MINIMUM DATA SET (MDS) - Version 3.0

RESIDENT ASSESSMENT AND CARE SCREENING

Nursing Home Quarterly (NQ) Item Set

Section A Identification Information

A0100. Facility Provider Numbers

A. National Provider Identifier (NPI):

B. CMS Certification Number (CCN):

C. State Provider Number:

A0200. Type of Provider

Enter Code

Type of provider
1. **Nursing home (SNF/NF)**
2. **Swing Bed**

A0310. Type of Assessment

Enter Code

A. Federal OBRA Reason for Assessment
01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code

B. PPS Assessment
PPS Scheduled Assessments for a Medicare Part A Stay
01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment
PPS Unscheduled Assessments for a Medicare Part A Stay
07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)
Not PPS Assessment
99. **Not PPS** assessment

Enter Code

C. PPS Other Medicare Required Assessment - OMRA
0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

Enter Code

D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2
0. **No**
1. **Yes**

Enter Code

E. Is this assessment the first assessment (OBRA, PPS, or Discharge) **since the most recent admission?**
0. **No**
1. **Yes**

Enter Code

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

Resident _____ Identifier _____ Date _____

Section A Identification Information

A0410. Submission Requirement

Enter Code ☐

1. **Neither federal nor state required submission**
2. **State but not federal required submission** (FOR NURSING HOMES ONLY)
3. **Federal required submission**

A0500. Legal Name of Resident

A. First name: ☐☐☐☐☐☐☐☐☐☐☐☐

B. Middle initial: ☐

C. Last name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. Suffix: ☐☐☐

A0600. Social Security and Medicare Numbers

A. Social Security Number: ☐☐☐ – ☐☐ – ☐☐☐☐

B. Medicare number (or comparable railroad insurance number)**:** ☐☐☐☐☐☐☐☐☐☐☐☐

A0700. Medicaid Number - Enter "+" if pending, "N" if not a Medicaid recipient

☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A0800. Gender

Enter Code ☐

1. **Male**
2. **Female**

A0900. Birth Date

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

A1000. Race/Ethnicity

Check all that apply

- ☐ **A. American Indian or Alaska Native**
- ☐ **B. Asian**
- ☐ **C. Black or African American**
- ☐ **D. Hispanic or Latino**
- ☐ **E. Native Hawaiian or Other Pacific Islander**
- ☐ **F. White**

A1100. Language

Enter Code ☐

A. Does the resident need or want an interpreter to communicate with a doctor or health care staff?

0. **No**
1. **Yes** → Specify in A1100B, Preferred language
9. **Unable to determine**

B. Preferred language: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1200. Marital Status

Enter Code ☐

1. **Never married**
2. **Married**
3. **Widowed**
4. **Separated**
5. **Divorced**

A1300. Optional Resident Items

A. Medical record number:

☐☐☐☐☐☐☐☐☐☐☐☐

B. Room number:

☐☐☐☐☐☐☐☐☐☐

C. Name by which resident prefers to be addressed:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

D. Lifetime occupation(s) - put "/" between two occupations**:**

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

A1500. Preadmission Screening and Resident Review (PASRR)

Complete only if A0310A = 01

Enter Code ☐

Has the resident been evaluated by Level II PASRR and determined to have a serious mental illness and/or mental retardation or a related condition?

0. **No**
1. **Yes**
9. **Not a Medicaid certified unit**

A1550. Conditions Related to MR/DD Status

If the resident is 22 years of age or older, complete only if A0310A = 01

If the resident is 21 years of age or younger, complete only if A0310A = 01, 03, 04, or 05

↓ **Check all conditions that are related to MR/DD status** that were manifested before age 22, and are likely to continue indefinitely

MR/DD With Organic Condition

☐ **A. Down syndrome**

☐ **B. Autism**

☐ **C. Epilepsy**

☐ **D. Other organic condition related to MR/DD**

MR/DD Without Organic Condition

☐ **E. MR/DD with no organic condition**

No MR/DD

☐ **Z. None of the above**

A1600. Entry Date (date of this admission/reentry into the facility)

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

A1700. Type of Entry

Enter Code ☐

1. **Admission**
2. **Reentry**

Resident _____ Identifier _____ Date _____

Section A Identification Information

A1800. Entered From

Enter Code: ☐☐

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
99. **Other**

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

A2100. Discharge Status

Complete only if A0310F = 10, 11, or 12

Enter Code: ☐☐

01. **Community** (private home/apt., board/care, assisted living, group home)
02. **Another nursing home or swing bed**
03. **Acute hospital**
04. **Psychiatric hospital**
05. **Inpatient rehabilitation facility**
06. **MR/DD facility**
07. **Hospice**
08. **Deceased**
99. **Other**

A2200. Previous Assessment Reference Date for Significant Correction

Complete only if A0310A = 05 or 06

☐☐ – ☐☐ – ☐☐☐☐

Month Day Y ear

A2300. Assessment Reference Date

Observation end date:

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

A2400. Medicare Stay

Enter Code: ☐

A. Has the resident had a Medicare-covered stay since the most recent entry?

0. **No** → Skip to B0100, Comatose
1. **Yes** → Continue to A2400B, Start date of most recent Medicare stay

B. Start date of most recent Medicare stay:

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

Resident _____ Identifier _____ Date _____

Look back period for all items is 7 days unless another time frame is indicated

Section B Hearing, Speech, and Vision

B0100. Comatose

Enter Code ☐

Persistent vegetative state/no discernible consciousness
0. **No** → Continue to B0200, Hearing
1. **Yes** → Skip to G0110, Activities of Daily Living (ADL) Assistance

B0200. Hearing

Enter Code ☐

Ability to hear (with hearing aid or hearing appliances if normally used)
0. **Adequate** - no difficulty in normal conversation, social interaction, listening to TV
1. **Minimal difficulty** - difficulty in some environments (e.g., when person speaks softly or setting is noisy)
2. **Moderate difficulty** - speaker has to increase volume and speak distinctly
3. **Highly impaired** - absence of useful hearing

B0300. Hearing Aid

Enter Code ☐

Hearing aid or other hearing appliance used in completing B0200, Hearing
0. **No**
1. **Yes**

B0600. Speech Clarity

Enter Code ☐

Select best description of speech pattern
0. **Clear speech** - distinct intelligible words
1. **Unclear speech** - slurred or mumbled words
2. **No speech** - absence of spoken words

B0700. Makes Self Understood

Enter Code ☐

Ability to express ideas and wants, consider both verbal and non-verbal expression
0. **Understood**
1. **Usually understood** - difficulty communicating some words or finishing thoughts **but** is able if prompted or given time
2. **Sometimes understood** - ability is limited to making concrete requests
3. **Rarely/never understood**

B0800. Ability To Understand Others

Enter Code ☐

Understanding verbal content, however able (with hearing aid or device if used)
0. **Understands** - clear comprehension
1. **Usually understands** - misses some part/intent of message **but** comprehends most conversation
2. **Sometimes understands** - responds adequately to simple, direct communication only
3. **Rarely/never understands**

B1000. Vision

Enter Code ☐

Ability to see in adequate light (with glasses or other visual appliances)
0. **Adequate** - sees fine detail, including regular print in newspapers/books
1. **Impaired** - sees large print, but not regular print in newspapers/books
2. **Moderately impaired** - limited vision; not able to see newspaper headlines but can identify objects
3. **Highly impaired** - object identification in question, but eyes appear to follow objects
4. **Severely impaired** - no vision or sees only light, colors or shapes; eyes do not appear to follow objects

B1200. Corrective Lenses

Enter Code ☐

Corrective lenses (contacts, glasses, or magnifying glass) used in completing B1000, Vision
0. **No**
1. **Yes**

Section C Cognitive Patterns

C0100. Should Brief Interview for Mental Status (C0200-C0500) be Conducted?
Attempt to conduct interview with all residents

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete C0700-C1000, Staff Assessment for Mental Status
1. **Yes** → Continue to C0200, Repetition of Three Words

Brief Interview for Mental Status (BIMS)

C0200. Repetition of Three Words

Enter Code ☐

Ask resident: *"I am going to say three words for you to remember. Please repeat the words after I have said all three. The words are:* ***sock, blue, and bed.*** *Now tell me the three words."*

Number of words repeated after first attempt

0. **None**
1. **One**
2. **Two**
3. **Three**

After the resident's first attempt, repeat the words using cues ("*sock, something to wear; blue, a color; bed, a piece of furniture*"). You may repeat the words up to two more times.

C0300. Temporal Orientation (orientation to year, month, and day)

Enter Code ☐

Ask resident: "*Please tell me what year it is right now*."

A. Able to report correct year

0. **Missed by > 5 years** or no answer
1. **Missed by 2-5 years**
2. **Missed by 1 year**
3. **Correct**

Enter Code ☐

Ask resident: "*What month are we in right now?*"

B. Able to report correct month

0. **Missed by > 1 month** or no answer
1. **Missed by 6 days to 1 month**
2. **Accurate within 5 days**

Enter Code ☐

Ask resident: "*What day of the week is today?*"

C. Able to report correct day of the week

0. **Incorrect** or no answer
1. **Correct**

C0400. Recall

Enter Code ☐

Ask resident: "*Let's go back to an earlier question. What were those three words that I asked you to repeat?*"
If unable to remember a word, give cue (something to wear; a color; a piece of furniture) for that word.

A. Able to recall "sock"

0. **No** - could not recall
1. **Yes, after cueing** ("something to wear")
2. **Yes, no cue required**

Enter Code ☐

B. Able to recall "blue"

0. **No** - could not recall
1. **Yes, after cueing** ("a color")
2. **Yes, no cue required**

Enter Code ☐

C. Able to recall "bed"

0. **No** - could not recall
1. **Yes, after cueing** ("a piece of furniture")
2. **Yes, no cue required**

C0500. Summary Score

Enter Score ☐☐

Add scores for questions C0200-C0400 and fill in total score (00-15)
Enter 99 if the resident was unable to complete the interview

Resident _____ Identifier _____ Date _____

Section C Cognitive Patterns

C0600. Should the Staff Assessment for Mental Status (C0700 - C1000) be Conducted?

Enter Code ☐

0. **No** (resident was able to complete interview) → Skip to C1300, Signs and Symptoms of Delirium
1. **Yes** (resident was unable to complete interview) → Continue to C0700, Short-term Memory OK

Staff Assessment for Mental Status

Do not conduct if Brief Interview for Mental Status (C0200-C0500) was completed

C0700. Short-term Memory OK

Enter Code ☐

Seems or appears to recall after 5 minutes
0. **Memory OK**
1. **Memory problem**

C0800. Long-term Memory OK

Enter Code ☐

Seems or appears to recall long past
0. **Memory OK**
1. **Memory problem**

C0900. Memory/Recall Ability

↓ **Check all that the resident was normally able to recall**

☐ **A. Current season**

☐ **B. Location of own room**

☐ **C. Staff names and faces**

☐ **D. That he or she is in a nursing home**

☐ **Z. None of the above** were recalled

C1000. Cognitive Skills for Daily Decision Making

Enter Code ☐

Made decisions regarding tasks of daily life
0. **Independent** - decisions consistent/reasonable
1. **Modified independence** - some difficulty in new situations only
2. **Moderately impaired** - decisions poor; cues/supervision required
3. **Severely impaired** - never/rarely made decisions

Delirium

C1300. Signs and Symptoms of Delirium (from CAM©)

Code **after completing** Brief Interview for Mental Status or Staff Assessment, and reviewing medical record

Coding:
0. **Behavior not present**
1. **Behavior continuously present, does not fluctuate**
2. **Behavior present, fluctuates** (comes and goes, changes in severity)

↓ **Enter Codes in Boxes**

☐ **A. Inattention** - Did the resident have difficulty focusing attention (easily distracted, out of touch or difficulty following what was said)?

☐ **B. Disorganized thinking** - Was the resident's thinking disorganized or incoherent (rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable switching from subject to subject)?

☐ **C. Altered level of consciousness** - Did the resident have altered level of consciousness (e.g., **vigilant** - startled easily to any sound or touch; **lethargic** - repeatedly dozed off when being asked questions, but responded to voice or touch; **stuporous** - very difficult to arouse and keep aroused for the interview; **comatose** - could not be aroused)?

☐ **D. Psychomotor retardation**- Did the resident have an unusually decreased level of activity such as sluggishness, staring into space, staying in one position, moving very slowly?

C1600. Acute Onset Mental Status Change

Enter Code ☐

Is there evidence of an acute change in mental status from the resident's baseline?
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section D Mood

D0100. Should Resident Mood Interview be Conducted? - Attempt to conduct interview with all residents

Enter Code ☐

0. **No** (resident is rarely/never understood) → Skip to and complete D0500-D0600, Staff Assessment of Resident Mood (PHQ-9-OV)
1. **Yes** → Continue to D0200, Resident Mood Interview (PHQ-9©)

D0200. Resident Mood Interview (PHQ-9©)

Say to resident: "*Over the last 2 weeks, have you been bothered by any of the following problems?*"

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*"
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. Symptom Presence
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)
9. **No response** (leave column 2 blank)

2. Symptom Frequency
0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the days)
3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. ***Little interest or pleasure in doing things***	☐	☐
B. ***Feeling down, depressed, or hopeless***	☐	☐
C. ***Trouble falling or staying asleep, or sleeping too much***	☐	☐
D. ***Feeling tired or having little energy***	☐	☐
E. ***Poor appetite or overeating***	☐	☐
F. ***Feeling bad about yourself - or that you are a failure or have let yourself or your family down***	☐	☐
G. ***Trouble concentrating on things, such as reading the newspaper or watching television***	☐	☐
H. ***Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual***	☐	☐
I. ***Thoughts that you would be better off dead, or of hurting yourself in some way***	☐	☐

D0300. Total Severity Score

☐☐ Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 27. Enter 99 if unable to complete interview (i.e., Symptom Frequency is blank for 3 or more items).

D0350. Safety Notification - Complete only if D0200I1 = 1 indicating possibility of resident self harm

Enter Code ☐

Was responsible staff or provider informed that there is a potential for resident self harm?
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section D Mood

D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)

Do not conduct if Resident Mood Interview (D0200-D0300) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. Symptom Presence
0. **No** (enter 0 in column 2)
1. **Yes** (enter 0-3 in column 2)

2. Symptom Frequency
0. **Never or 1 day**
1. **2-6 days** (several days)
2. **7-11 days** (half or more of the days)
3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things	☐	☐
B. Feeling or appearing down, depressed, or hopeless	☐	☐
C. Trouble falling or staying asleep, or sleeping too much	☐	☐
D. Feeling tired or having little energy	☐	☐
E. Poor appetite or overeating	☐	☐
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down	☐	☐
G. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual	☐	☐
I. States that life isn't worth living, wishes for death, or attempts to harm self	☐	☐
J. Being short-tempered, easily annoyed	☐	☐

D0600. Total Severity Score

☐☐ Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30.

D0650. Safety Notification - Complete only if D0500I1 = 1 indicating possibility of resident self harm

Enter Code ☐

Was responsible staff or provider informed that there is a potential for resident self harm?
0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section E Behavior

E0100. Psychosis

↓ Check all that apply

- ☐ **A. Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
- ☐ **B. Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
- ☐ **Z. None of the above**

Behavioral Symptoms

E0200. Behavioral Symptom - Presence & Frequency

Note presence of symptoms and their frequency

Coding:
0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

↓ Enter Codes in Boxes

- ☐ **A. Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
- ☐ **B. Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others)
- ☐ **C. Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)

E0800. Rejection of Care - Presence & Frequency

Enter Code ☐

Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and/or determined to be consistent with resident values, preferences, or goals.

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

E0900. Wandering - Presence & Frequency

Enter Code ☐

Has the resident wandered?

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days**, but less than daily
3. **Behavior of this type occurred daily**

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0110. Activities of Daily Living (ADL) Assistance

Refer to the ADL flow chart in the RAI manual to facilitate accurate coding

Instructions for Rule of 3

- When an activity occurs three times at any one given level, code that level.
- When an activity occurs three times at multiple levels, code the most dependent, exceptions are total dependence (4), activity must require full assist every time, and activity did not occur (8), activity must not have occurred at all. Example, three times extensive assistance (3) and three times limited assistance (2), code extensive assistance (3).
- When an activity occurs at various levels, but not three times at any given level, apply the following:
  - When there is a combination of full staff performance, and extensive assistance, code extensive assistance.
  - When there is a combination of full staff performance, weight bearing assistance and/or non-weight bearing assistance code limited assistance (2).

If none of the above are met, code supervision.

1. ADL Self-Performance

Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times

0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times

7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity (or any part of the ADL) was not performed by resident or staff at all over the entire 7-day period

2. ADL Support Provided

Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:

0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** during entire period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
A. Bed mobility - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture	☐	☐
B. Transfer - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)	☐	☐
C. Walk in room - how resident walks between locations in his/her room	☐	☐
D. Walk in corridor - how resident walks in corridor on unit	☐	☐
E. Locomotion on unit - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	☐	☐
F. Locomotion off unit - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	☐	☐
G. Dressing - how resident puts on, fastens and takes off all items of clothing, including donning/removing a prosthesis or TED hose. Dressing includes putting on and changing pajamas and housedresses	☐	☐
H. Eating - how resident eats and drinks, regardless of skill. Do not include eating/drinking during medication pass. Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition, IV fluids administered for nutrition or hydration)	☐	☐
I. Toilet use - how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes. Do not include emptying of bedpan, urinal, bedside commode, catheter bag or ostomy bag	☐	☐
J. Personal hygiene - how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**excludes** baths and showers)	☐	☐

Resident _____ Identifier _____ Date _____

Section G Functional Status

G0120. Bathing

How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (**excludes** washing of back and hair). Code for **most dependent** in self-performance and support

Enter Code ☐

A. Self-performance
0. **Independent** - no help provided
1. **Supervision** - oversight help only
2. **Physical help limited to transfer only**
3. **Physical help in part of bathing activity**
4. **Total dependence**
8. **Activity itself did not occur** during the entire period

Enter Code ☐

B. Support provided
(Bathing support codes are as defined in item **G0110 column 2, ADL Support Provided**, above)

G0300. Balance During Transitions and Walking

After observing the resident, **code the following walking and transition items for most dependent**

Coding:
0. **Steady at all times**
1. **Not steady, but able to stabilize without human assistance**
2. **Not steady, only able to stabilize with human assistance**
8. **Activity did not occur**

↓ **Enter Codes in Boxes**

☐	**A. Moving from seated to standing position**
☐	**B. Walking** (with assistive device if used)
☐	**C. Turning around** and facing the opposite direction while walking
☐	**D. Moving on and off toilet**
☐	**E. Surface-to-surface transfer** (transfer between bed and chair or wheelchair)

G0400. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury

Coding:
0. **No impairment**
1. **Impairment on one side**
2. **Impairment on both sides**

↓ **Enter Codes in Boxes**

☐	**A. Upper extremity** (shoulder, elbow, wrist, hand)
☐	**B. Lower extremity** (hip, knee, ankle, foot)

G0600. Mobility Devices

↓ **Check all that were normally used**

☐	**A. Cane/crutch**
☐	**B. Walker**
☐	**C. Wheelchair** (manual or electric)
☐	**D. Limb prosthesis**
☐	**Z. None of the above** were used

Resident _____ Identifier _____ Date _____

Section H Bladder and Bowel

H0100. Appliances

↓ **Check all that apply**

- ☐ **A. Indwelling catheter** (including suprapubic catheter and nephrostomy tube)
- ☐ **B. External catheter**
- ☐ **C. Ostomy** (including urostomy, ileostomy, and colostomy)
- ☐ **D. Intermittent catheterization**
- ☐ **Z. None of the above**

H0200. Urinary Toileting Program

Enter Code ☐

C. Current toileting program or trial - Is a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) currently being used to manage the resident's urinary continence?

0. **No**
1. **Yes**

H0300. Urinary Continence

Enter Code ☐

Urinary continence - Select the one category that best describes the resident

0. **Always continent**
1. **Occasionally incontinent** (less than 7 episodes of incontinence)
2. **Frequently incontinent** (7 or more episodes of urinary incontinence, but at least one episode of continent voiding)
3. **Always incontinent** (no episodes of continent voiding)
9. **Not rated,** resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days

H0400. Bowel Continence

Enter Code ☐

Bowel continence - Select the one category that best describes the resident

0. **Always continent**
1. **Occasionally incontinent** (one episode of bowel incontinence)
2. **Frequently incontinent** (2 or more episodes of bowel incontinence, but at least one continent bowel movement)
3. **Always incontinent** (no episodes of continent bowel movements)
9. **Not rated,** resident had an ostomy or did not have a bowel movement for the entire 7 days

H0500. Bowel Toileting Program

Enter Code ☐

Is a toileting program currently being used to manage the resident's bowel continence?

0. **No**
1. **Yes**

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply
Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

	Heart/Circulation
☐	**I0200. Anemia** (e.g., aplastic, iron deficiency, pernicious, and sickle cell)
☐	**I0600. Heart Failure** (e.g., congestive heart failure (CHF) and pulmonary edema)
☐	**I0700. Hypertension**
☐	**I0800. Orthostatic Hypotension**
	Genitourinary
☐	**I1550. Neurogenic Bladder**
☐	**I1650. Obstructive Uropathy**
	Infections
☐	**I1700. Multidrug-Resistant Organism (MDRO)**
☐	**I2000. Pneumonia**
☐	**I2100. Septicemia**
☐	**I2200. Tuberculosis**
☐	**I2300. Urinary Tract Infection (UTI) (LAST 30 DAYS)**
☐	**I2400. Viral Hepatitis** (e.g., Hepatitis A, B, C, D, and E)
☐	**I2500. Wound Infection** (other than foot)
	Metabolic
☐	**I2900. Diabetes Mellitus (DM)** (e.g., diabetic retinopathy, nephropathy, and neuropathy)
☐	**I3100. Hyponatremia**
☐	**I3200. Hyperkalemia**
☐	**I3300. Hyperlipidemia** (e.g., hypercholesterolemia)
	Musculoskeletal
☐	**I3900. Hip Fracture** - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck)
☐	**I4000. Other Fracture**
	Neurological
☐	**I4200. Alzheimer's Disease**
☐	**I4300. Aphasia**
☐	**I4400. Cerebral Palsy**
☐	**I4500. Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke**
☐	**I4800. Dementia** (e.g. Non-Alzheimer's dementia such as vascular or multi-infarct dementia; mixed dementia; frontotemporal dementia such as Pick's disease; and dementia related to stroke, Parkinson's or Creutzfeldt-Jakob diseases)
☐	**I4900. Hemiplegia or Hemiparesis**
☐	**I5000. Paraplegia**
☐	**I5100. Quadriplegia**
☐	**I5200. Multiple Sclerosis (MS)**
☐	**I5250. Huntington's Disease**
☐	**I5300. Parkinson's Disease**
☐	**I5400. Seizure Disorder or Epilepsy**
☐	**I5500. Traumatic Brain Injury (TBI)**
	Nutritional
☐	**I5600. Malnutrition** (protein or calorie) or at risk for malnutrition

Resident _____ Identifier _____ Date _____

Section I Active Diagnoses

Active Diagnoses in the last 7 days - Check all that apply

Diagnoses listed in parentheses are provided as examples and should not be considered as all-inclusive lists

Psychiatric/Mood Disorder

- ☐ **I5700. Anxiety Disorder**
- ☐ **I5800. Depression** (other than bipolar)
- ☐ **I5900. Manic Depression** (bipolar disease)
- ☐ **I5950. Psychotic Disorder** (other than schizophrenia)
- ☐ **I6000. Schizophrenia** (e.g., schizoaffective and schizophreniform disorders)
- ☐ **I6100. Post Traumatic Stress Disorder (PTSD)**

Pulmonary

- ☐ **I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease** (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
- ☐ **I6300. Respiratory Failure**

Other

☐ **I8000. Additional active diagnoses**

Enter diagnosis on line and ICD code in boxes. Include the decimal for the code in the appropriate box.

A. _____ | | | | | | | | |

B. _____ | | | | | | | | |

C. _____ | | | | | | | | |

D. _____ | | | | | | | | |

E. _____ | | | | | | | | |

F. _____ | | | | | | | | |

G. _____ | | | | | | | | |

H. _____ | | | | | | | | |

I. _____ | | | | | | | | |

J. _____ | | | | | | | | |

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J0100. Pain Management - Complete for all residents, regardless of current pain level

At any time in the last **5** days, has the resident:

Enter Code ☐ **A. Been on a scheduled pain medication regimen?**
0. **No**
1. **Yes**

Enter Code ☐ **B. Received PRN pain medications?**
0. **No**
1. **Yes**

Enter Code ☐ **C. Received non-medication intervention for pain?**
0. **No**
1. **Yes**

J0200. Should Pain Assessment Interview be Conducted?

Attempt to conduct interview with all residents. If resident is comatose, skip to J1100, Shortness of Breath (dyspnea)

Enter Code ☐
0. **No** (resident is rarely/never understood) → Skip to and complete J0800, Indicators of Pain or Possible Pain
1. **Yes** → Continue to J0300, Pain Presence

Pain Assessment Interview

J0300. Pain Presence

Enter Code ☐ Ask resident: "***Have you had pain or hurting at any time*** *in the last 5 days?*"
0. **No** → Skip to J1100, Shortness of Breath
1. **Yes** → Continue to J0400, Pain Frequency
9. **Unable to answer** → Skip to J0800, Indicators of Pain or Possible Pain

J0400. Pain Frequency

Enter Code ☐ Ask resident: "***How much of the time have you experienced pain or hurting*** *over the last 5 days?*"
1. **Almost constantly**
2. **Frequently**
3. **Occasionally**
4. **Rarely**
9. **Unable to answer**

J0500. Pain Effect on Function

Enter Code ☐ **A.** Ask resident: "*Over the past 5 days,* ***has pain made it hard for you to sleep at night****?*"
0. **No**
1. **Yes**
9. **Unable to answer**

Enter Code ☐ **B.** Ask resident: "*Over the past 5 days,* ***have you limited your day-to-day activities because of pain****?*"
0. **No**
1. **Yes**
9. **Unable to answer**

J0600. Pain Intensity - Administer **ONLY ONE** of the following pain intensity questions (A or B)

Enter Rating ☐☐ **A. Numeric Rating Scale (00-10)**
Ask resident: "*Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine.*" (Show resident 00 -10 pain scale)
Enter two-digit response. Enter 99 if unable to answer.

Enter Code ☐ **B. Verbal Descriptor Scale**
Ask resident: "*Please rate the intensity of your worst pain over the last 5 days.*" (Show resident verbal scale)
1. **Mild**
2. **Moderate**
3. **Severe**
4. **Very severe, horrible**
9. **Unable to answer**

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J0700. Should the Staff Assessment for Pain be Conducted?

Enter Code ☐

0. **No** (J0400 = 1 thru 4) → Skip to J1100, Shortness of Breath (dyspnea)
1. **Yes** (J0400 = 9) → Continue to J0800, Indicators of Pain or Possible Pain

Staff Assessment for Pain

J0800. Indicators of Pain or Possible Pain in the last 5 days

↓ **Check all that apply**

- ☐ **A. Non-verbal sounds** (e.g., crying, whining, gasping, moaning, or groaning)
- ☐ **B. Vocal complaints of pain** (e.g., that hurts, ouch, stop)
- ☐ **C. Facial expressions** (e.g., grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw)
- ☐ **D. Protective body movements or postures** (e.g., bracing, guarding, rubbing or massaging a body part/area, clutching or holding a body part during movement)
- ☐ **Z. None of these signs observed or documented** → If checked, skip to J1100, Shortness of Breath (dyspnea)

J0850. Frequency of Indicator of Pain or Possible Pain in the last 5 days

Enter Code ☐

Frequency with which resident complains or shows evidence of pain or possible pain

1. **Indicators of pain** or possible pain observed **1 to 2 days**
2. **Indicators of pain** or possible pain observed **3 to 4 days**
3. **Indicators of pain** or possible pain observed **daily**

Other Health Conditions

J1100. Shortness of Breath (dyspnea)

↓ **Check all that apply**

- ☐ **A. Shortness of breath** or trouble breathing **with exertion** (e.g., walking, bathing, transferring)
- ☐ **B. Shortness of breath** or trouble breathing **when sitting at rest**
- ☐ **C. Shortness of breath** or trouble breathing **when lying flat**
- ☐ **Z. None of the above**

J1400. Prognosis

Enter Code ☐

Does the resident have a condition or chronic disease that may result in a **life expectancy of less than 6 months?** (Requires physician documentation)

0. **No**
1. **Yes**

J1550. Problem Conditions

↓ **Check all that apply**

- ☐ **A. Fever**
- ☐ **B. Vomiting**
- ☐ **C. Dehydrated**
- ☐ **D. Internal bleeding**
- ☐ **Z. None of the above**

Resident _____ Identifier _____ Date _____

Section J Health Conditions

J1700. Fall History on Admission

Complete only if A0310A = 01 or A0310E = 1

Enter Code ☐

A. Did the resident have a fall any time in the **last month** prior to admission?
0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code ☐

B. Did the resident have a fall any time in the **last 2-6 months** prior to admission?
0. **No**
1. **Yes**
9. **Unable to determine**

Enter Code ☐

C. Did the resident have any **fracture related to a fall in the 6 months** prior to admission?
0. **No**
1. **Yes**
9. **Unable to determine**

J1800. Any Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent

Enter Code ☐

Has the resident **had any falls since admission or the prior assessment** (OBRA, PPS, or Discharge), whichever is more recent?
0. **No** → Skip to K0100, Swallowing Disorder
1. **Yes** → Continue to J1900, Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge)

J1900. Number of Falls Since Admission or Prior Assessment (OBRA, PPS, or Discharge), whichever is more recent

Coding:
0. **None**
1. **One**
2. **Two or more**

↓ **Enter Codes in Boxes**

☐ **A. No injury** - no evidence of any injury is noted on physical assessment by the nurse or primary care clinician; no complaints of pain or injury by the resident; no change in the resident's behavior is noted after the fall

☐ **B. Injury (except major)** - skin tears, abrasions, lacerations, superficial bruises, hematomas and sprains; or any fall-related injury that causes the resident to complain of pain

☐ **C. Major injury** - bone fractures, joint dislocations, closed head injuries with altered consciousness, subdural hematoma

Resident _____ Identifier _____ Date _____

Section K Swallowing/Nutritional Status

K0100. Swallowing Disorder

Signs and symptoms of possible swallowing disorder

Check all that apply

- ☐ **A. Loss of liquids/solids from mouth when eating or drinking**
- ☐ **B. Holding food in mouth/cheeks or residual food in mouth after meals**
- ☐ **C. Coughing or choking during meals or when swallowing medications**
- ☐ **D. Complaints of difficulty or pain with swallowing**
- ☐ **Z. None of the above**

K0200. Height and Weight - While measuring, if the number is X.1 - X.4 round down; X.5 or greater round up

☐☐ inches

A. Height (in inches). Record most recent height measure since admission

☐☐☐ pounds

B. Weight (in pounds). Base weight on most recent measure in last 30 days; measure weight consistently, according to standard facility practice (e.g., in a.m. after voiding, before meal, with shoes off, etc.)

K0300. Weight Loss

Enter Code ☐

Loss of 5% or more in the last month or loss of 10% or more in last 6 months

0. **No** or unknown
1. **Yes, on** physician-prescribed weight-loss regimen
2. **Yes, not on** physician-prescribed weight-loss regimen

K0500. Nutritional Approaches

Check all that apply

- ☐ **A. Parenteral/IV feeding**
- ☐ **B. Feeding tube** - nasogastric or abdominal (PEG)
- ☐ **C. Mechanically altered diet** - require change in texture of food or liquids (e.g., pureed food, thickened liquids)
- ☐ **D. Therapeutic diet** (e.g., low salt, diabetic, low cholesterol)
- ☐ **Z. None of the above**

K0700. Percent Intake by Artificial Route - Complete K0700 only if K0500A or K0500B is checked

Enter Code ☐

A. Proportion of total calories the resident received through parenteral or tube feeding

1. **25% or less**
2. **26-50%**
3. **51% or more**

Enter Code ☐

B. Average fluid intake per day by IV or tube feeding

1. **500 cc/day or less**
2. **501 cc/day or more**

Section L Oral/Dental Status

L0200. Dental

Check all that apply

- ☐ **A. Broken or loosely fitting full or partial denture** (chipped, cracked, uncleanable, or loose)
- ☐ **F. Mouth or facial pain, discomfort or difficulty with chewing**

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

Report based on highest stage of existing ulcer(s) at its worst; do not "reverse" stage

M0100. Determination of Pressure Ulcer Risk

↓ **Check all that apply**

- ☐ **A. Resident has a stage 1 or greater, a scar over bony prominence, or a non-removable dressing/device**
- ☐ **B. Formal assessment instrument/tool** (e.g., Braden, Norton, or other)
- ☐ **C. Clinical assessment**
- ☐ **Z. None of the above**

M0150. Risk of Pressure Ulcers

Enter Code ☐

Is this resident at risk of developing pressure ulcers?

0. **No**
1. **Yes**

M0210. Unhealed Pressure Ulcer(s)

Enter Code ☐

Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher?

0. **No** → Skip to M0900, Healed Pressure Ulcers
1. **Yes** → Continue to M0300, Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

M0300. Current Number of Unhealed (non-epithelialized) Pressure Ulcers at Each Stage

Enter Number ☐

A. Number of Stage 1 pressure ulcers

Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues

B. Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister

Enter Number ☐

1. **Number of Stage 2 pressure ulcers -** If 0 → Skip to M0300C, Stage 3

Enter Number ☐

2. **Number of these Stage 2 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

3. **Date of oldest Stage 2 pressure ulcer** - Enter dashes if date is unknown:

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Number ☐

C. Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling

1. **Number of Stage 3 pressure ulcers** - If 0 → Skip to M0300D, Stage 4

Enter Number ☐

2. **Number of these Stage 3 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

Enter Number ☐

D. Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling

1. **Number of Stage 4 pressure ulcers** - If 0 → Skip to M0300E, Unstageable: Non-removable dressing

Enter Number ☐

2. **Number of these Stage 4 pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

M0300 continued on next page

Section M Skin Conditions

M0300. Current Number of Unhealed (non-epithelialized) **Pressure Ulcers at Each Stage** - Continued

E. Unstageable - Non-removable dressing: Known but not stageable due to non-removable dressing/device

Enter Number ☐

1. **Number of unstageable pressure ulcers due to non-removable dressing/device** - If 0 → Skip to M0300F, Unstageable: Slough and/or eschar

Enter Number ☐

2. **Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar

Enter Number ☐

1. **Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar** - If 0 → Skip to M0300G, Unstageable: Deep tissue

Enter Number ☐

2. **Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

G. Unstageable - Deep tissue: Suspected deep tissue injury in evolution

Enter Number ☐

1. **Number of unstageable pressure ulcers with suspected deep tissue injury in evolution** - If 0 → Skip to M0610, Dimension of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar

Enter Number ☐

2. **Number of these unstageable pressure ulcers that were present upon admission/reentry** - enter how many were noted at the time of admission

M0610. Dimensions of Unhealed Stage 3 or 4 Pressure Ulcers or Eschar
Complete only if M0300C1, M0300D1 or M0300F1 is greater than 0

If the resident has one or more unhealed (non-epithelialized) Stage 3 or 4 pressure ulcers or an unstageable pressure ulcer due to slough or eschar, identify the pressure ulcer with the largest surface area (length x width) and record in centimeters:

☐☐.☐ cm **A. Pressure ulcer length:** Longest length from head to toe

☐☐.☐ cm **B. Pressure ulcer width:** Widest width of the same pressure ulcer, side-to-side perpendicular (90-degree angle) to length

☐☐.☐ cm **C. Pressure ulcer depth:** Depth of the same pressure ulcer from the visible surface to the deepest area (if depth is unknown, enter a dash in each box)

M0700. Most Severe Tissue Type for Any Pressure Ulcer

Enter Code ☐

Select the best description of the most severe type of tissue present in any pressure ulcer bed

1. **Epithelial tissue** - new skin growing in superficial ulcer. It can be light pink and shiny, even in persons with darkly pigmented skin
2. **Granulation tissue** - pink or red tissue with shiny, moist, granular appearance
3. **Slough** - yellow or white tissue that adheres to the ulcer bed in strings or thick clumps, or is mucinous
4. **Necrotic tissue (Eschar)** - black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin

M0800. Worsening in Pressure Ulcer Status Since Prior Assessment (OBRA, PPS, or Discharge)
Complete only if A0310E = 0

Indicate the number of current pressure ulcers that were **not present or were at a lesser stage** on prior assessment (OBRA, PPS, or Discharge).
If no current pressure ulcer at a given stage, enter 0

Enter Number ☐ **A. Stage 2**

Enter Number ☐ **B. Stage 3**

Enter Number ☐ **C. Stage 4**

Resident _____ Identifier _____ Date _____

Section M Skin Conditions

M0900. Healed Pressure Ulcers

Complete only if A0310E = 0

Enter Code ☐

A. Were pressure ulcers present on the prior assessment (OBRA, PPS, or Discharge)?

0. **No** → Skip to M1030, Number of Venous and Arterial Ulcers
1. **Yes** → Continue to M0900B, Stage 2

Indicate the number of pressure ulcers that were noted on the prior assessment (OBRA, PPS, or Discharge) that have completely closed (resurfaced with epithelium). If no healed pressure ulcer at a given stage since the prior assessment (OBRA, PPS, or Discharge), enter 0

Enter Number	
☐	**B. Stage 2**
☐	**C. Stage 3**
☐	**D. Stage 4**

M1030. Number of Venous and Arterial Ulcers

Enter Number	
☐	**Enter the total number of venous and arterial ulcers present**

M1040. Other Ulcers, Wounds and Skin Problems

↓ **Check all that apply**

	Foot Problems
☐	**A. Infection of the foot** (e.g., cellulitis, purulent drainage)
☐	**B. Diabetic foot ulcer(s)**
☐	**C. Other open lesion(s) on the foot**
	Other Problems
☐	**D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)
☐	**E. Surgical wound(s)**
☐	**F. Burn(s)** (second or third degree)
	None of the Above
☐	**Z. None of the above** were present

M1200. Skin and Ulcer Treatments

↓ **Check all that apply**

☐	**A. Pressure reducing device for chair**
☐	**B. Pressure reducing device for bed**
☐	**C. Turning/repositioning program**
☐	**D. Nutrition or hydration intervention** to manage skin problems
☐	**E. Ulcer care**
☐	**F. Surgical wound care**
☐	**G. Application of nonsurgical dressings** (with or without topical medications) other than to feet
☐	**H. Applications of ointments/medications** other than to feet
☐	**I. Application of dressings to feet** (with or without topical medications)
☐	**Z. None of the above** were provided

Resident _____ Identifier _____ Date _____

Section N Medications

N0300. Injections

Enter Days ☐

Record the number of days that injections of any type were received during the last 7 days or since admission/reentry if less than 7 days. If 0 → Skip to N0400, Medications Received

N0350. Insulin

Enter Days ☐

A. Insulin injections - Record the number of days that insulin injections were received during the last 7 days or since admission/reentry if less than 7 days

Enter Days ☐

B. Orders for insulin - Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders during the last 7 days or since admission/reentry if less than 7 days

N0400. Medications Received

Check all medications the resident received at any time during the last 7 days or since admission/reentry if less than 7 days

- ☐ **A. Antipsychotic**
- ☐ **B. Antianxiety**
- ☐ **C. Antidepressant**
- ☐ **D. Hypnotic**

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0100. Special Treatments, Procedures, and Programs

Check all of the following treatments, procedures, and programs that were performed during the last **14 days**

1. **While NOT a Resident**
   Performed ***while NOT a resident*** of this facility and within the ***last 14 days***. Only check column 1 if resident entered (admission or reentry) IN THE LAST 14 DAYS. If resident last entered 14 or more days ago, leave column 1 blank
2. **While a Resident**
   Performed ***while a resident*** of this facility and within the ***last 14 days***

	1. While NOT a Resident	2. While a Resident
	↓ Check all that apply ↓	
Cancer Treatments		
A. Chemotherapy	☐	☐
B. Radiation	☐	☐
Respiratory Treatments		
C. Oxygen therapy	☐	☐
D. Suctioning	☐	☐
E. Tracheostomy care	☐	☐
F. Ventilator or respirator	☐	☐
Other		
H. IV medications	☐	☐
I. Transfusions	☐	☐
J. Dialysis	☐	☐
K. Hospice care		☐
M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)		☐

O0250. Influenza Vaccine - Refer to current version of RAI manual for current flu season and reporting period

Enter Code ☐

A. Did the **resident receive the Influenza vaccine in this facility** for this year's Influenza season?
0. **No** → Skip to O0250C, If Influenza vaccine not received, state reason
1. **Yes** → Continue to O0250B, Date vaccine received

B. Date vaccine received → Complete date and skip to O0300A, Is the resident's Pneumococcal vaccination up to date?

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Enter Code ☐

C. If Influenza vaccine not received, state reason:
1. **Resident not in facility** during this year's flu season
2. **Received outside of this facility**
3. **Not eligible** - medical contraindication
4. **Offered and declined**
5. **Not offered**
6. **Inability to obtain vaccine** due to a declared shortage
9. **None of the above**

O0300. Pneumococcal Vaccine

Enter Code ☐

A. Is the resident's Pneumococcal vaccination up to date?
0. **No** → Continue to O0300B, If Pneumococcal vaccine not received, state reason
1. **Yes** → Skip to O0400, Therapies

Enter Code ☐

B. If Pneumococcal vaccine not received, state reason:
1. **Not eligible** - medical contraindication
2. **Offered and declined**
3. **Not offered**

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0400. Therapies

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes ☐☐☐☐

1. **Individual minutes -** record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes ☐☐☐☐

2. **Concurrent minutes -** record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes ☐☐☐☐

3. **Group minutes -** record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400B, Occupational Therapy

Enter Number of Days ☐

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

B. Occupational Therapy

Enter Number of Minutes ☐☐☐☐

1. **Individual minutes -** record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes ☐☐☐☐

2. **Concurrent minutes -** record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes ☐☐☐☐

3. **Group minutes -** record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400C, Physical Therapy

Enter Number of Days ☐

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

C. Physical Therapy

Enter Number of Minutes ☐☐☐☐

1. **Individual minutes -** record the total number of minutes this therapy was administered to the resident **individually** in the last 7 days

Enter Number of Minutes ☐☐☐☐

2. **Concurrent minutes -** record the total number of minutes this therapy was administered to the resident **concurrently with one other resident** in the last 7 days

Enter Number of Minutes ☐☐☐☐

3. **Group minutes -** record the total number of minutes this therapy was administered to the resident as **part of a group of residents** in the last 7 days

If the sum of individual, concurrent, and group minutes is zero, → skip to O0400D, Respiratory Therapy

Enter Number of Days ☐

4. **Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

5. **Therapy start date** - record the date the most recent therapy regimen (since the most recent entry) started

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

6. **Therapy end date** - record the date the most recent therapy regimen (since the most recent entry) ended - enter dashes if therapy is ongoing

☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

O0400 continued on next page

Resident _____ Identifier _____ Date _____

Section O Special Treatments, Procedures, and Programs

O0400. Therapies - Continued

	D. Respiratory Therapy
Enter Number of Days ☐☐	**2. Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days
	E. Psychological Therapy (by any licensed mental health professional)
Enter Number of Days ☐☐	**2. Days** - record the **number of days** this therapy was administered for **at least 15 minutes** a day in the last 7 days

O0500. Restorative Nursing Programs

Record the **number of days** each of the following restorative programs was performed (for at least 15 minutes a day) in the last 7 calendar days (enter 0 if none or less than 15 minutes daily)

Number of Days	Technique
☐☐	**A. Range of motion (passive)**
☐☐	**B. Range of motion (active)**
☐☐	**C. Splint or brace assistance**
Number of Days	**Training and Skill Practice In:**
☐☐	**D. Bed mobility**
☐☐	**E. Transfer**
☐☐	**F. Walking**
☐☐	**G. Dressing and/or grooming**
☐☐	**H. Eating and/or swallowing**
☐☐	**I. Amputation/prostheses care**
☐☐	**J. Communication**

O0600. Physician Examinations

Enter Days ☐☐	Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) examine the resident?**

O0700. Physician Orders

Enter Days ☐☐	Over the last 14 days, **on how many days did the physician (or authorized assistant or practitioner) change the resident's orders?**

Resident _____ Identifier _____ Date _____

Section P Restraints

P0100. Physical Restraints

Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body

Coding:
0. **Not used**
1. **Used less than daily**
2. **Used daily**

↓ **Enter Codes in Boxes**

	Used in Bed
☐	**A. Bed rail**
☐	**B. Trunk restraint**
☐	**C. Limb restraint**
☐	**D. Other**
	Used in Chair or Out of Bed
☐	**E. Trunk restraint**
☐	**F. Limb restraint**
☐	**G. Chair prevents rising**
☐	**H. Other**

Resident _____ Identifier _____ Date _____

Section Q Participation in Assessment and Goal Setting

Q0100. Participation in Assessment

Enter Code ☐

A. Resident participated in assessment
0. **No**
1. **Yes**

Enter Code ☐

B. Family or significant other participated in assessment
0. **No**
1. **Yes**
9. **No family or significant other**

Enter Code ☐

C. Guardian or legally authorized representative participated in assessment
0. **No**
1. **Yes**
9. **No guardian or legally authorized representative**

Q0300. Resident's Overall Expectation

Complete only if A0310E = 1

Enter Code ☐

A. Resident's overall goal established during assessment process
1. Expects to be **discharged to the community**
2. Expects to **remain in this facility**
3. Expects to be **discharged to another facility/institution**
9. **Unknown or uncertain**

Enter Code ☐

B. Indicate information source for Q0300A
1. **Resident**
2. If not resident, then **family or significant other**
3. If not resident, family, or significant other, then **guardian or legally authorized representative**
9. **None of the above**

Q0400. Discharge Plan

Enter Code ☐

A. Is there an active discharge plan in place for the resident to return to the community?
0. **No**
1. **Yes** → Skip to Q0600, Referral

Enter Code ☐

B. What determination was made by the resident and the care planning team regarding discharge to the community?
0. **Determination not made**
1. **Discharge to community determined to be feasible** → Skip to Q0600, Referral
2. **Discharge to community determined to be not feasible** → Skip to X0100, Type of Record

Q0500. Return to Community

Enter Code ☐

A. Has the resident been asked about returning to the community?
0. **No**
1. **Yes** - previous response was **"no"**
2. **Yes** - previous response was **"yes"** → Skip to Q0600, Referral
3. **Yes** - previous response was **"unknown"**

Enter Code ☐

B. Ask the resident (or family or significant other if resident is unable to respond): **"Do you want to talk to someone about the possibility of returning to the community?"**
0. **No**
1. **Yes**
9. **Unknown or uncertain**

Q0600. Referral

Enter Code ☐

Has a referral been made to the local contact agency?
0. **No** - determination has been made by the resident and the care planning team that contact is not required
1. **No** - referral not made
2. **Yes**

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0100. Type of Record

Enter Code ☐

1. **Add new record** → Skip to Z0100, Medicare Part A Billing
2. **Modify existing record** → Continue to X0150, Type of Provider
3. **Inactivate existing record** → Continue to X0150, Type of Provider

Identification of Record to be Modified/Inactivated - The following items identify the existing assessment record that is in error. In this section, reproduce the information EXACTLY as it appeared on the existing erroneous record, even if the information is incorrect. This information is necessary to locate the existing record in the National MDS Database.

X0150. Type of Provider

Enter Code ☐

Type of provider

1. **Nursing home (SNF/NF)**
2. **Swing Bed**

X0200. Name of Resident on existing record to be modified/inactivated

A. First name:

☐☐☐☐☐☐☐☐☐☐☐☐

C. Last name:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

X0300. Gender on existing record to be modified/inactivated

Enter Code ☐

1. **Male**
2. **Female**

X0400. Birth Date on existing record to be modified/inactivated

☐☐ – ☐☐ – ☐☐☐☐

Month Day Year

X0500. Social Security Number on existing record to be modified/inactivated

☐☐☐ – ☐☐ – ☐☐☐☐

X0600. Type of Assessment on existing record to be modified/inactivated

Enter Code ☐☐

A. Federal OBRA Reason for Assessment

01. **Admission** assessment (required by day 14)
02. **Quarterly** review assessment
03. **Annual** assessment
04. **Significant change in status** assessment
05. **Significant correction** to **prior comprehensive** assessment
06. **Significant correction** to **prior quarterly** assessment
99. **Not OBRA required** assessment

Enter Code ☐☐

B. PPS Assessment

PPS Scheduled Assessments for a Medicare Part A Stay

01. **5-day** scheduled assessment
02. **14-day** scheduled assessment
03. **30-day** scheduled assessment
04. **60-day** scheduled assessment
05. **90-day** scheduled assessment
06. **Readmission/return** assessment

PPS Unscheduled Assessments for a Medicare Part A Stay

07. **Unscheduled assessment used for PPS** (OMRA, significant or clinical change, or significant correction assessment)

Not PPS Assessment

99. **Not PPS** assessment

Enter Code ☐

C. PPS Other Medicare Required Assessment - OMRA

0. **No**
1. **Start of therapy** assessment
2. **End of therapy** assessment
3. **Both Start and End of therapy** assessment

X0600 continued on next page

Resident _____ Identifier _____ Date _____

Section X Correction Request

X0600. Type of Assessment - Continued

Enter Code ☐

D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2
0. **No**
1. **Yes**

Enter Code ☐☐

F. Entry/discharge reporting
01. **Entry** record
10. **Discharge** assessment-**return not anticipated**
11. **Discharge** assessment-**return anticipated**
12. **Death in facility** record
99. **Not entry/discharge** record

X0700. Date on existing record to be modified/inactivated - Complete one only

A. Assessment Reference Date - Complete only if X0600F = 99
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

B. Discharge Date - Complete only if X0600F = 10, 11, or 12
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

C. Entry Date - Complete only if X0600F = 01
☐☐ – ☐☐ – ☐☐☐☐
Month Day Year

Correction Attestation Section - Complete this section to explain and attest to the modification/inactivation request

X0800. Correction Number

Enter Number ☐☐

Enter the number of correction requests to modify/inactivate the existing record, including the present one

X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (X0100 = 2)

Check all that apply

☐ **A. Transcription error**
☐ **B. Data entry error**
☐ **C. Software product error**
☐ **D. Item coding error**
☐ **Z. Other error requiring modification**
If "Other" checked, please specify: _____

X1050. Reasons for Inactivation - Complete only if Type of Record is to inactivate a record in error (X0100 = 3)

Check all that apply

☐ **A. Event did not occur**
☐ **Z. Other error requiring inactivation**
If "Other" checked, please specify: _____

Resident _____ Identifier _____ Date _____

Section X Correction Request

X1100. RN Assessment Coordinator Attestation of Completion

A. Attesting individual's first name:

B. Attesting individual's last name:

C. Attesting individual's title:

D. Signature

E. Attestation date

Month – Day – Year

Resident _____ Identifier _____ Date _____

Section Z Assessment Administration

Z0100. Medicare Part A Billing

Enter Code ☐

A. Medicare Part A HIPPS code (RUG group followed by assessment type indicator)**:**

☐☐☐☐☐☐☐

B. RUG version code:

☐☐☐☐☐☐☐☐☐☐

C. Is this a Medicare Short Stay assessment?

0. **No**
1. **Yes**

Z0150. Medicare Part A Non-Therapy Billing

A. Medicare Part A non-therapy HIPPS code (RUG group followed by assessment type indicator)**:**

☐☐☐☐☐☐☐

B. RUG version code:

☐☐☐☐☐☐☐☐☐☐

Z0200. State Medicaid Billing (if required by the state)

A. RUG Case Mix group:

☐☐☐☐☐☐☐☐☐☐

B. RUG version code:

☐☐☐☐☐☐☐☐☐☐

Z0250. Alternate State Medicaid Billing (if required by the state)

A. RUG Case Mix group:

☐☐☐☐☐☐☐☐☐☐

B. RUG version code:

☐☐☐☐☐☐☐☐☐☐

Z0300. Insurance Billing

A. RUG Case Mix group:

☐☐☐☐☐☐☐☐☐☐

B. RUG version code:

☐☐☐☐☐☐☐☐☐☐

Resident _____ Identifier _____ Date _____

Section Z Assessment Administration

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

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

Signature	Title	Sections	Date Section Completed
A.			
B.			
C.			
D.			
E.			
F.			
G.			
H.			
I.			
J.			
K.			
L.			

Z0500. Signature of RN Assessment Coordinator Verifying Assessment Completion

A. Signature:

B. Date RN Assessment Coordinator signed assessment as complete:

		–			–				
Month			Day			Year			