MINIMUM DATA SET (MDS)
FOR SWING BED HOSPITALS

1. RESIDENT NAME AA1
a. (First) **b.** (Middle Initial) **c.** (Last) **d.** (Suffix)

2. GENDER AA2
1. Male 2. Female

3. BIRTHDATE AA3
[ ][ ]-[ ][ ]-[ ][ ][ ][ ]

4. MARITAL STATUS A5
1. Never Married 3. Widowed 5. Divorced
2. Married 4. Separated

5. RACE/ ETHNICITY
(***Check all that apply***)
a. American Indian/Alaskan Native
b. Asian
c. Black or African American
d. Hispanic or Latino
e. Native Hawaiian or other Pacific Islander
f. White

6. ZIP CODE AB4
Enter code for the pre-hospital residence
[ ][ ][ ][ ][ ]

7. RESIDENT SSN and MEDICARE NUMBERS AA5
a. Social Security Number
[ ][ ][ ]-[ ][ ]-[ ][ ][ ][ ]
b. Medicare or Railroad Insurance Number
[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

8. RESIDENT MEDICAID NUMBER AA7
Enter **+** if pending or **N** if not a Medicaid recipient in first digit followed by blanks
[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

9. FACILITY PROVIDER NUMBER AA6a
a. State Medicaid Provider Number
[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]
b. Medicare Provider Number
[ ][ ]-[ ][ ][ ][ ]

10. ASSESSMENT REFERENCE DATE A3a
a. Last day of MDS observation period
[ ][ ]-[ ][ ]-[ ][ ][ ][ ]
b. Original (00) or correction (enter number of correction) [ ][ ]

11. REASONS FOR ASSESSMENT AA8
a. **Primary Reasons for Assessment** [ ][ ]
00. PPS assessment for Medicare Payment
06. Discharged–Return Not Anticipated
07. Discharged–Return Anticipated
09. Reentry
11. Assessment–Not for Medicare payment

b. **PPS Scheduled Assessments** [ ]
1. 5-day 4. 90-day 9. Other
2. 30-day 5. Readmission/Return
3. 60-day 7. 14-day

c. **OMRA Assessment** [ ]
0. No 1. Yes

d. **Clinical Change Assessment** [ ]
0. No 1. Yes

e. **State-Required Assessment** [ ]
0. No 1. Yes

f. **Assessment Needed for Other Reasons** [ ]
(e.g., HMOs, MSP, sanction situations, etc.)
0. No 1. Yes

12. PRIOR ACUTE CARE STAY
Date of admission for prior qualifying hospital stay
[ ][ ]-[ ][ ]-[ ][ ][ ][ ]

13. ADMISSION DATE AB1
Date of initial admission for extended care swing bed services
[ ][ ]-[ ][ ]-[ ][ ][ ][ ]

14. ADMISSION/ DISCHARGE STATUS CODE
01. Private Home/apt with no home health care
02. Private Home/apt with home health care
03. Board and Care/assisted living/group home
04. Another nursing facility
05. Acute unit at own hospital
06. Acute unit at another hospital
07. Psychiatric hospital
08. Rehabilitation hospital
09. MR/DD facility
10. Hospice
11. Deceased
12. Other

a. Admitted From – Code with all records [ ][ ]
b. Discharge Status – Complete if Item 11a = 06 or 07 [ ][ ]
c. Reentered From – Complete if Item 11a = 09 [ ][ ]

15. DISCHARGE DATE R4
Complete if Item 11a = 06 or 07
[ ][ ]-[ ][ ]-[ ][ ][ ][ ]

16. REENTRY DATE A4
Complete if Item 11a = 09
[ ][ ]-[ ][ ]-[ ][ ][ ][ ]

CLINICAL DATA

17. COMATOSE B1
Persistent vegetative state with no discernible consciousness
If yes, skip to Item 23
0. No 1. Yes

18. SHORT TERM MEMORY B2a
Seems/appears to recall after 5 minutes
0. Memory okay 1. Memory problem

19. COGNITIVE SKILLS B4
Makes decisions regarding tasks of daily life
0. Independent 2. Moderately impaired
1. Modified independence 3. Severely impaired

20. MAKING SELF UNDERSTOOD C4
Expressing information content – (however able)
0. Understood 2. Sometimes understood
1. Usually understood 3. Rarely/never understood

21. INDICATORS OF DEPRESSION E1
Code for indicators observed in the last 30 days, regardless of the assumed cause
0. Indicator not exhibited in last 30 days
1. Indicator exhibited up to five days a week
2. Indicator exhibited daily or almost daily (6 or 7 days a week)

a. Negative statements
b. Repetitive questions
c. Repetitive verbalizations
d. Persistent anger with self/others
e. Self deprecation
f. Expression of unrealistic fears
g. Recurrent statements that something terrible is about to happen.
h. Repetitive health complaints
i. Repetitive anxious complaints/concerns
j. Unpleasant mood in morning
k. Insomnia/change in usual sleep pattern
l. Sad, pained, worried facial expression
m. Crying,tearfulness
n. Repetitive physical movements
o. Withdrawal from activities of interest
p. Reduced social interaction

22. BEHAVIORAL SYMPTOMS E4
Behavioral symptom frequency in last 7 days
0. Behavior NOT exhibited in last 7 days
1. Behavior occurred 1 to 3 days in last 7 days
2. Behavior occurred 4 to 6 days, but less than daily
3. Behavior occurred daily

a. Wandering (E4aA)
b. Verbally abusive behavioral symptoms (E4bA)
c. Physically abusive behavioral symptoms (E4cA)
d. Socially inappropriate/disruptive behavioral symptom (E4dA)
e. Resists care (E4eA)

23. ADLs G1
(A) ADL Self-Performance—Code for resident's performance over all shifts **during the last 7 days**
0. Independent 3. Extensive assistance
1. Supervision 4. Total dependence
2. Limited assistance 8. Activity did not occur

(B) ADL support provided—Code for most support provided over all shifts **during last 7 days**
0. No setup or physical help 3. Two + persons physical assist
1. Setup help only 8. Activity did not occur
2. One person assist

	A	B
a. Bed Mobility (G1a)		
b. Transfer (G1b)		
c. Eating (G1h)		
d. Toilet Use (G1i)		

Resident Name _____ **Numeric Identifier** _____

24. TOILETING PROGRAMS (H3)

Check any that apply during the last 14 days

a. Any scheduled toileting plan

b. Bladder retraining program

25. DISEASES (I1)

Check only those conditions/diseases that have a relationship to current ADL status, medical treatments, nursing monitoring or risk of death. Do not code inactive diagnoses.

a. Diabetes mellitus (I1a)
b. Aphasia (I1r)
c. Cerebral palsy (I1s)
d. Hemiplegia/hemiparesis (I1v)
e. Multiple sclerosis (I1w)
f. Quadriplegia (I1z)

26. INFECTIONS (I2)

Check any that apply

a. Pneumonia (I2e)
b. Septicemia (I2g)

27. PROBLEM CONDITIONS (J1)

Check all problems present in the last 7 days

a. Dehydrated, output exceeds input (J1c)
b. Delusions (J1e)
c. Fever (J1h)
d. Hallucinations (J1i)
e. Internal bleeding (J1j)
f. Vomiting (J1o)

28. WEIGHT LOSS (K3a)

Weight loss - **5% or more in last 30 days** or **10% or more in the last 180 days**

0. No 1. Yes

29. NUTRITIONAL APPROACHES (K5)

Check all that apply in last 7 days

a. Parenteral/IV
b. Feeding tube

30. PARENTERAL OR ENTERAL INTAKE (K6)

Skip to item 31 if neither 29a nor 29b is coded

a. Code the proportion of total calories the resident received through parenteral or tube feedings **in the last 7 days**

0. None
1. 1% to 25%
2. 26% to 50%
3. 51% to 75%
4. 76% to 100%

b. Code the average fluid intake per day by IV or tube feedings **in last 7 days**

0. None
1. 1 to 500 cc/day
2. 501 to 1000 cc/day
3. 1001 to 1500 cc/day
4. 1501 to 2000 cc/day
5. 2001 or more cc/day

31. ULCERS (M1)

Record the number of ulcers at each ulcer stage — regardless of cause. If none present at a stage, record "0". Code all that apply **during last 7 days**. Code 9 for 9 or more.

a. Stage 1 A persistent area of skin redness

b. Stage 2 A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater

c. Stage 3 A full thickness of skin is lost, exposing the subcutaneous tissues

d. Stage 4 A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

32. PRESSURE ULCERS (M2a)

Code pressure ulcers for the highest stage **in the last 7 days** (0=None, stages =1, 2, 3, or 4)

33. OTHER SKIN PROBLEMS OR LESIONS (M4)

Check all that apply in last 7 days

a. Burns (second or third degree) (M4b)

b. Open lesions other than ulcers, rashes, cuts (M4c)

c. Surgical Wounds (M4g)

34. SKIN TREATMENTS (M5)

Check all that apply in last 7 days

a. Pressure relieving device(s) for chair

b. Pressure relieving device(s) 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 dressings (with or without topical medications) other than to feet.

h. Application of ointments/medications (other than to feet)

35. FOOT CARE PROBLEMS (M6)

Check all that apply in last 7 days

a. Infection of the foot – e.g., cellulitis, purulent drainage (M6b)

b. Open lesions on the foot (M6c)

c. Application of dressings (with or without topical medications) (M6f)

36. TIME AWAKE (N1)

Check appropriate time periods over the last 7 days the Resident was awake all or most of time (i.e., naps no more than one hour per time period) in the:

a. Morning
b. Afternoon
c. Evening

37. INJECTIONS (O3)

Record the **number of days** injections of any type received **in last 7 days**. If none, enter "0".

38. SPECIAL TREATMENTS AND PROCEDURES (P1)

a. SPECIAL CARE – Check treatments received **during the last 14 days**

a. Chemotherapy (P1aa)
b. Dialysis (P1ab)
c. IV medication (P1ac)
d. Oxygen therapy (P1ag)
e. Radiation (P1ah)
f. Suctioning (P1ai)
g. Tracheostomy care (P1aj)
h. Transfusions (P1ak)
i. Ventilator or respirator (P1al)

b. THERAPIES – *Record the number of days and total minutes each of the following therapies was administered (for at least 15 minutes a day)* ***in the last 7 calendar days.***

Note: Count only therapies provided after admission for extended care swing bed services.

(A) = # of days administered for **15 minutes or more**
(B) = total # of minutes provided in the **last 7 days**

	DAYS (A)	MIN (B)
a. Speech language pathology and audiology		
b. Occupational therapy		
c. Physical therapy		
d. Respiratory therapy		

39. NURSING REHABILITATION/ RESTORATIVE CARE (P3)

Record the number of days each of the following was provided to the resident for **more than or equal to 15 minutes per day in the last 7 days**. (Enter 0 if none or less than 15 minutes per day.)

a. Range of motion(passive)
b. Range of motion(active)
c. Splint/Brace assistance
d. Bed mobility
e. Transfer
f. Walking
g. Dressing or grooming
h. Eating or swallowing
i. Amputation/ Prosthesis Care
j. Communication

40. PHYSICIAN VISITS (P7)

In the last 14 days (or since swing bed admission/ readmission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident. (Enter 0 if none.)

41. PHYSICIAN ORDERS (P8)

In the last 14 days (or since swing bed admission/ readmission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter 0 if none).

42. ORDERED THERAPIES (T1)

Skip unless this is a PPS 5 day or PPS Readmission/Return assessment.

a. **Ordered Therapies:** Has physician ordered any of the following therapy services to begin in the **FIRST 14 days of stay** — physical therapy, occupational therapy or speech pathology services. (T1b)

0. No 1. Yes

If No, skip to item 45.

b. **Through day 15**, provide an estimate of the number of days when at least 1 therapy can be expected to be delivered. (T1c)

c. **Through day 15**, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered. (T1d)

43. CASE MIX GROUP (T3)

Medicare State

44. HIPPS Code

45. SIGNATURE (R2)

a. Name/Signature of RN Coordinating Assessment

b. Date RN Assessment Coordinator signed as complete