobility

- F100** \_\_\_ Bedfast all or most of time
- F101** \_\_\_ In a chair all or most of time
- F102** \_\_\_ Independently ambulatory
- F103** \_\_\_ Ambulation with assistance or assistive device
- F104** \_\_\_ Physically restrained
- F105** Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints \_\_\_?
- F106** \_\_\_ With contractures
- F107** Of the total number of residents with contractures, how many had a contracture(s) on admission \_\_\_?

### C. Mental Status

**F108-114** – indicate the number of residents with:

- F108** \_\_\_ Intellectual and/or developmental disability
- F109** \_\_\_ Documented signs and symptoms of depression
- F110** \_\_\_ Documented psychiatric diagnosis (exclude dementias and depression)
- F111** \_\_\_ Dementia: (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases), or Alzheimer's Disease
- F112** \_\_\_ Behavioral healthcare needs
- F113** Of the total number of residents with behavioral healthcare needs, how many have an individualized care plan to support them \_\_\_?
- F114** \_\_\_ Receiving health rehabilitative services for MI and/or ID/DD

### D. Skin Integrity

**F115-118** – indicate the number of residents with:

- F115** \_\_\_ Pressure ulcers (exclude Stage 1)
- F116** Of the total number of residents with pressure ulcers excluding Stage 1, how many residents had pressure ulcers on admission \_\_\_?
- F117** \_\_\_ Receiving preventive skin care
- F118** \_\_\_ Rashes

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I certify that this information is accurate to the best of my knowledge.

### E. Special Care

**F119-132 – indicate the number of residents receiving:**

- F119 \_\_\_ Hospice care
- F120 \_\_\_ Radiation therapy
- F121 \_\_\_ Chemotherapy
- F122 \_\_\_ Dialysis
- F123 \_\_\_ Intravenous therapy, IV nutrition, and/or blood transfusion
- F124 \_\_\_ Respiratory treatment
- F125 \_\_\_ Tracheostomy care
- F126 \_\_\_ Ostomy care

- F127 \_\_\_ Suctioning
- F128 \_\_\_ Injections (exclude vitamin B12 injections)
- F129 \_\_\_ Tube feedings
- F130 \_\_\_ Mechanically altered diets including pureed and all chopped food (not only meat)
- F131 \_\_\_ Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.)  
Exclude health rehabilitation for MI and/or ID/DD
- F132 \_\_\_ Assistive devices with eating

### F. Medications

**F133-139 – indicate the number of residents receiving:**

- F133 \_\_\_ Any psychoactive medication
  - F134 \_\_\_ Antipsychotic medications
  - F135 \_\_\_ Antianxiety medications
  - F136 \_\_\_ Antidepressant medications
  - F137 \_\_\_ Hypnotic medications
- F138 \_\_\_ Antibiotics
- F139 \_\_\_ On pain management program

### G. Other

- F140 \_\_\_ With unplanned significant weight loss/gain
- F141 \_\_\_ Who do not communicate in the dominant language of the facility (include those who use American sign language)
- F142 \_\_\_ Who use non-oral communication devices
- F143 \_\_\_ With advance directives
- F144 \_\_\_ Received influenza immunization
- F145 \_\_\_ Received pneumococcal vaccine

Signature of Person Completing the Form

Title

Date

### TO BE COMPLETED BY SURVEY TEAM

- F146 Was ombudsman office notified prior to survey? \_\_\_ Yes \_\_\_ No
- F147 Was ombudsman present during any portion of the survey? \_\_\_ Yes \_\_\_ No
- F148 Medication error rate \_\_\_\_\_%