

MINIMUM DATA SET (MDS) - Version 3.0 RESIDENT ASSESSMENT AND CARE SCREENING

****DRAFT**** *Nursing Home and Swing Bed OMRA (NO/SO) Item Set* ****DRAFT****

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
4. **Change of therapy** assessment

Enter Code

D. Is this a Swing Bed clinical change assessment? Complete only if A0200 = 2

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

A0310 continued on next page

Section A

Identification Information

A0310. Type of Assessment - Continued

Enter Code <input type="checkbox"/>	E. Is this assessment the first assessment (OBRA, PPS, or Discharge) since the most recent admission? 0. No 1. Yes
Enter Code <input type="checkbox"/>	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

A0410. Submission Requirement

Enter Code <input type="checkbox"/>	1. Neither federal nor state required submission 2. State but not federal required submission (FOR NURSING HOMES ONLY) 3. Federal required submission
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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

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A0800. Gender

Enter Code <input type="checkbox"/>	1. Male 2. Female
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A0900. Birth Date

	- - - - -
	Month Day Year

A1000. Race/Ethnicity

↓ Check all that apply	
<input type="checkbox"/>	A. American Indian or Alaska Native
<input type="checkbox"/>	B. Asian
<input type="checkbox"/>	C. Black or African American
<input type="checkbox"/>	D. Hispanic or Latino
<input type="checkbox"/>	E. Native Hawaiian or Other Pacific Islander
<input type="checkbox"/>	F. White

Section A**Identification Information****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:**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:**A1600. Entry Date (date of this admission/reentry into the facility)**

— —

Month Day Year

A1700. Type of Entry

Enter Code

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

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

Section A**Identification Information****A2100. Discharge Status**

Complete only if A0310F = 10, 11, or 12

Enter Code <input type="text"/>	<ol style="list-style-type: none"> 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
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A2300. Assessment Reference Date**Observation end date:**

— —
 Month Day Year

A2400. Medicare Stay

Enter Code <input type="text"/>	<p>A. Has the resident had a Medicare-covered stay since the most recent entry?</p> <ol style="list-style-type: none"> 0. No → Skip to B0100, Comatose 1. Yes → Continue to A2400B, Start date of most recent Medicare stay <p>B. Start date of most recent Medicare stay:</p> <p style="text-align: center;"> — — Month Day Year </p> <p>C. End date of most recent Medicare stay - Enter dashes if stay is ongoing:</p> <p style="text-align: center;"> — — Month Day Year </p>
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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 <input type="text"/>	<p>Persistent vegetative state/no discernible consciousness</p> <ol style="list-style-type: none"> 0. No → Continue to B0700, Makes Self Understood 1. Yes → Skip to G0110, Activities of Daily Living (ADL) Assistance
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B0700. Makes Self Understood

Enter Code <input type="text"/>	<p>Ability to express ideas and wants, consider both verbal and non-verbal expression</p> <ol style="list-style-type: none"> 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
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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**

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 D0100, Should Resident Mood Interview be Conducted?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 minutes0. **Memory OK**1. **Memory problem****C1000. Cognitive Skills for Daily Decision Making**

Enter Code

Made decisions regarding tasks of daily life0. **Independent** - decisions consistent/reasonable1. **Modified independence** - some difficulty in new situations only2. **Moderately impaired** - decisions poor; cues/supervision required3. **Severely impaired** - never/rarely made decisions

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**

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	<input type="checkbox"/>	<input type="checkbox"/>
B. Feeling or appearing down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>
C. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>
D. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>
E. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down	<input type="checkbox"/>	<input type="checkbox"/>
G. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>
I. States that life isn't worth living, wishes for death, or attempts to harm self	<input type="checkbox"/>	<input type="checkbox"/>
J. Being short-tempered, easily annoyed	<input type="checkbox"/>	<input type="checkbox"/>

D0600. Total Severity Score

<input type="text"/>	Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30.
Enter Score	

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?
<input type="checkbox"/>	0. No
	1. Yes

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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	
	<input type="checkbox"/>	A. Physical behavioral symptoms directed toward others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually)
	<input type="checkbox"/>	B. Verbal behavioral symptoms directed toward others (e.g., threatening others, screaming at others, cursing at others)
	<input type="checkbox"/>	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 <input type="checkbox"/>	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
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E0900. Wandering - Presence & Frequency

Enter Code <input type="checkbox"/>	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
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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 ↓	
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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)

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

Section H

Bladder and Bowel

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**

H0500. Bowel Toileting Program

Enter Code **Is a toileting program currently being used to manage the resident's bowel continence?**
 0. **No**
 1. **Yes**

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

Infections	
<input type="checkbox"/>	I2000. Pneumonia
<input type="checkbox"/>	I2100. Septicemia
Metabolic	
<input type="checkbox"/>	I2900. Diabetes Mellitus (DM) (e.g., diabetic retinopathy, nephropathy, and neuropathy)
Neurological	
<input type="checkbox"/>	I4400. Cerebral Palsy
<input type="checkbox"/>	I4900. Hemiplegia or Hemiparesis
<input type="checkbox"/>	I5100. Quadriplegia
<input type="checkbox"/>	I5200. Multiple Sclerosis (MS)
<input type="checkbox"/>	I5300. Parkinson's Disease
Pulmonary	
<input type="checkbox"/>	I6200. Asthma, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease (e.g., chronic bronchitis and restrictive lung diseases such as asbestosis)
<input type="checkbox"/>	I6300. Respiratory Failure

Section J**Health Conditions****Other Health Conditions****J1100. Shortness of Breath (dyspnea)**

↓ Check all that apply

 C. Shortness of breath or trouble breathing **when lying flat****J1550. Problem Conditions**

↓ Check all that apply

 A. Fever **B. Vomiting**

Section K**Swallowing/Nutritional Status****K0300. Weight Loss**

Enter Code <input type="checkbox"/>	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
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K0500. Nutritional Approaches

↓ Check all that apply

<input type="checkbox"/>	A. Parenteral/IV feeding
<input type="checkbox"/>	B. Feeding tube - nasogastric or abdominal (PEG)

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

Enter Code <input type="checkbox"/>	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 <input type="checkbox"/>	B. Average fluid intake per day by IV or tube feeding 1. 500 cc/day or less 2. 501 cc/day or more

Section M

Skin Conditions

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

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

Enter Number <input type="text"/>	<p>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</p> <p>1. Number of Stage 2 pressure ulcers</p>
Enter Number <input type="text"/>	<p>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</p> <p>1. Number of Stage 3 pressure ulcers</p>
Enter Number <input type="text"/>	<p>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</p> <p>1. Number of Stage 4 pressure ulcers</p>
Enter Number <input type="text"/>	<p>F. Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar</p> <p>1. Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar</p>

M1030. Number of Venous and Arterial Ulcers

Enter Number <input type="text"/>	Enter the total number of venous and arterial ulcers present
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M1040. Other Ulcers, Wounds and Skin Problems

↓ Check all that apply

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

Section M

Skin Conditions

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

Section N

Medications

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**

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

E. Tracheostomy care

F. Ventilator or respirator

Other

H. IV medications

I. Transfusions

J. Dialysis

M. Isolation or quarantine for active infectious disease (does not include standard body/fluid precautions)

Section O

Special Treatments, Procedures, and Programs

O0400. Therapies

A. Speech-Language Pathology and Audiology Services

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Days

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

- 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

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Days

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

- 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

Enter Number of Minutes

Enter Number of Minutes

Enter Number of Days

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

- 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

Section O

Special Treatments, Procedures, and Programs

00400. Therapies - Continued

Enter Number of Days <input type="text"/>	D. Respiratory Therapy
	2. Days - record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days

00450. Resumption of Therapy - Complete only if A0310C = 2 or 3 and A0310F = 99

Enter Code <input type="text"/>	<p>A. Has a previous rehabilitation therapy regimen (speech, occupational, and/or physical therapy) ended, as reported on this End of Therapy OMRA, and has this regimen now resumed at exactly the same level for each discipline?</p> <p>0. No → Skip to O0500, Restorative Nursing Programs</p> <p>1. Yes</p> <p>B. Date on which therapy regimen resumed:</p> <p style="text-align: center;"> <input type="text"/> - <input type="text"/> - <input type="text"/> Month Day Year </p>
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00500. 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
<input type="text"/>	A. Range of motion (passive)
<input type="text"/>	B. Range of motion (active)
<input type="text"/>	C. Splint or brace assistance
Number of Days	Training and Skill Practice In:
<input type="text"/>	D. Bed mobility
<input type="text"/>	E. Transfer
<input type="text"/>	F. Walking
<input type="text"/>	G. Dressing and/or grooming
<input type="text"/>	H. Eating and/or swallowing
<input type="text"/>	I. Amputation/prostheses care
<input type="text"/>	J. Communication

Section Q

Participation in Assessment and Goal Setting

Q0100. Participation in Assessment

Enter Code <input type="text"/>	A. Resident participated in assessment
	0. No 1. Yes
Enter Code <input type="text"/>	B. Family or significant other participated in assessment
	0. No 1. Yes 9. No family or significant other
Enter Code <input type="text"/>	C. Guardian or legally authorized representative participated in assessment
	0. No 1. Yes 9. No guardian or legally authorized representative

Section X**Correction Request****X0100. Type of Record**

- | | |
|------------------------------------|---|
| Enter Code
<input type="text"/> | <ol style="list-style-type: none"> 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
<input type="text"/> | Type of provider <ol style="list-style-type: none"> 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
<input type="text"/> | <ol style="list-style-type: none"> 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
<input type="text"/> | A. Federal OBRA Reason for Assessment <ol style="list-style-type: none"> 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
<input type="text"/> | B. PPS Assessment <p><u>PPS Scheduled Assessments for a Medicare Part A Stay</u></p> <ol style="list-style-type: none"> 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 <p><u>PPS Unscheduled Assessments for a Medicare Part A Stay</u></p> <ol style="list-style-type: none"> 07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment) <p><u>Not PPS Assessment</u></p> <ol style="list-style-type: none"> 99. Not PPS assessment |

X0600 continued on next page

Section X**Correction Request****X0600. Type of Assessment - Continued**

Enter Code <input type="checkbox"/>	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 4. Change of therapy assessment
Enter Code <input type="checkbox"/>	D. Is this a Swing Bed clinical change assessment? Complete only if X0150 = 2 0. No 1. Yes
Enter Code <input type="checkbox"/>	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 <input type="checkbox"/>	Enter the number of correction requests to modify/inactivate the existing record, including the present one
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X0900. Reasons for Modification - Complete only if Type of Record is to modify a record in error (X0100 = 2)

↓ **Check all that apply**

<input type="checkbox"/>	A. Transcription error
<input type="checkbox"/>	B. Data entry error
<input type="checkbox"/>	C. Software product error
<input type="checkbox"/>	D. Item coding error
<input type="checkbox"/>	E. Add resumption of therapy date
<input type="checkbox"/>	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**

<input type="checkbox"/>	A. Event did not occur
<input type="checkbox"/>	Z. Other error requiring inactivation If "Other" checked, please specify: _____

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

Section Z

Assessment Administration

Z0100. Medicare Part A Billing

Enter Code <input type="text"/>	<p>A. Medicare Part A HIPPS code (RUG group followed by assessment type indicator):</p> <p>B. RUG version code:</p> <p>C. Is this a Medicare Short Stay assessment? 0. No 1. Yes</p>
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Z0150. Medicare Part A Non-Therapy Billing

	<p>A. Medicare Part A non-therapy HIPPS code (RUG group followed by assessment type indicator):</p> <p>B. RUG version code:</p>
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Z0300. Insurance Billing

	<p>A. RUG Case Mix group:</p> <p>B. RUG version code:</p>
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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