Blueprint for OASIS Accuracy Mock Exam

Use OASIS Guidance to select the best answer.

1) Your agency received a new referral for a patient with Medicare and a physician's order for PT three times a week for 4 weeks and nursing for 1 visit to remove staples in 5 days.

Which approach is compliant?

a. The PT may do the initial assessment visit, but the RN must do the SOC comprehensive assessment.
b. The RN must do the initial assessment visit, but PT may do the SOC comprehensive assessment.
c. The PT must do the initial assessment visit and the SOC comprehensive assessment.
d. The RN must do the initial assessment visit and the SOC comprehensive assessment.

2) Your patient has a past cardiac medical history and is sent to the ED with chest pain. From the ED he is transferred to the cardiac floor for observation where he remained for 3 days until being admitted to an inpatient bed. He was discharged home after 20 hours as an inpatient. Your Intake department verified the observation and inpatient status timing with the hospital billing department when accepting the referral.

Which of the following represents appropriate OASIS data collection?

a. Only the RFA 6 Transfer to Inpatient Facility - Patient not discharged is appropriate
b. Both RFA 6 Transfer to Inpatient Facility - Patient not discharged and RFA 3 ROC are required
c. Either the RFA 6 Transfer to Inpatient Facility - Patient not discharged or the RFA 7 Transfer to Inpatient - Patient discharged could be completed
d. No OASIS is required

3) Mr. Tom's SOC was on January 14 by the PT. Orders also included OT and home health aide services. The PT called to schedule the agency discharge visit for Jan. 25. Mr. Tom refused the visit stating he was going to begin Outpatient PT that day. Mr. Tom was discharged on Jan. 24 per agency policy. The PTA was the last to visit Mr. Tom on 1/22. Agency policy allows for a collaborative assessment process.

Visits received during the HH episode:

- **PT Jan. 14**
- **PTA Jan. 16, 18, 20 and 22**
- **OT Jan. 17, 19**
- **Aide Jan. 15, 17 and 19**

What is the most compliant way to complete the discharge OASIS assessment?

a. The PT must complete the discharge assessment based on Mr. Tom's status on his/her last visit of Jan. 14.
b. The PT may complete the discharge assessment based only on visits made in the last five days of care; in this scenario, the PTA and aide visits made on or between Jan. 20-24.
c. The OT may complete the discharge assessment based on his/her visit of Jan. 19 supplementing it with information from the last five visits made to the patient.
d. The OT may complete the discharge assessment based on his/her visit of Jan. 19 supplementing it with information from the PTA and aide visits made on or between Jan. 18-22.

4) Which of these statements about pressure ulcers/injuries is TRUE?

a. The unstageable response/code for a pressure ulcer/injury initially observed and documented in the pressure ulcer/injury items as being covered with a non-removable dressing at the SOC should be corrected when the dressing is removed, and the ulcer/injury is observed later in the assessment time frame.
b. A pressure ulcer treated with a skin graft is a surgical wound.
c. A stage 3 pressure ulcer completely covered with new epithelial tissue is reported as a Stage 3 pressure ulcer in OASIS.
d. A previously stageable Stage 4 pressure ulcer that is now covered with eschar is reported as a Stage 4 pressure ulcer.

5. **At the discharge visit, Mrs. Richardson has two pressure ulcers:**
   1. **Right hip - a Stage 3 that was a Stage 2 at SOC**
   2. **Right elbow - a Stage 4 which is fully granulated**

Your record review shows that at SOC, the ulcer/injury on the right elbow was unstageable due to a non- removable dressing. Three days after the SOC, the dressing was changed and the ulcer was observed to have 50% slough with a tendon visible.

How do you complete M1311 at Discharge?

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 - Go to M1311B1, Stage 3]	0
A2. Number of <u>these</u> Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 - Go to M1311C1, Stage 4]	1
B2. Number of <u>these</u> Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	0
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** [If 0 - Go to M1311D1, Unstageable: Non-removable dressing/device]	1
C2. Number of <u>these</u> Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	1
D1. Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** [If 0 - Go to M1311E1, Unstageable: Slough and/or eschar]	0
D2. Number of <u>these</u> unstageable pressure ulcers/injuries that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** [If 0 - Go to M1311F1, Unstageable: Deep tissue injury]	0
E2. Number of <u>these</u> unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
F1. Unstageable: Deep tissue injury **Number of unstageable pressure injuries presenting as deep tissue injury** [If 0 - Go to M1324]	0
F2. Number of <u>these</u> unstageable pressure injuries that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐

6) Mrs. Torres is assessed to have pressure ulcers in three locations:

1. Left elbow -- a Stage 3 at DC; was a Stage 1 at SOC.
2. Left ischium -- a Stage 4 at DC; was 100% covered with eschar at SOC, then debrided and assessed as a Stage 3 one week after SOC.
3. Sacrum -- covered with eschar at DC; was a Stage 2 at SOC.

How do you complete M1311 at Discharge?

(M1311) Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage	Enter Number
A1. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed, without slough. May also present as an intact or open/ruptured blister. **Number of Stage 2 pressure ulcers** [If 0 - Go to M1311B1, Stage 3]	0
A2. Number of these Stage 2 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
B1. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. **Number of Stage 3 pressure ulcers** [If 0 - Go to M1311C1, Stage 4]	1
B2. Number of these Stage 3 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	0
C1. Stage 4: Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling. **Number of Stage 4 pressure ulcers** [If 0 - Go to M1311D1, Unstageable: Non-removable dressing/device]	1
C2. Number of these Stage 4 pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	0
D1. Unstageable: Non-removable dressing/device: Known but not stageable due to non-removable dressing/device **Number of unstageable pressure ulcers/injuries due to non-removable dressing/device** [If 0 - Go to M1311E1, Unstageable: Slough and/or eschar]	0
D2. Number of these unstageable pressure ulcers/injuries that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐
E1. Unstageable: Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** [If 0 - Go to M1311F1, Unstageable: Deep tissue injury]	1
E2. Number of these unstageable pressure ulcers that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	0
F1. Unstageable: Deep tissue injury **Number of unstageable pressure injuries presenting as deep tissue injury** [If 0 - Go to M1324]	0
F2. Number of these unstageable pressure injuries that were present at most recent SOC/ROC – enter how many were noted at the time of most recent SOC/ROC	☐

7) **Mr. Adams had a cholecystectomy performed via laparoscopic surgery 10 days ago and you are admitting him to home care following exacerbation of his CHF post-op. His 1 cm incision was closed with a chemical bonding agent and is assessed to be completely closed, clean and dry with no signs of infection. Additionally, Mr. Adams has an implanted Baclofen infusion pump and the puncture site where the reservoir was filled in the hospital is reddened and tender.**

How do you complete M1342 Status of Most Problematic Surgical Wound that is Observable?

a. 0 - Newly epithelialized
b. 1 - Fully granulating
c. 2 - Early/partial granulation
d. 3 - Not healing

8) **Which statement regarding M1021 Primary Diagnosis and M1023 Other Diagnoses is TRUE?**

a. A diagnosis represented by a Z-code is permitted as a primary diagnosis.
b. The coder who has not seen the patient may determine the primary and other diagnoses and symptom control rating.
c. M1023 Other Diagnoses may be listed in any order.
d. The diagnoses listed in M1021 and M1023 must always be actively addressed in the patient's Plan of Care.

9) **Mrs. Stevens was referred for home care because she is experiencing severe symptoms related to an outbreak of shingles on her right lower abdomen. Her past health history is negative for any chronic illness.**

How do you complete M1028 Active Diagnoses at the SOC?

(M1028) Active Diagnoses- Comorbidities and Co-existing Conditions—Check all that apply
See OASIS Guidance Manual for a complete list of relevant ICD-10 codes.
☐ 1 – Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
☐ 2 – Diabetes Mellitus (DM)
☐ 3 – None of the above

a. Leave all boxes blank/empty.
b. Select box 1 and box 2 and box 3
c. Select box 3 only.
d. Enter a dash "(-)" in box 1 and box 2 and box 3

10) **During your SOC assessment interview, Mrs. Hatfield reports that she had never been in the hospital until she fell off a curb 5 months ago and broke her ankle. She was taken to the ER and then hospitalized for surgical repair of her ankle and several days of antibiotics. In the last month, she has noticed that she can't do what she used to every day. She tires easily and recently started napping in her chair while watching her game shows in the afternoon. Her doctor is running tests. She takes a vitamin, a laxative and an occasional over the counter pain reliever for headaches.**

How do you complete M1033 at the SOC?

#10 continued

(M1033) Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization? **(Mark all that apply.)**

1 History of falls (2 or more falls—or any fall with an injury—in the past 12 months)
2 Unintentional weight loss of a total of 10 pounds or more in the past 12 months
3 Multiple hospitalizations (2 or more) in the past 6 months
4 Multiple emergency department visits (2 or more) in the past 6 months
5 Decline in mental, emotional, or behavioral status in the past 3 months
6 Reported or observed history of difficulty complying with any medical instructions (for example, medications, diet, exercise) in the past 3 months
7 Currently taking 5 or more medications
8 Currently reports exhaustion
9 Other risk(s) not listed in 1–8
10 None of the above

a. Select 1 and 8 only
b. Select 3 and 4 only
c. Select 1, 3, and 4 only
d. Select 3, 4, and 8 only

11) Mr. Howell was admitted to your agency on February 1, and his SOC weight/height was measured and documented as 154 lbs. and 5 feet 7 inches. He was transferred to the hospital on February 10th with severe back pain. At the ROC visit on February 14, Mr. Howell could not be weighed accurately due to the presence of his back brace which was not to be removed. His height was measured following agency policy as 5 feet 7 inches.

How would you complete M1060 Height and Weight at ROC?

(M1060) Height and Weight—While measuring, if the number is X.1 – X.4 round down; X.5 or greater round up

☐☐ inches	a. Height (in inches). Record most recent height measure since the most recent
☐☐☐ pounds	b. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard agency practice (for example, in a.m. after voiding, before meal, with shoes off, etc.).

a. Height – 67 inches; Weight – enter a dash "(-)"
b. Height – 67 inches; Weight – leave the box empty/blank
c. Height – 67 inches; Weight – 154 lbs.
d. Leave both boxes blank

12) Mrs. Roberts lives with her son who is paid to take care of her under a State funded program. John is available in the home to provide care every day and night of the week except Saturday. Each Saturday, he volunteers at the local Food Bank from 8 AM until 4:30 PM. During that time, he keeps his cell phone handy, so his mom can call him if there are any emergencies.

What is the correct code for M1100 Patient Living Situation?

#12) continued
(M1100) Patient Living Situation: Which of the following best describes the patient's residential circumstance and availability of assistance? **(Check one box only.)**

Living Arrangement	Availability of Assistance				
	Around the clock	Regular daytime	Regular nighttime	Occasional / short-term assistance	No assistance available
a. Patient lives alone	☐ 01	☐ 02	☐ 03	☐ 04	☐ 05
b. Patient lives with other person(s) in the home	☐ 06	☐ 07	☐ 08	☐ 09	☐ 10
c. Patient lives in congregate situation (for example, assisted living, residential care home)	☐ 11	☐ 12	☐ 13	☐ 14	☐ 15

a. Code 01
b. Code 03
c. Code 08
d. Code 09

13) At SOC, you determine that Mr. Brooks requires assistance at all times to ambulate safely even though he lives alone. He ambulates with your supervision to the bathroom and then is able to perform his grooming independently and safely by standing at the sink and sitting on the toilet as needed.

Select the correct code for M1800 Grooming.

(M1800)	**Grooming:** Current ability to tend safely to personal hygiene needs (specifically: washing face and hands, hair care, shaving or make up, teeth or denture care, or fingernail care).
Enter Code ☐	0 Able to groom self unaided, with or without the use of assistive devices or adapted methods. 1 Grooming utensils must be placed within reach before able to complete grooming activities. 2 Someone must assist the patient to groom self. 3 Patient depends entirely upon someone else for grooming needs.

a. Code 0
b. Code 1
c. Code 2
d. Code 3

14) Mrs. Baker lives with her daughter. The home is being remodeled to accommodate the patient's needs. At the time of the SOC comprehensive assessment on Tuesday, the only bathroom is under construction and not available, therefore Mrs. Baker is using the kitchen sink to wash up. She is able to wash everything without her daughter's help except her hair.

What is the correct code for M1830 Bathing?

(M1830)	**Bathing:** Current ability to wash entire body safely. **Excludes grooming (washing face, washing hands, and shampooing hair).**
Enter Code ☐	0 Able to bathe self in shower or tub independently, including getting in and out of tub/shower. 1 With the use of devices, is able to bathe self in shower or tub independently, including getting in and out of the tub/shower. 2 Able to bathe in shower or tub with the intermittent assistance of another person: (a) for intermittent supervision or encouragement or reminders, OR (b) to get in and out of the shower or tub, OR (c) for washing difficult to reach areas. 3 Able to participate in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision. 4 Unable to use the shower or tub, but able to bathe self independently with or without the use of devices at the sink, in chair, or on commode. 5 Unable to use the shower or tub, but able to participate in bathing self in bed, at the sink, in bedside chair, or on commode, with the assistance or supervision of another person. 6 Unable to participate effectively in bathing and is bathed totally by another person.

a. Code 2
b. Code 3
c. Code 4
d. Code 5

15) **Mr. K has difficulty seeing on his left side since his stroke. At the time of discharge from your agency, his son still needs to remind him during the meal to scan the entire plate to ensure he has seen all the food.**

What is the appropriate code for GG0130 Eating at Discharge?

GG0130. Self-Care	
Discharge Performance	
☐☐	**A. Eating:** The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the patient.

a. Code 06, Independent
b. Code 05, Setup or Clean-up Assistance
c. Code 04, Supervision or Touching Assistance
d. Code 03, Partial/Moderate Assistance

16) **Mr. Gold is feeling weak and dizzy. After a struggle, he is able to get himself closer to the edge of the bed but is unable to get himself up and to a seated position. His wife helps lift his upper body up from the bed and you provide additional assistance and cues necessary for the safety of the patient and his spouse. With some therapy and a hospital bed, you think that Mr. Gold will be able to get from lying to sitting with only verbal cueing at discharge.**

How do you code GG0170C1 SOC/ROC Performance and GG0170C2 Discharge Goal?

(GG0170C) Mobility			
Code the patient's usual performance at the SOC/ROC using the 6-point scale. If activity was not attempted at SOC/ROC, code the reason. **Code the patient's discharge goal using the 6-point scale. Do not use codes 07, 09, or 88 to code discharge goal.**			
Coding: **Safety** and **Quality of Performance** – If helper assistance is required because patient's performance is unsafe or of poor quality, score according to amount of assistance provided. *Activity may be completed with or without assistive devices.*	**1. SOC/ROC Performance**	**2. Discharge Goal**	
	↓Enter Codes in Boxes↓		
06 **Independent** – Patient completes the activity by him/herself with no assistance from a helper. 05 **Setup or clean-up assistance** – Helper SETS UP or CLEANS UP; patient completes activity. Helper assists only prior to or following the activity. 04 **Supervision or touching assistance** – Helper provides VERBAL CUES or TOUCHING/STEADYING assistance as patient completes activity. Assistance may be provided throughout the activity or intermittently. 03 **Partial/moderate assistance** – Helper does LESS THAN HALF the effort. Helper lifts, holds or supports trunk or limbs, but provides less than half the effort. 02 **Substantial/maximal assistance** – Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 01 **Dependent** – Helper does ALL of the effort. Patient does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the patient to complete the activity. **If activity was not attempted, code reason:** 07 **Patient refused** 09 **Not applicable** 88 Not attempted due to **medical condition or safety concerns**	☐☐	☐☐	**Lying to Sitting on Side of Bed:** The ability to safely move from lying on the back to sitting on the side of the bed with feet flat on the floor, and with no back support.

a. SOC/ROC Performance 04 Discharge Goal 05
b. SOC/ROC Performance 03 Discharge Goal 04
c. SOC/ROC Performance 02 Discharge Goal 04
d. SOC/ROC Performance 01 Discharge Goal 04

17) **When asking the patient about falls on the discharge visit, Mr. E and his spouse report that one day he had a "near miss" when the therapist was teaching him to use his walker and he stumbled. The therapist "caught him" and prevented Mr. E from falling to the ground avoiding any injury. There was no other evidence of a fall when reviewing the medical record.**

Select the correct codes for J1800 Any Falls Since the SOC/ROC and J1900 Number of Falls Since the SOC/ROC?

J1800. Any Falls Since SOC/ROC, whichever is more recent	
Enter Code ☐	Has the patient **had any falls since SOC/ROC,** whichever is more recent? 0. **No** → *Skip J1900* 1. **Yes** → *Continue to J1900. Number of Falls Since SOC/ROC, whichever is more recent*

J1900. Number of Falls Since SOC/ROC, whichever is more recent		
CODING: 0. None 1. One 2. Two or more	↓ Enter Codes in Boxes	
	☐	**A. No injury:** No evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the patient; no change in the patient's behavior is noted after the fall
	☐	**B. Injury (except major):** Skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the patient to complain of pain
	☐	**C. Major injury:** Bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

a. J1800 – 0; J1900 skipped
b. J1800 – 0; J1900 A. (1), B. (0), C. (0)
c. J1800 – 1; J1900 A. (0), B. (0), C. (0)
d. J1800 – 1; J1900 A. (1), B. (0), C. (0)

18) **You admitted Mr. Jones to home care with 11 prescribed medications. As you performed the drug regimen review, you discovered that he only had 10 of the meds in the home. When questioned, he stated the other medication was an over-the-counter med, was not covered by his insurance, and he couldn't afford it. You believed the med was critical to his care and called the physician on the SOC visit. The physician called in a prescribed alternative the same day which the insurance covered and you arranged for his daughter to pick up the medication from the pharmacy during her lunch break. You reported the clinically significant medication issue in M2001 Drug Regimen Review and selected Yes for M2003 Medication Follow-up. Mr. Jones was not hospitalized during the episode of care and no additional medication issues were identified before his discharge from the agency.**

At Discharge, how do you code M2005 Medication Intervention?

(M2005)	**Medication Intervention:** Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?	
Enter Code	0	No
	1	Yes
	9	NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

a. Item would be skipped
b. 0 – No
c. 1 – Yes
d. 9 – NA

19) **Mr. Murphy, who is legally blind, has been taking 3 once-daily medications p.o. each morning. Recently, he was ordered to take a benzodiazepine wafer at bedtime sublingually. On the day of the assessment, he stated he had no problem taking his regular once-daily medications as long as his nephew comes over on Sunday and fills his medi-planner for him. Examination of the medi-planner supported this report. Mr. Murphy confessed he hadn't started his new medication for his panic attacks because he didn't understand what the doctor meant by the word "sublingual."**

What is the correct code for M2020 Management of Oral Medications?

(M2020)	**Management of Oral Medications:** Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**
Enter Code	0 Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times. 1 Able to take medication(s) at the correct times if: (a) individual dosages are prepared in advance by another person; OR (b) another person develops a drug diary or chart. 2 Able to take medication(s) at the correct times if given reminders by another person at the appropriate times 3 Unable to take medication unless administered by another person. NA No oral medications prescribed.

a. Code 0
b. Code 1
c. Code 2
d. Code 3

20) **Mrs. Cook lives alone but has 2 daughters who are very active in her care. At the time of the discharge, one daughter stops over each morning to help her mom shower. Mrs. Cook sometimes forgets to make her dinner and take her evening medications and the 2nd daughter stops by each evening to help her with these activities. Mrs. Cook has no medical treatments ordered.**

How do you code M2102 Types and Sources of Assistance rows a, d and f at discharge?

(M2102) Types and Sources of Assistance: Determine the ability and willingness of non-agency caregivers (such as family members, friends, or privately paid caregivers) to provide assistance for the following activities, if assistance is needed. Excludes all care by your agency staff.	
Enter Code ☐	a. **ADL assistance** (for example, transfer/ ambulation, bathing, dressing, toileting, eating/feeding) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	d. **Medical procedures/treatments** (for example, changing wound dressing, home exercise program) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available
Enter Code ☐	f. **Supervision and safety** (for example, due to cognitive impairment) 0 No assistance needed –patient is independent or does not have needs in this area 1 Non-agency caregiver(s) currently provide assistance 2 Non-agency caregiver(s) need training/ supportive services to provide assistance 3 Non-agency caregiver(s) are not likely to provide assistance OR it is unclear if they will provide assistance 4 Assistance needed, but no non-agency caregiver(s) available

a. Row a - 1; Row d - 0; Row f – 1
b. Row a - 0; Row d - 0; Row f – 0
c. Row a – 1; Row d – 0; Row f - 0
d. Row a – 0; Row d – 1; Row f – 0