



Welcome to the Centers for Medicare & Medicaid Services' OASIS-C Online Training. This module will provide foundational education on the Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) domain of the OASIS data set. The ADLs / IADLs domain module is divided into two parts. Part 1 focuses on items M1800 through M1845. Part 2 focuses on items M1850 through M1910.

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**Introduction**

This program provides an introduction to OASIS-C items found in the ADLs / IADLs domain.

This module continues the training provided in the module entitled ADLs / IADLs Domain (Part 1). It is recommended that you complete Part 1 before starting this module.

Discussion includes relevant guidance found in Chapter 3 of the December 2012 OASIS-C Guidance Manual.

The following information is provided in this lesson:

- Item intent for each specific item
- Time points for item completion
- Response-specific item instructions
- Data sources and resources



This program provides an introduction to OASIS-C items related to the ADLs / IADLs domain. This module continues the training provided in the module entitled ADLs / IADLs Domain (Part 1). It is recommended that you complete Part 1 before starting this module. This module includes relevant guidance found in the December 2012 version of the OASIS-C Guidance Manual, specifically from Chapter 3, which contains OASIS item-specific guidance. Topics covered in this module include item intent or clarification about what each item is intended to report, time points when each item should be completed, response-specific item instructions clarifying the differences between the various responses which could be selected for each item, and data sources and resources related to the ADLs / IADLs domain.

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**Module Objectives**

- Identify the intent of each item.
- Specify the data collection time points for each item.
- Apply item-specific guidance when selecting correct responses to items.
- Identify data sources for each item.



Following the presentation of this module on items M1850 through M1910 in the ADLs / IADLs domain, you will be able to identify the intent of each item, specify the data collection time points for each item, identify response-specific guidelines for completing each item, and identify data sources for each item.

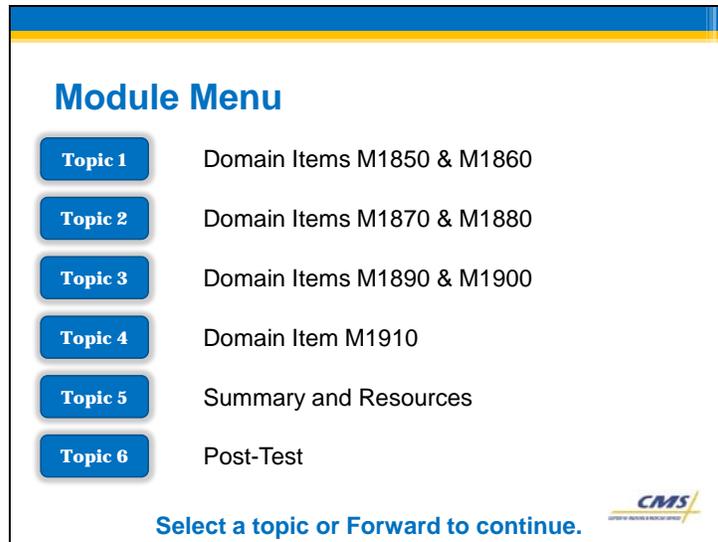
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The screenshot shows a 'Module Menu' interface. It features a blue header bar at the top. Below the header, the title 'Module Menu' is displayed in blue. There are six blue buttons, each labeled 'Topic 1' through 'Topic 6', arranged vertically. To the right of each button is the corresponding topic description. At the bottom of the menu, there is a blue link that says 'Select a topic or Forward to continue.' and the CMS logo.

Topic	Description
Topic 1	Domain Items M1850 & M1860
Topic 2	Domain Items M1870 & M1880
Topic 3	Domain Items M1890 & M1900
Topic 4	Domain Item M1910
Topic 5	Summary and Resources
Topic 6	Post-Test

Select a topic or [Forward to continue.](#)



Select the Forward button to review the entire module, or you may select a topic from the Module Menu to review a specific topic of interest.

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This topic addresses ADLs / IADLs domain items M1850 and M1860.

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**Summary of M- Items**

- M1800 Grooming
- M1810 Dressing Upper Body
- M1820 Dressing Lower Body
- M1830 Bathing
- M1840 Toilet Transferring
- M1845 Toileting Hygiene
- M1850 Transferring
- M1860 Ambulation/ Locomotion
- M1870 Feeding or Eating
- M1880 Plan & Prepare Light Meals
- M1890 Telephone Use
- M1900 Prior Functioning
- M1910 Fall Risk Assessment



There are 13 OASIS items in the ADLs / IADLs domain. This topic addresses M1850 Transferring and M1860 Ambulation/Locomotion.

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**M1850 Transferring**  
**Item Intent & Time Points**

**(M1850) Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- 0 - Able to independently transfer.
- 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
- 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- 5 - Bedfast, unable to transfer and is unable to turn and position self.

**Collected at SOC, ROC, FU & DC Not to Inpatient**

Item Intent      Time Points      Response-Specific Instructions      Data Sources/Resources



The intent of M1850 Transferring is for the assessing clinician to identify and report the patient’s ability to safely transfer from the bed to the chair (and back to bed), or the patient’s ability to position him or herself in bed if the patient is bedfast. This item is collected at the Start of Care, Resumption of Care, Follow-up, and Discharge assessment time points.

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**M1850 Transferring**  
**Item Intent**

**(M1850) Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- 0 - Able to independently transfer.
- 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
- 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- 5 - Bedfast, unable to transfer and is unable to turn and position self.

• Assess the patient holistically to determine if ability has been permanently or temporarily limited by physical impairments, emotional/cognitive/behavioral impairments, sensory impairments, and/or environmental barriers.

Item Intent — Time Points — Response-Specific Instructions — Data Sources/Resources



Remember that when we assess items in the ADLs / IADLs domain, we are to consider the patient’s safe ability, not their actual performance. M1850 Transferring addresses the patient’s ability to safely transfer given the current physical and mental/emotional/cognitive status, activities permitted, and environment. Assess the patient holistically to determine if ability has been permanently or temporarily limited by physical impairments, emotional/cognitive/behavioral impairments, sensory impairments and/or environmental barriers.

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### M1850 Transferring Response-Specific Instructions

**(M1850) Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- 0 - Able to independently transfer.
- 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
- 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- 5 - Bedfast, unable to transfer and is unable to turn and position self.

• For most patients a bed-to-chair transfer includes: Transferring from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a chair, and returning back to bed again.

Item Intent    Time Points    **Response-Specific Instructions**    Data Sources/  
Resources



When selecting the most accurate response, it will be important to understand what is included in this transferring item. For most patients a bed to chair transfer includes: moving from a supine position in bed to a sitting position at the bedside, then some type of standing, stand-pivot, or sliding board transfer to a chair, and back again.

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### M1850 Transferring Response-Specific Instructions, cont'd

**(M1850) Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- 0 - Able to independently transfer.
- 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
- 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- 5 - Bedfast, unable to transfer and is unable to turn and position self.

- The sitting surface could be a chair in another room, a bedside commode, the toilet, or a bench.
- Remember to include the ability to return back into bed from the sitting surface.



Item Intent    Time Points    **Response-Specific Instructions**    Data Sources/  
Resources

If there is no chair in the patient’s bedroom or the patient does not routinely transfer from the bed directly into a chair in the bedroom, report the patient’s ability to move from a supine position in bed to a sitting position at the side of the bed, and then the ability to stand and then sit on whatever surface is applicable to the patient’s environment and need. For example, the sitting surface could be a chair in another room, a bedside commode, the toilet, or a bench. Remember to include the ability to return back into bed from the sitting surface when completing this item.

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### M1850 Transferring Response-Specific Instructions, cont'd

(M1850) **Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- 0 - Able to independently transfer.
- 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
- 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- 5 - Bedfast, unable to transfer and is unable to turn and position self.

Most  
Optimal



Less  
Optimal

- If ability varies on the day of assessment, select the response describing the patient's ability for more than 50% of the time period.

Item Intent
Time Points
**Response-Specific Instructions**
Data Sources/  
Resources


When assessing your patient's ability to transfer, be sure to use observation techniques, watching how the patient moves around while you are in the home, and then interview the patient and/or caregivers to determine if your patient's ability has changed during the day of assessment (the prior 24 hours) compared to what you are seeing during your assessment visit. If ability varies on the day of assessment, select the response describing the patient's ability more than 50% of the time. Notice how the response options present the most independent level first, then proceed to the most dependent. Read each response option carefully to determine the one that best describes what the patient is able to do.

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### M1850 Transferring Response-Specific Instructions, cont'd

(M1850) **Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- 0 - Able to independently transfer.
- 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
- 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- 5 - Bedfast, unable to transfer and is unable to turn and position self.

- Select Response 0 if the patient does not require any human assistance or assistive device.
- Select Response 1 if the patient transfers with only minimal assistance OR with only an assistive device.

Item Intent    Time Points    **Response-Specific Instructions**    Data Sources/  
Resources

Let's take a look at each of the response options for M1850 Transferring. Response 0 - Able to independently transfer means that the patient does not require any human assistance or an assistive device to transfer safely. Response 1 - Able to transfer with minimal human assistance or with the use of an assistive device means that the patient requires either minimal human assistance OR the use of an assistive device to transfer safely.

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**M1850 Transferring**  
**Response-Specific Instructions, cont'd**

(M1850) **Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- 0 - Able to independently transfer.
- 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
- 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- 5 - Bedfast, unable to transfer and is unable to turn and position self.

- Select Response 2 if both minimal human assistance AND an assistive device are required for safe transferring.
- Patient must be able to both bear weight AND pivot to select Response 2.

Item Intent    Time Points    **Response-Specific Instructions**    Data Sources/  
Resources



If both minimal human assistance and an assistive device are required for safe transferring, then select Response 2. You will also select Response 2 if the patient can bear weight and pivot but requires more than minimal human assistance. The patient must be able to both bear weight and pivot in order to select Response 2.

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### M1850 Transferring Definitions

1 - Able to transfer with **minimal human assistance** or with use of an assistive device.

- Assistance includes any combination of verbal cueing, environmental set up, and/or actual hands-on assistance
- The assistance is minimal when the individual assisting the patient is contributing less than 25% of the total effort required to perform the transfer.

2 - **Able to bear weight** and pivot during the transfer process but unable to transfer self.

- “Able to bear weight” refers to the patient’s ability to support the majority of his/her body weight through any combination of weight-bearing extremities

Item Intent
Time Points
**Response-Specific Instructions**
Data Sources/  
Resources



Don’t forget that minimal human assistance can include any combination of verbal cueing, environmental set up, and/or actual hands-on assistance. In order for the assistance to be considered minimal, the individual assisting the patient must be contributing less than 25% of the total effort required to perform the transfer. “Able to bear weight” refers to the patient's ability to support the majority of his/her body weight through any combination of weight-bearing extremities (e.g., a patient with a weight-bearing restriction on one lower extremity may be able to support his/her entire weight through the other lower extremity and the upper extremities).

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**M1850 Transferring**  
**Response-Specific Instructions, cont'd**

(M1850) **Transferring:** Current ability to move safely from bed to chair, or ability to turn and position self in bed if patient is bedfast.

- 0 - Able to independently transfer.
- 1 - Able to transfer with minimal human assistance or with use of an assistive device.
- 2 - Able to bear weight and pivot during the transfer process but unable to transfer self.
- 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- 5 - Bedfast, unable to transfer and is unable to turn and position self.

• Bedfast means the patient is confined to bed, either per physician restriction or due to the patient's inability to tolerate being out of bed.

Item Intent      Time Points      **Response-Specific Instructions**      Data Sources/  
Resources



If the patient is unable to bear weight or unable to pivot and is not bedfast, select Response 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person. If the patient is bedfast, meaning that he or she is confined to bed, either per physician restriction or due to the patient's inability to tolerate being out of bed, select Response 4 or 5. If the patient is unable to transfer but is able to turn and position self in bed, select Response 4. If the patient is unable to transfer and is unable to turn and position self in bed, select Response 5.

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### M1850 Transferring Data Sources / Resources

- Gather information from several sources:
  - Observation
  - Patient interview
  - Caregiver interview
  - Physical assessment
  - Environmental assessment



Item Intent \_\_\_\_\_ Time Points \_\_\_\_\_ Response-Specific Instructions \_\_\_\_\_ Data Sources/Resources \_\_\_\_\_



When assessing your patient’s ability to safely perform the bed to chair transfer, consider the following sources when obtaining your assessment information. Use a combined observation/interview approach with the patient or caregiver to determine the most accurate response to this item. Ask the patient about transferring ability. Do they need to use a device to get up, or do they need someone’s help? Observe your patient during transfers and determine the amount of assistance required for safe transfer from bed to chair. Information collected during the physical and environmental assessment may also be useful in scoring this item accurately.

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### M1860 Ambulation/Locomotion Item Intent & Time Points

**(M1860) Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- 3 - Able to walk only with the supervision or assistance of another person at all times.
- 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- 5 - Chairfast, unable to ambulate and is unable to wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair.

**Collected at SOC, ROC, FU & DC Not to Inpatient**

Item Intent
Time Points
Response-Specific Instructions
Data Sources/  
Resources

The intent of M1860 Ambulation/Locomotion is for the assessing clinician to identify the patient’s ability and the type of assistance required to safely ambulate or propel self in a wheelchair over a variety of surfaces. M1860 Ambulation/Locomotion is collected at the Start of Care, Resumption of Care, Follow-up, and Discharge assessment time points.

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### M1860 Ambulation/Locomotion Item Intent

**(M1860) Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- 3 - Able to walk only with the supervision or assistance of another person at all times.
- 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- 5 - Chairfast, unable to ambulate and is unable to wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair.

- Consider the patient's ability, not necessarily their actual performance.
- Identify if there are barriers that temporarily or permanently limit the patient's ability.

Item Intent
Time Points
Response-Specific Instructions
Data Sources/  
Resources

As with all the ADLs / IADLs items, we must consider the patient’s ability, not necessarily their actual performance. “Willingness” and “compliance” are not the focus of these items. Assess the patient holistically and determine the patient’s safe ability to ambulate or use a wheelchair, given the current physical and mental/emotional/cognitive status, activities permitted, and environment. Identify if there are barriers that temporarily or permanently limit the patient’s ability, as previously discussed in Part 1 of this module.

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### M1860 Ambulation/Locomotion Response-Specific Instructions

**(M1860) Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device). Most Optimal
- 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- 3 - Able to walk only with the supervision or assistance of another person at all times.
- 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- 5 - Chairfast, unable to ambulate and is unable to wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair. Less Optimal

“Variety of surfaces” refers to typical surfaces that the patient would routinely encounter in his/her environment.

Item Intent    Time Points    **Response-Specific Instructions**    Data Sources/  
Resources

This item references the ability to safely walk once standing or use a wheelchair once in a seated position. Notice how the transfer is not included in this item. When assessing your patient’s ability to walk or use a wheelchair, consider the environment and surfaces the patient must encounter on a routine basis. For example, if the patient does not encounter stairs, then you do not need to assess the patient using stairs. As with other items in this domain, the response options present the most independent level first, then proceed to more dependent mobility levels. Be sure to read each response carefully to determine which one best describes what the patient is able to do.

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### M1860 Ambulation/Locomotion Response-Specific Instructions, cont'd

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- 3 - Able to walk only with the supervision or assistance of another person at all times.
- 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- 5 - Chairfast, unable to ambulate and is unable to wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair.

- Select Response 0 if the patient does not require human assistance or an assistive device.
- Select Response 1 if the patient does not require human assistance but must use a one-handed assistive device.

Item Intent
Time Points
**Response-Specific Instructions**
Data Sources/  
Resources



Responses 0, 1, 2, and 3 apply to patients who are ambulatory. Let's take a closer look at each of these response options. Response 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device) and Response 1 - With the use of a one-handed device (for example, cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings describe a patient who can ambulate safely without any human assistance.

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### M1860 Ambulation/Locomotion Response-Specific Instructions, cont'd

**(M1860) Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- 3 - Able to walk only with the supervision or assistance of another person at all times.
- 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- 5 - Chairfast, unable to ambulate and is unable to wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair.

- Select Response 2 if the patient requires the use of a two-handed device to ambulate safely alone.
- Select Response 2 if the patient requires intermittent human assistance, regardless of the need for an assistive device.

Item Intent
Time Points
**Response-Specific Instructions**
Data Sources/  
Resources

Response 2 is appropriate when a patient requires the use of a two-handed device (for example, a walker or two crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. Regardless of the need for an assistive device, if the patient requires intermittent human assistance (hands-on, supervision and/or verbal cueing) to safely ambulate, select Response 2. If the assistance required is continuous, select Response 3. In situations where the patient is safely able to ambulate without a device on level surfaces, but requires minimal assistance on stairs, steps, and uneven surfaces, Response 2 would be appropriate.

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**M1860 Ambulation/Locomotion**  
**Response-Specific Instructions, cont'd**

(M1860) **Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- 3 - Able to walk only with the supervision or assistance of another person at all times.
- 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- 5 - Chairfast, unable to ambulate and is unable to wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair.

- Select Response 3 when the patient requires the continuous presence of another individual to safely ambulate.
- If the patient does not have a walking device but is clearly not safe walking alone, select Response 3.

Item Intent    Time Points    **Response-Specific Instructions**    Data Sources/  
Resources

Response 3 - Able to walk only with the supervision or assistance of another person at all times is the appropriate response when the patient requires the continuous presence of another individual to safely ambulate. If the patient does not have a walking device but is clearly not safe walking alone, select Response 3 unless the patient is chairfast. If a patient does not require human assistance, but safely ambulates with a walker in some areas of the home, and a cane in other areas, select the response that reflects the device that best supports safe ambulation on all surfaces the patient routinely encounters.

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### M1860 Ambulation/Locomotion Response-Specific Instructions, cont'd

(M1860) Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- 5 - Chairfast, unable to ambulate and is unable to wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair.



Item Intent \_\_\_\_\_ Time Points \_\_\_\_\_ Response-Specific Instructions \_\_\_\_\_ Data Sources/ Resources 

Response 4 - Chairfast, unable to ambulate but is able to wheel self independently, and Response 5 - Chairfast unable to ambulate and is unable to wheel self, refer to a patient who is unable to ambulate, even with the use of assistive devices and/or continuous assistance, but is not confined to the bed. A patient who demonstrates or reports ability to take one or two steps to complete a transfer, but is otherwise unable to ambulate, even with assistance, should be considered chairfast, and would be scored 4 or 5 based on their wheelchair mobility. Select Response 6 if the patient is bedfast, unable to ambulate or be up in a chair. Bedfast refers to the patient who is confined to the bed, either per physician restriction or due to the patient's inability to tolerate being out of the bed.

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### M1860 Ambulation/Locomotion Data Sources / Resources

- Gather information from several sources:
  - Observation
  - Patient interview
  - Caregiver interview
  - Physical assessment
  - Environmental assessment



Item Intent
Time Points
Response-Specific Instructions
Data Sources/  
Resources


Assessment strategies include using several data sources. For example, you may utilize a combined observation/interview approach with the patient or caregiver to determine the most accurate response for this item. You may ask the patient about his or her ambulation ability. Observe the patient ambulating across the room or to the bathroom and note the type of assistance required. Notice if the patient uses furniture or walls for support, and assess the patient’s ability to safely use all assistive devices. Assess for the need for assistive devices, but do not assume that the patient will be safe with a device that they do not have at the time of the assessment. Instead, score the patient based on the amount of assistance required for safe walking or wheelchair use. During the physical and environmental assessment, you may observe the patient’s ability and safety on stairs if routinely encountered. If chairfast, assess ability to safely propel the wheelchair independently, whether the wheelchair is powered or a manual version.

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### **M1860 Ambulation/Locomotion Scenario**

At the Start of Care visit, you are greeted at the door by the patient. He directs you to follow him into his living room to complete the assessment. You observe he is very unsteady and weak using his walker, and you must provide contact guard and standby assistance the entire trip to the living room for his safety. When asked if his status has changed, he states that since he returned home from the hospital three days ago, he has been weak and unsteady, but since he lives alone and has no help, he performs activities without assistance.



Let's apply the concepts we have just learned to the following scenario. At the Start of Care visit, you are greeted at the door by the patient. He directs you to follow him into his living room to complete the assessment. You observe he is very unsteady and weak using his walker, and you must provide contact guard and standby assistance the entire trip to the living room for his safety. When asked if his status has changed, he states that since he returned home from the hospital three days ago, he has been weak and unsteady, but since he lives alone and has no help, he performs activities without assistance.

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**M1860 Ambulation/ Locomotion Scenario Question**

How would you score M1860 Ambulation/Locomotion?

**(M1860) Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- 3 - Able to walk only with the supervision or assistance of another person at all times.
- 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- 5 - Chairfast, unable to ambulate and is unable to wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair.

[Review Scenario](#) 

How would you score M1860 Ambulation/Locomotion?

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### M1860 Ambulation/ Locomotion Scenario Answer

**(M1860) Ambulation/Locomotion:** Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- 1 - With the use of a one-handed device (e.g. cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- 2 - Requires use of a two-handed device (e.g, walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- 3 - **Able to walk only with the supervision or assistance of another person at all times.**
- 4 - Chairfast, unable to ambulate but is able to wheel self independently.
- 5 - Chairfast, unable to ambulate and is unable to wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair.

That is correct! In this scenario, the patient's performance was that he was walking independently with his walker; however, based on your assessment, you saw that he was weak and unsteady and that he required continuous assistance to be safe. Did you remember the convention we follow when answering the questions in the ADLs / IADLs domain? We are to report the patient's safe ability, not their actual performance.



The correct response is Response 3 - Able to walk only with the supervision or assistance of another person at all times. In this scenario the patient's performance was that he was walking independently with his walker; however, based on your assessment, you saw that he was weak and unsteady and that he required continuous assistance to be safe. He was able to demonstrate that if you assisted him continuously, he could walk safely with his walker. Did you remember the convention we follow when answering the questions in the ADLs / IADLs domain? We are to report the patient's safe ability, not their actual performance.

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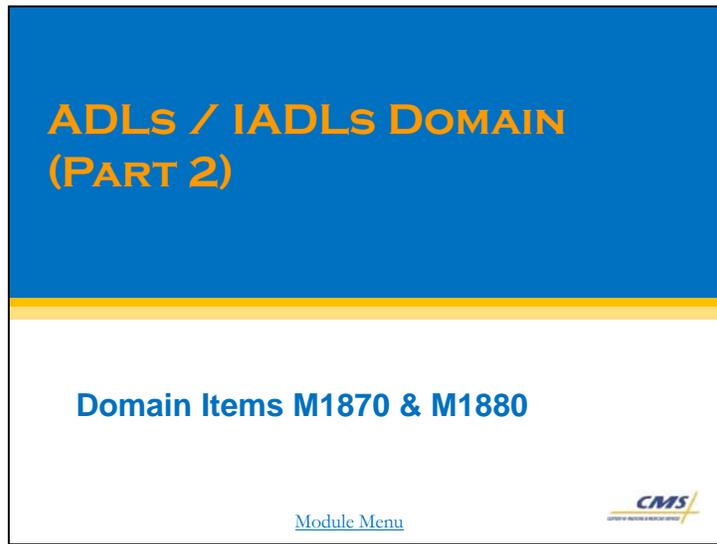
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This topic addresses ADLs / IADLs domain items M1870 and M1880.

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**Summary of M- Items**

- M1800 Grooming
- M1810 Dressing Upper Body
- M1820 Dressing Lower Body
- M1830 Bathing
- M1840 Toilet Transferring
- M1845 Toileting Hygiene
- M1850 Transferring
- M1860 Ambulation/ Locomotion
- M1870 Feeding or Eating
- M1880 Plan & Prepare Light Meals
- M1890 Telephone Use
- M1900 Prior Functioning
- M1910 Fall Risk Assessment



There are 13 OASIS items in the ADLs / IADLs domain. This topic addresses M1870 Feeding or Eating and M1880 Plan & Prepare Light Meals.

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**M1870 Feeding or Eating  
Item Intent & Time Points**

**(M1870) Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- 0 - Able to independently feed self.
- 1 - Able to feed self independently but requires:  
(a) meal set-up; OR  
(b) intermittent assistance or supervision from another person; OR  
(c) a liquid, pureed or ground meat diet.
- 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.
- 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- 5 - Unable to take in nutrients orally or by tube feeding.

**Collected at SOC, ROC & DC Not to Inpatient**

Item Intent      Time Points      Response-Specific Instructions      Data Sources/Resources



The intent of M1870 Feeding or Eating is for the assessing clinician to identify the patient’s ability to feed him/herself, including the process of eating, chewing, and swallowing food. We must assess the patient’s safe ability, not necessarily actual performance. Willingness and compliance are not considered for this item. M1870 Feeding or Eating is collected at the Start of Care, Resumption of Care, and Discharge assessment time points.

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### M1870 Feeding or Eating Includes & Excludes

**(M1870) Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

Includes	Excludes
Eating	Food preparation
Chewing	Transport to table
Swallowing	

Item Intent    Time Points    Response-Specific Instructions    Data Sources/Resources



To select the correct response for the item, we must be sure we are aware of the all the response-specific instructions. Let’s start with what is included and excluded in this item. Notice how the item itself tells us, using underlined words, that this item refers to the process of eating, chewing, and swallowing, not preparing the food to be eaten. The response-specific guidance also notes that transport of the food to the table is excluded. You are instructed to respond to this item based on the assistance needed by the patient to feed himself once the food is placed in front of him.

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### M1870 Feeding or Eating Response-Specific Instructions

**(M1870) Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- 0 - Able to independently feed self.
- 1 - Able to feed self independently but requires:
  - (a) meal set-up; OR
  - (b) intermittent assistance or supervision from another person; OR
  - (c) a liquid, pureed or ground meat diet.
- 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.
- 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- 5 - Unable to take in nutrients orally or by tube feeding.

Most  
Optimal

Less  
Optimal

- Assistance includes verbal cueing, supervision, and/or standby or hands-on assistance.
- If the patient's ability varies, choose the response describing the patient's ability more than 50% of the time period under consideration.

Item Intent
Time Points
Response-Specific  
Instructions
Data Sources/  
Resources

Assistance means human assistance in the form of verbal cueing/reminders, supervision, and/or standby or hands-on assistance. Notice how the response options present the most independent level first, then proceed to more dependent feeding/eating abilities. Read each response carefully to determine which one best describes the patient's ability. If the patient's ability varies during the day of assessment, choose the response describing the patient's ability more than 50% of the time period under consideration.

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### M1870 Feeding or Eating Response-Specific Instructions, cont'd

**(M1870) Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- 0 - Able to independently feed self.
- 1 - Able to feed self independently but requires:
  - (a) meal set-up; **OR**
  - (b) intermittent assistance or supervision from another person; **OR**
  - (c) a liquid, pureed or ground meat diet.
- 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.
- 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- 5 - Unable to take in nutrients orally or by tube feeding.

- Responses 0-3 report oral intake. Responses 4-5 report non-oral intake.
- Meal set-up includes such activities as mashing a potato, cutting up meat or vegetables when served, pouring milk on cereal, opening a milk carton, etc.

Item Intent
Time Points
**Response-Specific Instructions**
Data Sources/  
Resources



Let's take a closer look at each of the response options in this item. Notice that Responses 0-3 report oral intake, and Responses 4 and 5 report non-oral intake. Response 0 - Able to independently feed self means that the patient is able feed him/herself meals and snacks safely including the process of eating, chewing, and swallowing. Response 1 should be marked for a patient who is able to feed him/herself independently but requires:

- Meal set-up; OR
- Intermittent assistance or supervision from another person; OR
- A liquid, pureed or ground meat diet

Meal set-up includes activities such as mashing a potato, cutting up meat or vegetables when served, pouring milk on cereal, opening a milk carton, adding sugar to coffee or tea, and arranging food on a plate for ease of access – all of which are special adaptations of the meal for the patient.

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**M1870 Feeding or Eating  
Response-Specific Instructions, cont'd**

(M1870) **Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- 0 - Able to independently feed self.
- 1 - Able to feed self independently but requires:
  - (a) meal set-up; OR
  - (b) intermittent assistance or supervision from another person; OR
  - (c) a liquid, pureed or ground meat diet.
- 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.
- 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- 5 - Unable to take in nutrients orally or by tube feeding.

Item Intent \_\_\_\_\_ Time Points \_\_\_\_\_ **Response-Specific Instructions** \_\_\_\_\_ Data Sources/  
Resources 

Response 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack means that the patient requires continuous human assistance throughout the meal or snack to safely eat.

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### M1870 Feeding or Eating Response-Specific Instructions, cont'd

(M1870) **Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- 0 - Able to independently feed self.
- 1 - Able to feed self independently but requires:
  - (a) meal set-up; OR
  - (b) intermittent assistance or supervision from another person; OR
  - (c) a liquid, pureed or ground meat diet.
- 2 - Unable to feed self and must be assisted or supervised through-out the meal/snack.
- 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- 5 - Unable to take in nutrients orally or by tube feeding.

- Select Response 3 or 4 if tube feeding is being used to provide all or some nutrition.
- If the patient is being weaned from tube feedings, Response 3 or 4 will continue to apply until the patient no longer uses the tube for nutrition.

Item Intent
Time Points
**Response-Specific Instructions**
Data Sources/  
Resources



If tube feeding is being used to provide all or some nutrition, select Response 3 - Able to take in some nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy, or Response 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy, depending on the patient's ability to take in nutrients orally. If the patient is being weaned from tube feedings, Response 3 or 4 will continue to apply until the patient no longer uses the tube for nutrition, at which time you would select Response 0, 1, or 2. This will be true even if the tube remains in place, unused, for a period of time.

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### M1870 Feeding or Eating Response-Specific Instructions, cont'd

(M1870) **Feeding or Eating:** Current ability to feed self meals and snacks safely. Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.

- 0 - Able to independently feed self.
- 1 - Able to feed self independently but requires:
  - (a) meal set-up; OR
  - (b) intermittent assistance or supervision from another person; OR
  - (c) a liquid, pureed or ground meat diet.
- 2 - Unable to feed self and must be assisted or supervised through-out the meal/snack.
- 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- 5 - Unable to take in nutrients orally or by tube feeding.

- Select Response 5 for patients who receive all nutrition intravenously or for patients who are only receiving intravenous hydration.

 CMS  
Data Sources/  
Resources

Item Intent    Time Points    Response-Specific Instructions    Data Sources/  
Resources

Response 5 - Unable to take in nutrients orally or by tube feeding is the best response for patients who receive all nutrition intravenously, such as Total Parenteral Nutrition, or for patients who are only receiving intravenous hydration.

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**M1870 Feeding or Eating  
Data Sources / Resources**

- Gather information from several sources:
  - Observation
  - Patient & caregiver interview
  - Physical, nutritional, and environmental assessments
  - Physician orders
  - Plan of Care
  - Referral
  - Past health history



Item Intent \_\_\_\_\_ Time Points \_\_\_\_\_ Response-Specific Instructions \_\_\_\_\_ Data Sources/ Resources 

You may gather data from several sources to collect the information necessary for identifying the correct response for this item. You can utilize a combined observation/interview approach. Observe the patient eating a meal or snack and observe the process of eating, chewing, and swallowing. While performing the comprehensive assessment, ask the patient or caregivers about physical, nutritional, or environmental factors that may impact the scoring of this item. Physician orders and a review of past medical history may also be valuable sources of information.

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### M1880 Ability to Prepare Light Meals Item Intent & Time Points

**(M1880)** Current **Ability to Plan and Prepare Light Meals** (e.g., cereal, sandwich) or reheat delivered meals safely:

- 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR  
(b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
- 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- 2 - Unable to prepare any light meals or reheat any delivered meals.



Collected at SOC, ROC & DC Not to Inpatient

Item Intent
Time Points
Response-Specific Instructions
Data Sources/ Resources



The intent of M1880 Ability to Plan and Prepare Light Meals is for the assessing clinician to identify the patient’s physical, cognitive, and mental ability to plan and prepare meals, even if the patient does not routinely perform this task. Consider the patient’s ability, not necessarily actual performance. Willingness and compliance are not considered. Assess the patient holistically, taking into consideration the patient’s current physical and mental/emotional/ cognitive status, activities permitted, and environment. Identify if there are barriers that temporarily or permanently limit the patient’s ability to complete these tasks. This item is collected at the Start of Care, Resumption of Care, and Discharge assessment time points.

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### M1880 Ability to Prepare Light Meals Response-Specific Instructions

(M1880) Current Ability to Plan and Prepare Light Meals (e.g., cereal, sandwich) or reheat delivered meals safely:

- 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; **OR**  
(b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
- 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- 2 - Unable to prepare any light meals or reheat any delivered meals.

- Select response based on what the patient is able to do on the day of assessment.
- If ability varies, select the response that best describes the patient's level of ability to perform the majority of light meal preparation tasks.



Item Intent \_\_\_\_\_ Time Points \_\_\_\_\_ **Response-Specific Instructions** \_\_\_\_\_ Data Sources/ Resources 

When assessing your patient, consider the following response-specific instructions when selecting the correct response. Select your response based on what the patient is able to do on the day of assessment. If ability varies, select the response that best describes the patient's level of ability to perform the majority of light meal preparation tasks.

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**M1880 Ability to Prepare Light Meals  
Response-Specific Instructions, cont'd**

(M1880) Current Ability to Plan and Prepare Light Meals (e.g., cereal, sandwich) or reheat delivered meals safely:

- 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR  
(b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
- 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- 2 - Unable to prepare any light meals or reheat any delivered meals.

- Select Response 0 if the patient has consistent physical and cognitive ability to plan and prepare meals, even though they may not perform the tasks routinely.



Item Intent \_\_\_\_\_ Time Points \_\_\_\_\_ **Response-Specific Instructions** \_\_\_\_\_ Data Sources/Resources [www.cms.gov](#)

Select Response 0 if the patient is able to independently plan and prepare all light meals for him or herself or reheat delivered meals OR if the patient is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past. Both of these options for Response 0 indicate that during the day of assessment, the patient has the consistent physical and cognitive ability to plan and prepare meals even though he or she may not perform the tasks routinely.

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### M1880 Ability to Prepare Light Meals Response-Specific Instructions, cont'd

(M1880) Current Ability to Plan and Prepare Light Meals (e.g., cereal, sandwich) or reheat delivered meals safely:

- 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR  
(b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
- 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- 2 - Unable to prepare any light meals or reheat any delivered meals.

- Select Response 1 if on the day of assessment the patient has inconsistent ability to prepare light meals.
- Select Response 2 if the patient does not have the ability to prepare light meals at any point during the day of assessment.



Data Sources/  
Resources 

Item Intent \_\_\_\_\_ Time Points \_\_\_\_\_ **Response-Specific Instructions** \_\_\_\_\_

Select Response 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations, when during the day of assessment, the patient has inconsistent ability to prepare light meals. For example, the patient may not be able to prepare breakfast due to morning arthritic stiffness, but can prepare other meals throughout the day.

Response 2 - Unable to prepare any light meals or reheat any delivered meals, indicates the patient does not have the ability to prepare light meals at any point during the day of assessment.

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### M1880 Ability to Prepare Light Meals Response-Specific Instructions, cont'd

(M1880) Current Ability to Plan and Prepare Light Meals (e.g., cereal, sandwich) or reheat delivered meals safely:

- 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; **OR**  
(b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
- 1 - **Unable** to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- 2 - Unable to prepare any light meals or reheat any delivered meals.

- Consider the patient's ability to plan and prepare a prescribed diet, including their knowledge of the feeding amount and ability to prepare the enteral feeding.
- The ability to set up, monitor, and change feeding equipment is excluded from this item.

Item Intent
Time Points
**Response-Specific Instructions**
Data Sources/  
Resources



While the nutritional appropriateness of the patient's food selections is not the focus of this item, any prescribed diet requirements (and related planning and preparation) should be considered when selecting a response. When a patient's prescribed diet consists either partially or completely of enteral nutrition, assess the patient's ability to plan and prepare their prescribed diet, including their knowledge of the feeding amount and ability to prepare the enteral feeding, based on the product used. Note that the ability to set up, monitor and change the feeding equipment is excluded from M1880, but it is addressed in another OASIS item, M2100 row (e).

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### M1880 Ability to Prepare Light Meals Data Sources / Resources

- Gather information from several sources:
  - Observation
  - Patient interview
  - Caregiver interview
  - Physical, nutritional, and environmental assessments



Item Intent \_\_\_\_\_ Time Points \_\_\_\_\_ Response-Specific Instructions \_\_\_\_\_ Data Sources/ Resources 

When assessing your patient’s ability to plan and prepare light meals, you may gather information from several sources to help you select an appropriate response. For identifying meal planning and preparation ability, the preferred method is to observe the patient demonstrating the tasks. You can also interview the patient and/or caregiver. You may obtain this information while performing your physical, nutritional, and environmental assessments.

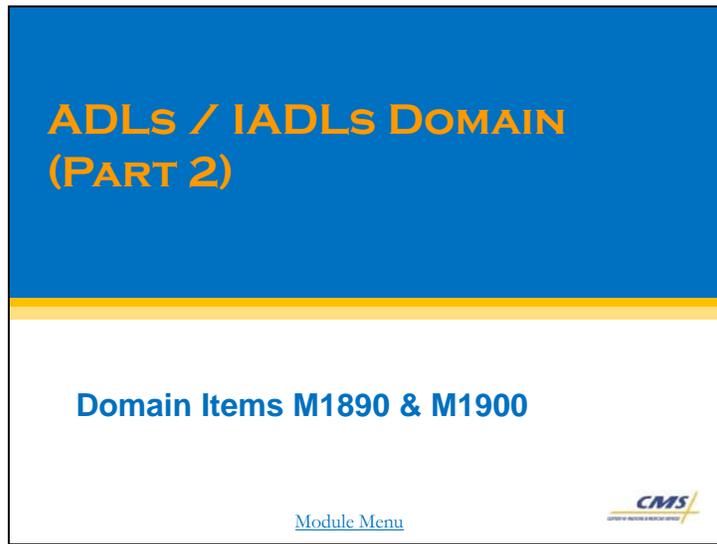
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This topic addresses ADLs / IADLs domain items M1890 and M1900.

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**Summary of M- Items**

- M1800 Grooming
- M1810 Dressing Upper Body
- M1820 Dressing Lower Body
- M1830 Bathing
- M1840 Toilet Transferring
- M1845 Toileting Hygiene
- M1850 Transferring
- M1860 Ambulation/ Locomotion
- M1870 Feeding or Eating
- M1880 Plan & Prepare Light Meals
- M1890 Telephone Use
- M1900 Prior Functioning
- M1910 Fall Risk Assessment



There are 13 OASIS items in the ADLs / IADLs domain. This topic addresses M1890 Telephone Use and M1900 Prior Functioning.

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### M1890 Telephone Use Item Intent & Time Points

**(M1890) Ability to Use Telephone:** Current ability to answer the phone safely, including dialing number and effectively using the telephone to communicate.

- 0 - Able to dial numbers and answer calls appropriately and as desired.
- 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.
- 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
- 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
- 4 - Unable to answer the telephone at all but can listen if assisted with equipment.
- 5 - Totally unable to use the telephone.
- NA - Patient does not have a telephone.



**Collected at SOC, ROC & DC Not to Inpatient**

Item Intent \_\_\_\_\_ Time Points \_\_\_\_\_ Response-Specific Instructions \_\_\_\_\_ Data Sources/Resources \_\_\_\_\_



The intent of M1890 Telephone Use is for the assessing clinician to identify the ability of the patient to answer the phone, dial numbers, and effectively use the telephone to communicate. Assessment should identify the patient’s safe ability, not necessarily actual performance. Willingness and compliance are not considered for this item. When assessing for this item, take into consideration the patient’s current physical and mental/emotional/cognitive status, activities permitted, and environment to determine if ability has been permanently or temporarily limited. This item is collected at the Start of Care, Resumption of Care, and Discharge assessment time points.

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### M1890 Telephone Use

#### Response-Specific Instructions

(M1890) Ability to Use Telephone: Current ability to answer the phone safely, including dialing number and effectively using the telephone to communicate.

- 0 - Able to dial numbers and answer calls appropriately and as desired.
- 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.
- 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
- 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
- 4 - Unable to answer the telephone at all but can listen if assisted with equipment.
- 5 - Totally unable to use the telephone.
- NA - Patient does not have a telephone.

Most  
Optimal



Less  
Optimal

- If ability varies on the day of assessment, choose the response describing the patient's ability greater than 50% of the time period under consideration.
- Select Response 1 for a speech-impaired patient who can only communicate using a phone equipped with texting functionality.

Item Intent
Time Points
**Response-Specific Instructions**
Data Sources/  
Resources



When selecting the correct response for M1890 Telephone Use, consider what the patient is able to do on the day of assessment. If ability varies, choose the response that describes the patient's ability greater than 50% of the time period under consideration. Notice how the response options present the most independent level first, then proceed to the most dependent. This item identifies the patient's ability to safely answer the phone, dial a number, and effectively use the telephone to communicate. If a speech-impaired patient can only communicate using a phone equipped with texting functionality, select Response 1 - Able to use a specially adapted telephone.

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### M1890 Telephone Use Data Sources / Resources

- Gather information from several sources:
  - Observation
  - Patient interview
  - Caregiver interview
  - Physical and environmental assessments



Item Intent \_\_\_\_\_ Time Points \_\_\_\_\_ Response-Specific Instructions \_\_\_\_\_ Data Sources/ Resources 

When assessing your patient’s ability to use the telephone, you may gather information from several sources to help you select an appropriate response. For identifying the patient’s ability to use the phone, the preferred method is to have the patient demonstrate the tasks for you to observe. You can also interview the patient and/or caregiver. You may obtain this information while performing your physical and environmental assessments.

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### M1900 Prior Functioning ADL/IADL Item Intent & Time Points

(M1900) **Prior Functioning ADL/IADL:** Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury. Check only **one** box in each row.

Functional Area	Independent	Needed Some Help	Dependent
a. Self-Care (e.g., grooming, dressing, and bathing)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. Ambulation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. Transfer	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. Household tasks (e.g., light meal preparation, laundry, shopping)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2

Collected at SOC & ROC

Item Intent    Time Points    Response-Specific Instructions    Data Sources/Resources

M1900 Prior Functioning ADL/IADL is used to report the patient’s functional ability prior to the onset of the current illness, exacerbation of a chronic condition, or injury (whichever is the most recent) that initiated this episode of care. Assess the patient’s prior ability, not necessarily their actual performance. This item is collected at the Start of Care and Resumption of Care assessment time points and can be helpful for setting realistic goals for the patient.

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### M1900 Prior Functioning ADL/IADL Response-Specific Instructions

Functional Area	Includes:
Self-care	Grooming, dressing, bathing, and toileting hygiene
Ambulation	Walking (with or without assistive device)
Transfer	Tub, shower, commode, and bed to chair transfers
Household tasks	Light meal preparation, laundry, shopping, and phone use

- Wheelchair mobility is not directly addressed in this item. A patient who is unable to walk (even with devices and/or assistance) but is able to use a wheelchair (with or without assistance) would be reported as “dependent” in ambulation for this item.

Item Intent
Time Points
**Response-Specific Instructions**
Data Sources/  
Resources

To select the correct response for this item, it is important to understand what is included in each functional area. “Self-care” includes grooming, dressing, bathing, and toileting hygiene. “Ambulation” includes walking (with or without an assistive device). Wheelchair mobility is not directly addressed in this item. For example, a patient who is unable to walk safely (even with devices and/or assistance) but is able to use a wheelchair (with or without assistance) would be reported as “dependent” in ambulation for this item. “Transfer” refers specifically to tub, shower, commode, and bed to chair transfers. “Household tasks” refers specifically to light meal preparation, laundry, shopping, and phone use.

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### M1900 Prior Functioning ADL/IADL Response-Specific Instructions, cont'd

(M1900) **Prior Functioning ADL/IADL:** Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury. Check only **one** box in each row.

Functional Area	Independent	Needed Some Help	Dependent
a. Self-Care (e.g., grooming, dressing, and bathing)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. Ambulation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. Transfer	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. Household tasks (e.g., light meal preparation, laundry, shopping)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2

**Independent** means the patient had the ability to complete the activity by him or herself (with or without assistive devices) without physical or verbal assistance from a helper.

**Needed some help** means the patient contributed effort but required help from another person to accomplish the task/activity safely.

**Dependent** means the patient was physically and/or cognitively unable to contribute effort toward completion of the task, and the helper must contribute all the effort.

Item Intent    Time Points    **Response-Specific Instructions**    Data Sources/ Resources

Let's also define what is meant by Independent, Needed Some Help, and Dependent. "Independent" means that the patient had the ability to complete the activity by him or herself (with or without assistive devices), without physical or verbal assistance from a helper. "Needed Some Help" means that the patient contributed effort but required help from another person to accomplish the task/activity safely. "Dependent" means that the patient was physically and/or cognitively unable to contribute effort toward completion of the task, and the helper contributed all the effort.

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### M1900 Prior Functioning ADL/IADL Response-Specific Instructions, cont'd

**(M1900) Prior Functioning ADL/IADL:** Indicate the patient's usual ability with everyday activities prior to this current illness, exacerbation, or injury. Check only **one** box in each row.

Functional Area	Independent	Needed Some Help	Dependent
a. Self-Care (e.g., grooming, dressing, and bathing)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
b. Ambulation	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
c. Transfer	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2
d. Household tasks (e.g., light meal preparation, laundry, shopping)	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2

- If the patient's ability to perform the tasks listed in each functional area varies, then you should select the response that best reflects the patient's level of ability to perform the majority of included tasks.

Item Intent
Time Points
**Response-Specific Instructions**
Data Sources/  
Resources

If the patient's ability to perform the tasks listed in each functional area varies, then you should select the response that best reflects the patient's level of ability to perform the majority of included tasks. For example, if the patient was previously independent in light meal preparation, but needed help with laundry, shopping and phone use, the correct response for household tasks would be "Needed Some Help."

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**M1900 Prior Functioning ADL/IADL  
Data Sources / Resources**

- Gather information from several sources:
  - Patient interview
  - Caregiver interview
  - Referral information
  - Past medical history
  - Physician



Item Intent \_\_\_\_\_ Time Points \_\_\_\_\_ Response-Specific Instructions \_\_\_\_\_ Data Sources/  
Resources 

When assessing the patient’s prior functioning related to ADL and IADL ability, you may gather the data from a variety of sources. You may gather valuable information from interviewing the patient or caregiver, from reviewing relevant referral information, from past medical history, or from the physician.

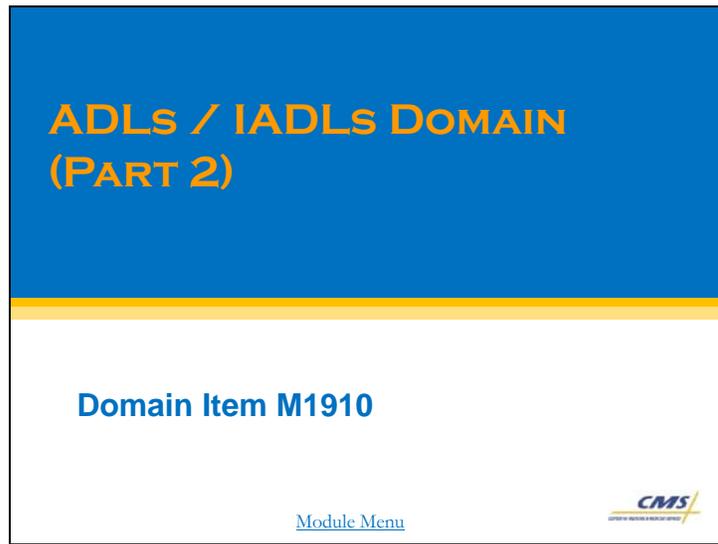
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This topic addresses ADLs / IADLs domain item M1910.

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**Summary of M- Items**

- M1800 Grooming
- M1810 Dressing Upper Body
- M1820 Dressing Lower Body
- M1830 Bathing
- M1840 Toilet Transferring
- M1845 Toileting Hygiene
- M1850 Transferring
- M1860 Ambulation/ Locomotion
- M1870 Feeding or Eating
- M1880 Plan & Prepare Light Meals
- M1890 Telephone Use
- M1900 Prior Functioning
- M1910 Fall Risk Assessment



There are 13 OASIS items in the ADLs / IADLs domain. This topic addresses M1910 Fall Risk Assessment.

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**M1910 Fall Risk Assessment**  
**Item Intent & Time Points**

**(M1910)** Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?

- 0 - No multi-factor falls risk assessment conducted.
- 1 - Yes, and it does not indicate a risk for falls.
- 2 - Yes, and it indicates a risk for falls.



**Collected at SOC & ROC**

Item Intent    Time Points    Response-Specific Instructions    Data Sources/Resources



M1910 Fall Risk Assessment identifies whether the home health agency has assessed the patient and home environment for characteristics that put the patient at risk for falls. This item is used to calculate process measures to capture the agency’s use of the best practice of including a falls risk assessment as part of the comprehensive assessment. The best practice, as stated in the item, is not necessarily required in the Conditions of Participation. M1910 is collected at the Start of Care and Resumption of Care assessment time points.

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**M1910 Fall Risk Assessment  
Item Intent**

- Multi-factor Falls Risk Assessment must:
  - Include at least one standardized tool that
    - Has been scientifically tested in a population with characteristics similar to that of the patient being assessed and shown to be effective in identifying people at risk for falls, and
    - Includes a standard response scale
  - Be appropriate for the patient based on cognitive and physical status
  - Be appropriately administered as indicated in the instructions

Item Intent    Time Points    Response-Specific Instructions    Data Sources/Resources



The multi-factor falls risk assessment must include at least one standardized tool that has been scientifically tested *in a population with characteristics similar to that of the patient being assessed; for example, community dwelling elders or non-institutionalized adults with disabilities*. The assessment must be shown to be effective in identifying people at risk for falls and include a standard response scale. The standardized tool must be both appropriate for the patient based on their cognitive and physical status and appropriately administered as indicated in the instructions. In other words, the patient must have the cognitive ability to follow commands and the physical ability to be able to perform the tasks exactly as stated in the specific tool used.

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### M1910 Fall Risk Assessment Response-Specific Instructions

(M1910) Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?

0 - No multi-factor falls risk assessment conducted.  
 1 - Yes, and it does not indicate a risk for falls.  
 2 - Yes, and it indicates a risk for falls.

Select Response 0 if:

- Standard validated multi-factor falls risk screening was NOT conducted by the home health agency, OR
- Screening was conducted but NOT during required assessment time frame, OR
- Screening was conducted but NOT by the assessing clinician, OR
- Patient is not able to participate in tasks required to allow completion and scoring of the standardized assessment.

Item Intent
Time Points
**Response-Specific Instructions**
Data Sources/  
Resources

The assessing clinician will select Response 0 – No multi-factor falls risk assessment conducted if:

- A standardized validated multi-factor falls risk screening was NOT conducted by the home health agency, OR
- A standardized validated multi-factor falls risk screening was conducted by the home health agency but NOT during the required assessment time frame; OR
- A standardized validated multi-factor falls risk screening was conducted during the assessment time frame, but NOT by the assessing clinician; OR
- The patient is not able to participate in tasks required to allow the completion and scoring of the standardized assessment that the agency chooses to utilize.

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**M1910 Fall Risk Assessment  
Response-Specific Instructions, cont'd**

(M1910) Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?

0 - No multi-factor falls risk assessment conducted.  
 1 - Yes, and it does not indicate a risk for falls.  
 2 - Yes, and it indicates a risk for falls.

- For Responses 1 and 2, the agency may use a single comprehensive multi-factor falls risk assessment tool that meets the criteria described in the item intent, or it may incorporate several tools as long as one of them meets the criteria described in the item intent.



Item Intent    Time Points    **Response-Specific Instructions**    Data Sources/  
Resources

It is important to note that for this item, the Centers for Medicare & Medicaid Services (CMS) does not mandate that clinicians conduct a falls risk screening for all patients, nor is there a mandate for the use of a specific tool. For Responses 1 and 2, the assessing clinician may use a single comprehensive multi-factor falls risk assessment tool that meets the criteria described in the item intent, or the clinician may combine two or more tools, as long as one of them meets the criteria described in the item intent.

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### M1910 Fall Risk Assessment Response-Specific Instructions, cont'd

(M1910) Has this patient had a multi-factor **Fall Risk Assessment** (such as falls history, use of multiple medications, mental impairment, toileting frequency, general mobility/transferring impairment, environmental hazards)?

0 - No multi-factor falls risk assessment conducted.  
 1 - Yes, and it does not indicate a risk for falls.  
 2 - Yes, and it indicates a risk for falls.

- Select Response 1 if the standardized response scale rates the patient as no-risk, low-risk, or minimal risk.
- Select Response 2 if the standardized response scale rates the patient as anything above low/minimal risk.
- To select Response 1 or 2, the fall risk assessment must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS.

Item Intent
Time Points
**Response-Specific Instructions**
Data Sources/  
Resources

The assessing clinician must use the scoring parameters included in the specific tool used to identify if a patient is at risk for falls. Select Response 1 if the findings from applying the standardized response scale rate the patient as no-risk, low-risk, or minimal risk. Select Response 2 if the standardized response scale rates the patient as anything above low/minimal risk. In order to select Response 1 or 2, the fall risk assessment must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment.

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**M1910 Fall Risk Assessment  
Data Sources / Resources**

- Gather information from several sources:
  - Observation
  - Patient interview
  - Caregiver interview
  - Physical and environmental assessments
  - Referral information
  - Past medical history
  - Physician
- Links to guidelines listing fall risk assessment factors can be found in [Chapter 5 of the OASIS-C Guidance Manual](#).



Item Intent \_\_\_\_\_ Time Points \_\_\_\_\_ Response-Specific Instructions \_\_\_\_\_ **Data Sources/ Resources** 

When assessing the patient’s risk for falls, you may gather the data from a variety of sources. You may gain valuable information from observing the patient performing tasks, interviewing the patient or caregiver, from reviewing relevant referral information, from past medical history, or from the physician. Several links to guidelines listing fall risk assessment factors can be found in Chapter 5 of the OASIS-C Guidance Manual.

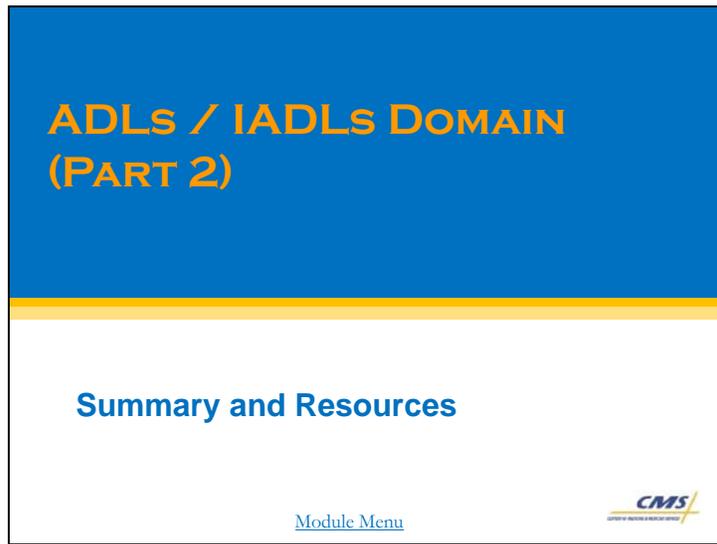
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We have completed the instruction for this module. You may want to review the material again or refer to the CMS OASIS-C Guidance Manual and Q & As. Let’s recap some highlights of what we learned.

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**Summary of Domain**

- Understand each item and the individual responses.
- Use Chapter 3 of the OASIS- C guidance manual as your reference for the following concepts:
  - Item intent
  - Time points for completion
  - Response-specific instructions
  - Data sources and resources
- Additional guidance can be found in the CMS Q & As and the CMS Quarterly Q & As.



In summary, in order to accurately collect the items in the ADLs / IADLs domain, it will be important for the assessing clinician to understand each item and its individual responses. Use Chapter 3 of the OASIS-C guidance manual as your reference to apply concepts and details related to the intent of each OASIS item, when each item should be completed, what the various response options mean, and what data sources and resources you can use to facilitate an accurate assessment. You can find additional guidance related to data collection in the CMS Q & As and the CMS Quarterly OASIS Q & As.

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**Resources / References**

- OASIS-C Guidance Manual
  - [www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual.html)
  - Chapter 3 provides guidance on OASIS-C questions.
  - Chapter 5 provides links to guidelines listing fall risk assessment factors.
- CHAMP Program
  - [www.champ-program.org/](http://www.champ-program.org/)
- Home Health Quality Improvement (HHQI) National Campaign
  - [www.homehealthquality.org](http://www.homehealthquality.org)
- OASIS Answers, Inc.
  - [www.oasisanswers.com](http://www.oasisanswers.com)

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You can access additional resources and references at the links listed here. Particularly important is the guidance in Chapter 3 of the OASIS-C Guidance Manual, which served as the foundational content for this educational module. Home care nurses and therapists responsible for collecting OASIS data should consider having a copy of the Chapter 3 guidance accessible while conducting comprehensive assessments to enhance data accuracy.

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**Questions**

- Talk with your clinical managers.
- Email OASIS training feedback site.
  - [oasisctrainingfeedback@cms.hhs.gov](mailto:oasisctrainingfeedback@cms.hhs.gov)
- Check the CMS Q & As.
  - [www.qtso.com/hhdownload.html](http://www.qtso.com/hhdownload.html)
- Check the Quarterly Q & As.
  - [www.oasisanswers.com](http://www.oasisanswers.com)
- Contact State OASIS Educational Coordinators.
  - [www.cms.gov/OASIS/Downloads/OASISeducationalcoordinators.pdf](http://www.cms.gov/OASIS/Downloads/OASISeducationalcoordinators.pdf)
- Submit Q & As to CMS.
  - [Send email to: CMSOASISquestions@oasisanswers.com](mailto:CMSOASISquestions@oasisanswers.com)



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If you have questions, consider talking with your clinical managers. If you have comments related to this training module, consider providing feedback to the OASIS training feedback mailbox at [oasisctrainingfeedback@cms.hhs.gov](mailto:oasisctrainingfeedback@cms.hhs.gov). For additional guidance, download and review the CMS Q & As and the Quarterly Q & A updates, available at the links provided here. If you still have an unanswered data collection question after consulting the guidance contained in Chapter 3 of the OASIS-C Guidance Manual and the OASIS Q & As, contact your State OASIS Educational Coordinator, who can provide free assistance in answering your OASIS data collection questions. If your question cannot be resolved with the help of your OEC, consider submitting your inquiry to the CMS OASIS mailbox at [CMSOASISquestions@oasisanswers.com](mailto:CMSOASISquestions@oasisanswers.com). Thank you for your commitment to OASIS accuracy.

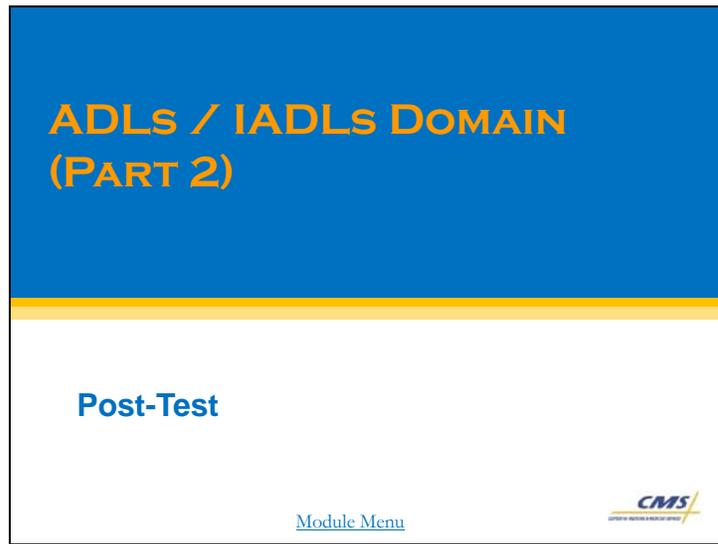
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This is the ADLs / IADLs Domain Part 2 Module Post-Test. This test consists of five questions pertaining to the material covered in this lesson. Read each question, select an answer, and then select the Submit button.

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**Post-Test Question #1**

A patient's family refused to let her be admitted to rehab after a long hospital stay, stating they could take care of her at home. She is severely deconditioned and needs considerable assistance to come to a sitting position at the side of the bed and then again to stand. Once standing, she requires someone to support the majority of her weight as she pivots to sit on the chair at the bedside. She only tolerates sitting up for 10 minutes before she requests to return to bed, again requiring the same level of assistance to safely transfer. How would you score M1850 Transferring?

- A. Response 0 – Able to independently transfer.
- B. Response 1 – Able to transfer with minimal human assistance or with use of an assistive device.
- C. Response 2 – Able to bear weight and pivot during the transfer process but unable to transfer self.
- D. Response 3 – Unable to transfer self and is unable to bear weight or pivot when transferred by another person.

That is correct! "Able to bear weight" refers to the patient's ability to support the majority of his/her weight through any combination of weight-bearing extremities. The patient must be able to both bear weight and pivot for Response 2 to apply. If the patient is unable to do one or the other and is not bedfast, select Response 3.

 [Submit](#)

The correct answer is D. Response 3 – Unable to transfer self and is unable to bear weight or pivot when transferred by another person. "Able to bear weight" refers to the patient's ability to support the majority of his/her weight through any combination of weight-bearing extremities. The patient must be able to both bear weight and pivot for Response 2 to apply. If the patient is unable to do one or the other and is not bedfast, select Response 3.

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**Post-Test Question #2**

During your assessment, you observe your patient ambulates with a single point cane. You observe that he is safe on all surfaces, except he needs someone close by when he negotiates the two steps into his sunken family room as he tends to lose his balance easily on stairs. How would you score M1860 Ambulation/Locomotion?

- A. Response 0 – Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings (i.e., needs no human assistance or assistive device).
- B. Response 1 – With the use of a one-handed device (e.g., cane, single crutch, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- C. Response 2 – Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires supervision or assistance to negotiate stairs or steps or uneven surfaces.
- D. Response 3 – Able to walk only with the supervision or assistance of another person at all times.

That is correct! Response 2 is the correct response since the scenario identifies that the patient requires a one-handed device AND assistance on the stairs.

[Submit](#)



The correct answer is C. Response 2 - Requires use of a two-handed device (e.g., walker or crutches) to walk alone on a level surface and/or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces. Response 2 is the correct response since the scenario identifies that the patient requires a one-handed device AND assistance on the stairs.

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**Post-Test Question #3**

At the Start of Care visit on Tuesday, your patient had a gastrostomy tube in place. Although the physician's order on the referral stated, "No p.o. intake until Wednesday," the RN found the G-tube clamped, and the patient was drinking a milkshake without difficulty. What is the correct response to M1870 Feeding or Eating?

- A. Response 1 – Able to feed self independently but requires:
  - (a) meal set-up; **OR**
  - (b) intermittent assistance or supervision from another person; **OR**
  - (c) a liquid, pureed or ground meat diet.
- B. Response 2 – Unable to feed self and must be assisted or supervised throughout the meal/snack.
- C. Response 3 – Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- D. Response 4 – Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.

That is correct! The patient was performing above his ability when drinking a milkshake. The physician's medical restriction sets the patient's safe ability at "Unable to take in nutrients orally." Ability is reported in the OASIS. Ability and performance do not necessarily match.

[Submit](#)



The correct answer is D. Response 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy. The patient was performing above his ability when drinking a milkshake. The physician's medical restriction sets the patient's safe ability at "Unable to take in nutrients orally." Ability is reported in the OASIS. Ability and performance do not necessarily match.

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**Post-Test Question #4**

Your patient safely and independently prepared a bowl of cereal and peeled a banana for breakfast on the day of the assessment. She states and you observe that she has difficulty with tasks that require more than a few steps. You determine she would not be able to prepare a sandwich or dinner meal. What is the correct score for M1880 Ability to Plan and Prepare Light Meals?

- A. Response 0 – (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR  
(b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
- B. Response 1 – Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- C. Response 2 – Unable to prepare any light meals or reheat any delivered meals.
- D. Response UK – Unknown

That is correct! Response 1 indicates that during the day of the assessment, the patient has inconsistent ability to prepare light meals. This patient was able to plan and prepare breakfast, but not lunch or dinner.

 Submit

The correct answer is B. Response 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations. Response 1 indicates that during the day of the assessment, the patient has inconsistent ability to prepare light meals. This patient was able to plan and prepare breakfast, but not lunch or dinner.

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**Post-Test Question #5**

The RN performs the Start of Care comprehensive assessment but waits to answer M1910 Fall Risk Assessment until the Physical Therapist sees the patient the next day and completes the fall risk assessment and calls the RN with results, which indicate that the patient is at minimal risk for falls. How would you answer M1910 Fall Risk Assessment?

- A. Response 0 – No multi-factor falls risk assessment conducted.
- B. Response 1 – Yes, and it does not indicate a risk for falls.
- C. Response 2 – Yes, and it indicates a risk for falls.
- D. Response UK – Unknown

That is correct! The response-specific guidance states that in order to select Response 1 or 2, the fall risk assessment must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment.

Submit



The correct answer is A. Response 0 - No multi-factor falls risk assessment conducted. The response-specific guidance states that in order to select Response 1 or 2, the fall risk assessment must be conducted by the clinician responsible for completing the comprehensive assessment during the time frame specified by CMS for completion of the assessment.

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